Assessment Report

WASH Social behaviours and practices assessment in Anaka Cluster of towns (Anaka, Amuru, Purongo, Koch Goma and Olwiyo) under the GIZ “Sanitation for Millions” (S4M) Programme, Uganda.

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List of Abbreviations and Acronyms

AMR	Antimicrobial Resistance
ADHO-EH	Assistant District Health Officer-Environmental Health
BCC	Behaviour Change Campaign
BOQs	Bills of Quantities
CBO	Community Based Organization
CDOs	Community Development Officers
CME	Continuous Medical Education
CAPI	Computer Aided Personal Interviews
EWB-USA	Engineers Without Borders-United States of America
FGDs	Focus Group Discussions
FS	Faecal Sludge
FSM	Faecal Sludge Management
FSMEs	Faecal Sludge Management Enterprises
GBV	Gender-Based Violence
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GoU	Government of Uganda
HCFs	Health Care Facilities
H/As	Health Assistants
HH	Household(s)
HIs	Health Inspectors
HIV/AIDS	Human Immuno Virus/Acquired Immuno Deficiency Syndrome
H/Ts	Head Teachers
HWF	Hand Washing Facility
HWWS	Hand Washing with Water and Soap
IEC	Information Education Communication
IPC	Infection Prevention & Control
IR	Inception Report
JMP	Joint Monitoring Programme
KAPs	Knowledge, Attitude, Practices
KCCA	Kampala Capital City Authority
KIs	Key Informants
KII	Key Informant Interviews
LC I	Local Council I
MHHM	Menstrual Health & Hygiene Management
M&E	Monitoring & Evaluation
MoES	Ministry of Education and Sports
MoH	Ministry of Health
MSPH	Makerere School of Public Health
MWE	Ministry of Water & Environment

NWSC	National Water and Sewerage Corporation
OD	Open Defecation
O&M	Operation & Maintenance
OPD	Out-Patients Department
PHA	Public Health Act
PHC	Primary Health Care
PTA	Parents Teachers Association
PWDs	People with Disabilities
RAs	Research Assistants
RDC	Resident District Commissioner
RHITES	Regional Health Integration to Enhance Services
RUMPs	Re-Usable Menstrual Pads
SAR	Situation Analysis Report
SFG	School Facilities Grant
SHC	School Health Club
S4M	Sanitation for Millions
SDGs	Sustainable Development Goals
SF	Sanitation Forum
SFD	Shit Flow Diagram
S&H	Sanitation and Hygiene
SMC	School Management Committee
SOW	Scope of Work
SP	Sanitation Promoter
STF	Sanitation Task Force
SWM	Solid Waste Management
SWT	Senior Woman Teacher
TSP	Town Sanitation Plan
UBOS	Uganda Bureau of Statistics
UNICEF	United Nations International Childrens Education Fund
UPE	Universal Primary Education
USE	Universal Secondary Education
USHA	Uganda Sanitation for Health Activity
VHTs	Village Health Teams
WBTs	Water Borne Toilets
WASH	Water, Sanitation & Hygiene
WHO	World Health Organization
WinS	WASH in Schools
WSDF	Water and Sanitation Development Facility

EXECUTIVE SUMMARY

1.0 Introduction

This report presents findings of an assessment titled: “Water, Sanitation and Hygiene (WASH) Social Behaviours and Practices Assessment in Anaka Cluster of Towns (Anaka, Amuru, Purongo, Koch Goma and Olwiyo) under the GIZ “Sanitation for Millions” (S4M) Programme, Uganda”. The overall purpose was to undertake a social behaviour and practices assessment to ascertain the existing WASH knowledge, attitude, behaviours, and practices at institutional and households in the Anaka cluster towns to inform implementation of awareness and mobilisation measures of the project

2.0 Methodology

The knowledge and social practices assessment adopted a mixed methods approach using both qualitative approaches involving key informant interviews (KIIs) with GIZ’s partner institutions and quantitative approaches involving surveys in households (HHs) and Institutions (schools, health care facilities-HCFs, religious places and markets). Although a sample of 305 households (HHs) were statistically determined across the five small towns, a total of 323 were actually interviewed. A take all strategy was applied for schools and health facilities while purposive sampling was used for religious centres and major markets. These methods were supported by observations especially of WASH facilities in the HHs and in the various institutions.

3.0 KEY FINDINGS AND RESULTS

3.1 DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Out of the 323 respondents reached by the study, female-respondents at HH level constituted 57.2 %. Majority (40.8%) of these respondents are youth and fell within the age bracket of 35-49 years, while 31.8% were between 25-34 years. In many HHs (62.7%), primary school education was the highest level of education completed by the household heads, which may have an implication on the promotional approaches to be used by GIZ S4M programme and partners to reach the target audience.

Recommendation:

- GIZ S4M and partners adopts use of simple but effective approaches such as drama performances by selected local folk groups, who will be identified and trained on the messaging before conducting performances in communities.

Household occupancy status

Most HHs (90%) in Anaka cluster of towns own their houses and also own the land on which their houses are built. This means that utmost, only 10% of the populations are not at liberty to easily build latrines, as they do not own the land. In Amuru, ownership of the land stands at 96%, followed by Anaka at 91%; the town councils of Purongo, Koch Goma and Olwiyo follow closely at 90%, 88% and 82%, in that order. 90% ownership of land on which to build sanitation infrastructure is good finding for the GIZ S4M programme because, unlike other towns where majority of residents are tenants, the HHs in the Anaka cluster can be targeted to build and use their own latrines on their own land.

Household income

The main source of income at HH level was subsistence farming (85.5%), with only 1.6% of the targeted population in wage employment. The relatively highest proportion of farmers is in Purongo town council (95%) and least in Anaka (75%); Olwiyo Town Board had over 93%, Amuru (92%) and Koch Goma (82%). Majority (40.2%) of HHs earn below 50,000 UGX per month and only 10.9% earn above 500,000 UGX. Olwiyo had the highest proportion of its HHs earning below 50,000 UGX at 77%, followed closely by Anaka at 66%. Purongo, Amuru and Koch Goma had 35%, 20% and 14% earning less than 50,000 UGX per month, in that order. Interesting to note is that Purongo town council had relatively more HHs earning more than 500,000 UGX per month (11%). The implication of these statistics is that incomes of majority of HHs is seasonal. Additionally, the number of female-headed HHs was equally high, averagely 32% across the five cluster towns which points to possible vulnerability.

Recommendations

- GIZ S4M and partners will need to intensify promotion targeting to increase the rate of purchase and uptake of improved latrine products and services particularly during harvest time when farmers have some money.
- There will be need for well-targeted subsidies by the GIZ S4M programme for some of the vulnerable HHs.

3.2 WASH AT HOUSEHOLD-HH LEVEL

Access to water services at HH level

Access to safely managed water in Anaka cluster of towns is still very low with only 6.4% of the HHs having access to safe water within their premises with the majority (46.6%) having the water source between 1-5 kilometers. No HH was reported to access water more than 5 kilometers from their dwelling. Olwiyo town had relatively the highest proportion (60%) of HHs having their main water source less than 200 meters from their premises; however, no HH in this town reported having water within their premises, except Anaka town council that stood at 31%, followed by Koch Goma (12%), and Purongo (7%). All the four towns of Purongo, Olwiyo, Amuru and Koch Goma except Anaka rely heavily on boreholes, with 90% of the population of Olwiyo using this infrastructure type as its main source of drinking water. Functionality stood at 97%. 23.2% treat water by chlorinating and 61% by boiling, though this figure contradicts the existing beliefs and practices related to drinking boiled water. 3.39 % of the respondents did not know what method to use to make the water clean or safer.

The main concerns of the residents in the five towns with regard to access to safe water were varied, ranging from intermittent supply (e.g. Anaka and Purongo town councils); high cost of water; poor paying culture and behaviour leading to disconnection (Purongo); poor attitude and beliefs of residents towards piped water (e.g. in Anaka and Purongo town councils); poor Operation & Maintenance (O&M) of existing point water sources such as boreholes (Purongo); and town councils with inadequate improved water supply (such as Amuru town council and Olwiyo town board).

The other challenges were the social beliefs and practices related to water use, as some of the existing point water sources such as boreholes in some of the towns such as Amuru

are affected by negative practices such as witchcraft and poisoning. Consequently, boreholes are left for one HH or family to use. There is belief in use of unprotected water sources with some residents reported to pay up to UGX 500 per 20-liter e.g., in Anaka town council. Hence there is need for mindset and attitudinal change towards piped water as some people were reported to detest piped water due to the test of residual chlorine.

A section of the community (e.g., in Purongo town council) has a belief that water from boreholes and unprotected sources tests sweeter; that boiled drinking water does not have freshness and therefore is not sweet to drink. Some people claimed that their thirst is not quenched when they drink boiled water. There is also a belief that some children in the community developed diarrhea because of drinking boiled or tap water, and that children cannot fall sick after consuming borehole water because it is considered safe; they also believe that children cannot get sick from drinking unboiled water because they get used to drinking it directly right from childhood, and hence develop immunity.

Recommendations

- NWSC & Umbrella utilities need to improve and provide reliable water services to motivate residents to make HHs connections and to pay for services.
- WSDF/MWE needs to fast-track construction of water supply system for Amuru town
- Umbrella Authority needs to take over management of Koch Goma town council water system and plan for a new source to augment the existing smaller system.
- NWSC & Umbrella should conduct marketing of water services to the HHs (e.g., in Anaka and Purongo town councils) to counter the identified negative behaviours, attitudes and beliefs. This may also include use of radio programmes to sensitize HHs & communities.

Access to HH sanitation services

In the five towns, access to sanitation services as per the JMP ladder was: Basic, 28.6 %; Limited, 22.2%; Unimproved, 39.2%; and Open Defecation (OD), 10%. The town with the highest prevalence of OD was Amuru town (40.6%), OD was lowest in Purongo and Olwiyo town councils at 0.9 %, followed by Anaka town at 1.3%. Purongo and Olwiyo have the highest proportion (71.5%) of HHs with unimproved sanitation services, followed by Koch Goma town at 61.4%. To note is that Anaka town council had the highest proportion of HHs with basic sanitation services, owing to the fact that it is more developed than all the other towns in the cluster; while Koch Goma had the lowest proportion of HHs with basic sanitation services (1.8%).

Recommendation:

GIZ S4M & partners should target the HHs with unimproved latrines/toilets to improve or upgrade to basic, those with limited to construct their own latrines, and put more effort in ending OD in Amuru town council. Therefore, two of the priority behaviours for the Behaviour Change Campaign (BCC) should be:

- ***Build new/upgrade an improved, individual household toilet facility (HHs)***
- ***End the practice of open defecation (HHs)***

Latrine type, ownership and use in HHs

A total of 87.1% of HHs owned latrines/toilets in the five towns, which corresponds to the finding on occupancy. Over 90% of the HHs predominantly use on-site sanitation systems i.e., ordinary traditional unlined or unimproved pit latrines, which has an implication on pit emptying. 57.2% use traditional pit latrines without slabs (57.2%), followed by pit latrines

with slab (35.7%); only 1.9% of the HHs own flush toilets. Koch Goma town had the highest number of HHs with latrines built with slabs (43.9%), followed by Purongo/Olwiyo (39.8%), Anaka (39.5 %) and lastly Amuru (21.7%). Amuru town council had the highest proportion of HHs with no latrines/toilets. The survey data shows 22.8% of respondents were unsatisfied with sharing of latrines, as this has an impact on use of toilets because often shared toilets have unhygienic outcomes.t

Recommendations:
GIZ S4M & partners should target:
- the 87% individual HHs to construct basic latrines since these HHs own land on which their houses are built.
- the 13% Landlords in the five cluster towns to construct their own latrines and for their tenants. Liaise with NWSC or Umbrella-North (and the town councils*) that is willing to share with the programme partners the list of landlords who use water services.

Construction & maintenance of HH latrines/toilets

There were two issues the study assessed that affect adoption and use of improved toilets in communities: one is, who takes a decision at HH level to construct latrine/toilet; and secondly, who does the actual construction (owner Vs service provider). Issues of gender roles and decision-making are also an important element in latrine construction. In the majority (76.5%) of the HHs within the cluster of towns, the decision to construct the toilet was made by the men as heads of the HHs. However, men rarely attend S&H sensitization meetings.

Recommendation:
- GIZ S4M & partners should target selling/marketing improved toilets and hygiene services to the 68% of male-headed HHs to construct and use improved latrines/toilets. Male HH heads should be targeted as key decision-makers in latrine construction, which may involve either finding them at home, their places of work or their drinking joints.

Who constructs latrines in the HHs

The study established that several HHs (70.8%) contracted professional services to assist with the construction of toilets, with the highest percentage (86.4%) being in Amuru town, which may explain why the cost of latrine construction was higher in this town. Anaka town had the least proportion (69.9%) of HHs contracting professional service providers to construct latrines. These statistics point to the fact that there exists already some service providers (masons) for latrine construction, although the current quality of latrines is poor.

Recommendations:
- GIZ S4M & partners need to identify (with support from communities & local leaders) and build the capacity of masons to offer better services given the quality of latrines currently in use; equip masons with the necessary tools (such as BoQs) to provide information to HHs on how to construct improved toilets and to market their services.
- Health Assistants (H/As) and Health Inspectors (HIs) will need to play a role to guide HHs on the required standards.

Knowledge & awareness on WASH at HH level

Due to limited funding and hence limited outreach by the HIs and H/As, it was estimated by some of the KIs that only about 30% of HHs in Anaka cluster of towns are aware of WASH issues, particularly those who have been to school. A high number of HHs (82.3%)

had knowledge that having no pit latrines leads to spread of diseases but the practice was different as evidenced by the high levels of OD. Knowledge levels in Olwiyo, Purongo and Koch Goma towns were relatively lower than the other two towns of Anaka and Amuru.

Recommendation:
Use innovative participatory approaches such use of local folk groups and radio programs to conduct sensitizations and create awareness about the dangers of OD and the benefits of improved WASH to motivate HHs to construct and use improved latrines/toilets. Therefore, the BCC campaign should:

- promote behaviours from a positive side (prestige, convenience, privacy, durability, safety, no smell, family pride, … as opposed to shame, disgust, …)
- focus on changing one additional priority behaviour around "***consistent and proper use and maintenance"*** and keeping latrines clean to keep away flies.

Existing community level structures

The study established that there exists a Ministry of Health-MoH structure of Village Health Teams (VHTs) at village/cell level that communities and HHs believe in. It was confirmed that communities love VHTs; they sensitize communities on Sanitation and Hygiene (S&H) and how to keep homes hygienically clean. They ensure homes have pit latrines, bathrooms, and wires for hanging clothes.

Recommendation:

- GIZ S4M & partners should consider working with VHTs particularly as Sanitation Promoters (SPs) or Sales Agents to market and conduct door-to-door sells to persuade/convince HHs to purchase improved sanitation products and services. However, this will require training VHTs on WASH and on their roles as SPs.

Current Sanitation & Hygiene (S&H) beliefs, norms and practices at HH level

Sanitation and hygiene practices of concern in the Anaka cluster of towns include practice of OD especially in Amuru town council, unhygienic practice of use of polythene bags aka "kaveera" or "flying toilets", poor disposal of childrens' faeces; lack of handwashing with water and soap (HWWS) after toilet use and after cleaning babies after defecation. Other poor S&H practices include construction of poor-quality latrines; poor use and maintenance of existing latrines; and sharing of latrines between a number of households with no clear responsibilities for cleaning, hence misuse which leaves existing latrines dirty. The major reasons for the rampart practice of OD include ignorance about the dangers of OD; negative attitude and beliefs; few or no latrines (both household and public); and availability of bushes around the towns as an alternative option for defecation. Periodic water quality testing by NWSC in Anaka town, for example, has found traces of E.coli in drinking water

Some of the cultural myths, beliefs and practices that the GIZ S4M programme and partners have to deal with are the following: i) a pregnant woman does not use a toilet because they think they will deliver or drop the foetus in the pit latrine and lose their baby; Therefore, pregnant women were reported to be the biggest culprits of OD particularly at health centers; ii) belief that "you do not look where you have defecated"; iii) belief of not disposing babies' faeces in the latrines because it is considered safe; iv) the belief that defecation in the bush (OD) is normal; and v) the belief that the more faeces one has in his/her compound, the wealthier or a sign of more food or ability to feed the family.

Recommendations

- GIZ S4M and partners should adopt use of MoH S&H Social Behaviour Change (SBC) materials under the "Living Freshi" Brand".
- Develop BCC campaign materials focusing on changing the identified negative behaviours, beliefs and attitudes at HH and community level; focus messaging around two additional key priority behaviour i.e., ***"children's faeces management" and the "unhygienic practice of use of polythene bags/"kaveera" or "flying toilets".***

Factors limiting HHs from constructing & using improved latrines in HHs

Some of the major factors that limit people in the Anaka cluster of small towns from constructing and using improved toilet facilities include the following: i) low levels of education; ii) cultural myths, beliefs and practices; iii) poor attitude (including that of local leaders); iv) lack of knowledge and information about other available or alternative toilet/latrine options; v) lack of experts such as trained masons to provide information and guide households to construct better quality toilets; vi) inadequate water to facilitate adoption of waterborne (WBTs) or pour-flash toilets; and v) inadequate capacity of town councils (e.g. to enforce laws such as the Public Health Act-PHA).

Recommendations:

- Develop a clear delivery, sales and marketing model to achieving basic sanitation, while learning from previous projects (e.g., USAID-USHA; and GIZ S4M-Apac Cluster)
- Aim at addressing/removing barriers to HH investment in sanitation (e.g., develop best-fit products for the target market, including options for difficult soils; train & mentor sales agents/SPs/VHTs; on-board masons as sanitation entrepreneurs; unlock financing).
- Trigger and change the attitude of local leaders (e.g., cultural-Rwot Kweri, religious, political) who have influence on HHs and communities
- Use a phased approach to reach HHs and communities because market-based sanitation takes time to develop in low-income or poor areas such as Olwiyo and Amuru towns.

Access to household hygiene services

Handwashing devices and practices

Over 70% of the HHs in the Anaka cluster lacked designated Handwashing Facilities (HWFs) and only 22% of the HHs had identifiable handwashing place; 9% of the HHs in the cluster had HWFs within their HHs, but these were not observed by the enumerators. Koch Goma town had the highest number of homes with no HWFs standing at 89% while Purongo/Olwiyo had the least (60%). Amuru and Anaka towns had 61% and 73% with no HWFs within their HHs respectively, which is still negatively significant. Amuru town council had the highest proportion of HWFs within their HHs and observed at 36% while Koch Goma had the least proportion of HHs with observed HWFs within their HHs at 9%. Anaka and Purongo /Olwiyo town councils had 13% and 25% of their HHs with observable HWFs respectively. Majority of the HHs had a movable container also known as "jerry-can" as the handwashing device (58.3%), especially in Amuru town council, where over 84% of the HHs had this device.

Amuru town council had the majority of HHs with soap at the HWF (34.8%) while Purongo and Olwiyo towns had the least proportion of HHs with soap or ash at the HWF or next to the toilet (1.8%). Anaka and Koch Goma town councils had 7.9% and 10.5% of their HHs with soap or ash present at or near the handwashing facilities, respectively. The HH heads

were responsible for making the decision to buy soap at all times, regardless of gender of the HH head as revealed during the Focus Group Discussions (FGDs).

Knowledge of critical times when to wash hands with soap at HH level

The majority of HHs (55.9%) had knowledge that hands need to be critically washed before eating food, while 64% had knowledge that hands are to be washed after using the toilet. This means that close to about 33% of the population did not know that hands are to be washed after using the toilet and this trend was similar across the five towns. Again, knowledge and awareness on the need for hand washing at critical times was found to be quite high, but the practice was very low. The practice of hand washing with water and soap (HWWS) was reported to have ended with the end of the COVID-19 pandemic.

Recommendations

- One additional priority behaviour for the BCC campaign should be on ***"hand washing with soap and water in HHs and communities".***
- Develop clear and consistent messages on HWWS to include critical times when to WASH hands with water and soap including:
  - Before eating food
  - Before feeding a baby
  - After using the toilet
  - After cleaning the baby who has defecated
- Develop BCC materials on hand washing with soap and water, to be informed by the above messages.
- Demonstrate cheaper options of hand washing devices but also the "how to properly wash hands".

Access to information on WASH at HH level

Overall, in the Anaka cluster, the survey showed that radios were the most frequently used source of information on WASH (30.2%), followed by health workers (23.8%) and community health volunteers/VHTs (18%). Notably, using print media to relay WASH information was non-existent, while use of TV and social media was very low. GIZ S4M & partners need to take note of the frequently used channels through which communities and HHs readily get information on WASH for future BCC.

With regard to exposure to WASH messages, a smaller proportion of HHs in the Anaka cluster were exposed to some form of information on WASH, either through seeing WASH messages (e.g., on posters) or through attendance of community meetings, where WASH issues were discussed (e.g., at 77% of the meetings attended). Amuru reported that 93% of the community meetings attended discussed WASH, followed by Purongo (92.3%). Koch Goma had the least proportion of HHs attending these meetings and discussing sanitation related issues (45%).

Further analysis showed that overall, 53% of the population in Anaka cluster had ever attended a community meeting, while 41% said they saw a WASH message in the past 12 months. Respondents from Purongo town council were more likely to attend community meetings (70%) and see a WASH message (48%), while respondents from Olwiyo were the least likely to attend a community meeting (37%) and get exposed to WASH messages (11%).

Sources of information about latrine/toilet construction at HH level

VHTs, Health Assistants and Health Inspectors and LC1s are the most common source of information in the community about latrine/toilet construction and use, pit emptying and hand washing, within the cluster, across board. The least source of information were the masons yet they play a critical role in toilet construction.

Use of Radio as a source of information at HH level

Overall, over 61.7% of the HHs in Anaka's cluster of towns listen to radio. Koch Goma had the highest proportion of HHs who listen to radio at 75%, followed by Anaka and Amuru at 71% and 65 % respectively. Unfortunately, the reverse is true in Olwiyo and Purongo with about 54% of the HHs who do not listen to radio, in both cases.

In terms of listenership to radio, Mega FM, Rupiny and Voice of Nwoya FM are the most listened to radios. Mega FM102 is the most listened to radio station (42%), followed by Rupiny FM (34.7%) and Nwoya FM (31.8%). To note is that these radios appeal to different audiences as Favour FM was said to appeal to Born Again Christians; Rupiny, is listened to majorly by young people; Mega FM appeals to older people; while Voice of Nwoya is listened to by everyone. The least listened to Radios are Mega FM 100, Gulu FM and Radio Maria with 5% of the respondents mentioning these radios respectively. In terms of the preferred language, as expected, Luo is by far the most preferred language for listening (96%) and reading (75%), among the respondents.

Recommendations

- GIZ S4M & partners should use radio as a tool of communication to sensitize communities so as to bring about mind-set change, while being mindful of the different radios that appeal to different audiences.
- Develop a BCC strategy to provide knowledge and reinforce awareness, so that people know and buy into the promoted improved latrines and behaviour(s).
- Adopt the use of community meetings in towns such as Purongo as a strategy to pass on WASH messages and information.

3.3 WASH AT INSTITUTIONAL LEVEL

The social practices assessment covered mainly two types of institutions: schools (both primary and secondary government aided schools); and healthcare facilities-HCFs (i.e., HCF IIs and HCFs IIIs) including one general hospital located in Anaka town council.

Assessment on WASH practices in schools

Background characteristics of schools

Majority of the schools accessed are in Anaka Town Council (6), 3 in Koch Goma, another 3 in Amuru, 4 in Purongo, and only one assessed in Olwiyo town; 11 out of 17 schools assessed were primary schools. Only 36% (6,082) of the learners were females with majority of the learners being males (64%; 10,956). There were no refugee pupils registered in the assessed cluster schools.

Access to water services in schools

Schools in town councils without piped water such as Olwiyo and Amuru depend on point water sources such as boreholes, while schools in town councils with piped water systems

such as Anaka and Purongo use both point water sources and tap water. However, the water from the piped systems was reported to be unreliable. A total of 16 schools out of the 17 assessed have safely managed water on their premises and with water available at the time of the visit. A total of 12 (70.5%) schools had access to boreholes, while 5 (29.4%) schools had access to tap/piped water outside dwelling. Where piped water exists, due to increased bills, head teachers had the tendency to limit use and direct it to only critical areas such as kitchens and not to latrines/toilets (e.g., Anaka P7 school). Generally, O&M was a challenge in all schools, with the communities leaving the repair of broken-down wells to only schools.

Sanitation service levels and practices

A total of 12 (70.6%) schools had access to and were using VIP drainable latrines, while the pupil: stance ratio was 60:1 for boys and 81:1 for girls; the overall Pupil: stance ratio for all schools was 73:1 which is quite high compared to the national standard, which is 40:1. School latrines were found to be shared with communities in six (35.2%) out of 17 schools, while OD was found practiced in 4 (23.5%) out of the 17 schools. Sharing of school toilets with neighbouring communities negatively impacts use and maintenance of toilets. A total of 10 (58.8%) of the 17 schools assessed had ever emptied their latrines/toilets, with manual pit emptying practiced by all schools because it was considered available, cost effective and efficient.

The major sanitation challenges faced in schools included vandalism, poor workmanship, regular filling up of latrines, lack of pit emptying service providers; locking up of toilets and denying learners access during the day e.g. in Anaka P.7 schools; poor use and maintenance; inadequate water; poor hygiene practices by learners (e.g. dirty latrines and practice of OD); poorly designed latrines; and low practice of hand washing with soap, despite 88.2% of schools reporting installation of HWFs. Additionally, 14 out of 17 schools assessed reported to have School Health Clubs (SHC); however, of these, only 10 were reported to be functional.

Awareness of schools about WASH

Overall learners in the assessed schools in the Anaka cluster were reported to be aware and knowledgeable about S&H issues, because majority of schools (94%) have appointed teachers in charge of WASH issues. However, to note is that information on WASH was not adequate or being put in practice as evidenced by poor management of the sanitary facilities which is exacerbated by lack of adequate water in the schools.

Recommendations:

1. Develop and implement a comprehensive Schools WASH approach with a clear end-in-mind, which focuses on software measures and changing the bad S&H practices identified by the study. Consider promotion of three priority behaviours & messages in schools:
   - ***Consistent and proper use of toilets***
   - ***Practice of hand washing with water and soap at critical junctures***
   - ***Proper menstrual hygiene management***
2. Develop and/or print BCC campaign materials, while borrowing a leaf from previous projects such as S4M Phase I (Apac Cluster) and the USAID funded Uganda Sanitation for Health Activity (USAID-USHA). Examples of BCC materials include Snakes & Ladders games, jingles, behaviour calendars, posters, champion badges, etc.
3. Train teachers on BCC and how to use the materials to engage learners to change behaviours.

4. Support schools to construct and/or rehabilitee toilets in schools with inadequate facilities, especially those without drainable toilets; and address the issue of disposal of used menstrual pads through construction of incinerators.
5. Support installation of adequate HWFs in strategic locations in each school e.g., near the toilets, and next to the dining and/or eating areas; and sensitize learners, so they all know how to wash hands and the critical times when to WASH hands.
6. Paint nudges in strategic places / locations such as toilet walls with key hygiene messages to promote behaviours but also to reinforce or keep learners reminded of hygiene messages.
7. Involve and strengthen all key stakeholders and school level structures: the head teachers and teachers; the SMC; PTAs; the Learners (SHC) and parents so they are aware of their roles and responsibilities on WASH in schools.
8. Support each school to develop an O&M plan and budget for incorporation in the overall schools' work plans and budgets on an annual basis.

Assessment on WASH practices in Health Care Facilities (HCFs)

The assessment focused on understanding and appreciating the existing practices on WASH; healthcare waste management systems and environmental cleanliness as per the JMP service ladder for monitoring WASH in HCFs as well as the Ministry of Health's National Guideline for WASH in Health Care Facilities-HCFs (2021).

Access to water services in HCFs

Anaka General Hospital-GH has its own piped water system with two production wells; however, the GH has intermittent water supply due to inadequate planning and budgeting for O&M. Consequently, all the departments in the GH were found connected to the water supply system but had no running water because the system was not working effectively because of lack of qualified technical personnel to help run the system.

The rest of lower-level HCF IIIs and IIs that were assessed use point water sources such as boreholes which are located on the HCF premises. However, this was viewed as a big challenge because in a HCF III, for example, there is need for running water especially in the laboratories, the maternity wards and in the examination rooms. O&M of the point water sources was a challenge, since the water facilities are shared with the neighbouring communities around the HCFs. Additionally, some of the HCFs did not have a management and operational plan in place for WASH.

Sanitation Service Levels in HCFs

Anaka GH has two (2) blocks of latrines of two stances each: one for OPD and one for in-patients but for a hospital which receives on average 300 patients a day, these facilities are inadequate. All buildings (departments and wards) have flush toilets but these were closed due to lack of water and high volume of patients, except for hospital staff who use pour-flush system. A beautiful washing facility for clothes provided for in the hospital is non-functional and the toilets close to this facility were also closed due to lack of running water. The GH also has a lagoon which is not functioning well, with blockages in the system leading to faecal matter being discharged into the environment.

The lower level HCFs that were assessed have drainable latrines which were all functional, except three (3) HCFs assessed had less than 50% of the required number of stances. All HCFs reported lack of proper bathing or washing facilities for the general wards, besides the in-patient and OPD toilets. Regarding pit emptying all the HCFs, except

Anaka GH, practice manual pit emptying of latrines because it is the cheaper option available but is unhygienic. Disposal of Faecal Sludge-FS is onsite. Most of the HCF IIIs reported to have incinerators; however, they do not have ash pits.

In terms of provision of sanitation for different gender, girls and women have access to latrines and toilets; however, one HCF assessed did not have clearly demarcated toilet facility for females. All toilet facilities had no provision for buckets inside the toilets for disposal of menstrual pads; there were no incinerators and no changing rooms besides the toilets to take care of the needs of women. There are no washing places and bathrooms close to the in-patient and OPD toilets. OD is practiced in HCFs by pregnant women, because of traditional beliefs of pregnant women not using toilets.

Use and maintenance of sanitary facilities in HCFs

Anaka GH and the lower level HCFs all employ cleaners for toilets who clean toilets on a daily basis; however, despite this, majority of the healthcare sanitary facilities were dirty and littered with faecal matter due to misuse by patients and caregivers. Patients and caregivers were also reported not to use the right anal cleaning materials. The HCFs expressed the prevalent delay in the receipt of cleaning products as well as disinfectants, because of delayed disbursement of funds by GoU to the National Medical Stores for purchase and distribution of the necessary supplies and products to HCFs around the country.

Hand Hygiene in the HCFs

It was established that majority of patients who come to the hospital and lower level HCFs are aware about the importance of washing hands, but people do not put knowledge into practice. The assessment also established that HCFs (Anaka GH inclusive) were flooded with hand washing stations during the Covid-19 pandemic but since the pandemic ended, the facilities are either broken down or non-existent (read stolen), and hence there is no effective hand washing with soap and water particularly by patients and their caregivers.

Solid Waste Management in the HCFs (including medical waste)

Anaka GH has a garbage bank for temporal solid waste storage outside the main gate of the hospital. However, solid waste was reported to take long in the hospital before it is collected and hauled away for disposal by the town council. As for the lower level HCFs, the H/As and/or HIs are responsible for the establishment of waste bins in and around the health centers and ensuring that the cleaners collect these regularly and burn them in the pit. The cleaners dispose of the solid waste at the rubbish pits regularly, where it is burnt. All the HCFs practice sorting of medical waste at the generation point, where these are sorted into highly infectious, infectious, sharps, etc. However, the current practice is that these are mixed at the time of disposal.

Governance/Existence of Infection Prevention Control-IPC Committees

All HCFs assessed, except one (Anaka GH), had IPC committees after the interventions by Makerere University School of Public Health-MUSPH. The IPCs help to: i) sensitize staff, community and patients about infection prevention including in the wards and at home; and on WASH ii) Continuous Medical Education (CME) to remind staff; and iii) contact tracing (hand hygiene, how to prevent coughing/technique of coughing, waste disposal, rubbish pits including distance of rubbish pit from home), etc.

The study established that the HCFs receive PHC funding but the guideline on how it is supposed to be utilized, how much is planned and budgeted for, and how much is received was not clear to the team, yet this would be one of the sources of funding to support the work of IPC committees.

Recommendations:

Develop and implement a comprehensive WASH in HCFs programme which focuses on software measures and changing the bad practices identified by the study; and a BCC campaign with clear messages. Some of the key recommendations include the following:

1. Facilitate formation of a small committee of 5-6 people to discuss and agree on how to rectify the faults with the water system in Anaka GH.
2. Support HCFs to construct WASHaLots at strategic locations within each HCFs.
3. Enhance O&M capacity of WASH facilities for all HCFs, but also facilitate the development of O&M plans and budgets, per HCF (for integration into overall HCF plan & budget).
4. Work with the H/As, HIs and VHTs in each town council to engage clients in and around HCFs on WASH.
5. Follow-up the use of PHC funds in the HCFs to facilitate the Health Assistants to conduct sensitizations of patients and care-givers and communities within a radius of 5 kms from the HCFs.
6. IPC members should target clients during clinic days to pass on WASH messages (e.g. clinic days for clients with chronic illnesses such as TB and HIV/AIDS; and/or antenatal clinics.
7. Consider adoption of GIZ's "Toilet Make Grades-TMG" and tailor it to HCFs, to encourage competitions between healthcare facilities (*see details in the conclusion sub-section*).
8. Urgently support Anaka GH and the lower level HCFs to address gaps in hardware e.g. the rehabilitate the hospital lagoon for treatment of FS and construction of new or rehabilitation of existing sanitary facilities in HCFs and ensure provision for washrooms and incinerators for women (patients and caregivers).

3.4 WASH IN PUBLIC PLACES (E.G. MARKETS & CHURCHES/MOSQUES)

Public sanitation facilities are always found on highways, markets, and taxis and/or bus parks majorly meant to help the residents as well as the transient population. The biggest challenges with public sanitation in the five Anaka cluster of towns are five: one, is that facilities are inadequate; secondly, is that existing management structures do not know their roles and responsibilities; thirdly, is limited knowledge especially on how to use waterborne toilets-WBTs (e.g., in Anaka town council market); fourthly, is the poor use and management of the existing latrines; and lastly is lack of water.

Access to WASH services in the markets

Access to water services in the markets

For S&H to be improved, the markets must have access to water. Unfortunately, all markets in the five small towns do not have any source of water inside the markets. Overall, reasons for inadequate access to water in the markets is more administrative but unfortunately has kept the hygiene of the markets very poor.

Access to sanitation services in the markets

The assessment established that there are existing latrines that serve each market; however, besides being inadequate, the facilities are not in good working conditions due to poor O&M and are not sex-segregated. Neither do the current toilet facilities have

provisions for people living with disability (PWDs). Overall, all the five (5) small towns lack adequate public sanitary facilities (e.g., in the taxi parks); the few existing ones serve mainly markets. They also lack hand washing facilities with soap and/or water. There were also concerns about the location of some of the toilets, for example, in Anaka town council the market toilet is located outside the market which contributes to its misuse.

Current management models for public latrines

The management model adopted for the existing public latrines is either by the Town Councils (TCs), who tender out management to private operators/market masters/Tenderers, or by utility companies such as Umbrella organizations (e.g., for Purongo town council highway sanitation facility). However, despite generation of adequate revenue all the public latrines in the town council markets currently suffer from O&M challenges due to unclear roles and responsibilities between the town councils and the Tenderers.

Hand hygiene services and practices in the markets

The number of people who are knowledgeable about good hygiene practices in the markets (e.g., Anaka market) is high, estimated at about 60%. However, the practice of hand washing with soap and water at critical times is very low because: i) hand washing facilities or service is non-existent at the toilets; and ii) inadequate access to water services.

Willingness and ability to pay for use of public toilets

The assessment established that there is willingness to pay for use of public toilet and bathroom services as long as the facilities are functional and offering a good service. For example, in Anaka town council market, on ordinary days, users pay UGX 200/= per use while on the big market/auction days they pay UGX 500/= to use the toilet.

Governance of town council markets

All markets in the Anaka cluster of towns are managed by Town Councils, who tender out day-to-day management to private operators aka Market Masters or Managers or Tenderers. The sole responsibility of Tenderers is basically to collect daily revenue from market vendors and remit an agreed amount of funds to the town councils per month. Tenderers are willing to play a role in improving WASH in the markets, only if access to services can be improved by the town councils and other duty bearers.

Recommendations

- Support the construction of adequate sex-segregated drainable public toilets (pour flush) in the markets and other public spaces such as taxi parks and/or rehabilitate existing toilets, and ensure provision of facilities/stances for the disabled, washrooms for women, bathrooms and incinerators.
- GIZ S4M programme considers construction of WASHaLots closer to the public sanitary facilities in the markets and other public spaces to aid the practice of handwashing with water and soap by market vendors and other transient population.
- Conduct Training of Trainers (ToT) for the Market leadership and town councils on proper O&M of sanitary facilities; and develop and share with them the BCC materials on the “dos” and “don’ts” of public toilets (in local language).
- Umbrella should support the town councils to review agreements with Tenderers and to breakdown the roles and responsibilities of the Market stakeholders i.e. Town council and Market Operators/Masters/Tenderers.

- Consider the option of tendering management of public toilets to private operators, independent of Market Masters/Tenderers, so that toilets become a source of revenue for the town councils; training the private operators on the basics of managing public toilets and how to plan and budget for recurrent costs such as consumables and toilet emptying.
- NWSC and Umbrella should extend water services/connections inside the markets.

ASSESSMENT ON WASH AT THE RELIGIOUS CENTRES

Status of WASH at the Religious places of worship

The study selected sites for assessment on WASH to represent the mainstream churches and mosques and thus selected three sites: a mosque in Koch Goma town council, a Catholic Church in Anaka town council and an Anglican church in Purongo town council. Unfortunately, Anaka Catholic church did not have a toilet facility as the only available toilet was inside the Parish Priest's residence; Christians use a toilet located at the nearest Library. On the other hand, Purongo Church of Uganda (CoU) also did not have a toilet as Christians were reported to use the facility at a nearby school. Therefore, the information included here was basically picked from an interaction with a key informant at a mosque in Koch Goma town council.

Access to water at the mosque

The study established that the mosque has access to piped water supply. Aware that Muslims need to use water before prayers are held, water was extended and a meter installed at the mosque. Management of the water system periodically serve the mosque with the water bills, to which the Muslim community that pray at the mosque make contributions.

Access to sanitation at the mosque

Koch Goma mosque has a 3-stance drainable toilet, which is inadequate hence the need for another toilet facility. At the time of assessment, there was written information on the toilet walls, indicating the toilet was full and encouraging people to pay at least Ugx. 200= for using the toilet, to raise funds for pit emptying.

With regard to access to sanitary facilities by the vulnerable members, the assessment established that although the mosque has people with mobility problem who come for prayers, there was no provision of stances for people living with disability. Such people were reported to use the same existing toilet as-is.

Knowledge and awareness of the Muslim community on WASH

The key informant said that to Muslims the issue of water, sanitation and hygiene is obvious, as the community knows it very well as one of the principles in Islam. However, the Muslim leaders at the mosque only play a role of reminding the community about it.

Hand washing with soap practices

Regarding HWWS, it was established that hand washing was the order of the day in Islam; however, though the Muslim community do wash without soap. Overall, very few people were reported to wash their hands, as it is not a very common practice especially among the non-Muslims.

Pit emptying practices

On pit emptying, the study established that manual pit emptying was by the Mosque since it was too expensive (approx. UGX 800,000) to hire a cesspool truck from Gulu city. Due to limited resources, the mosque took a decision in 2023 to use the unhygienic manual pit emptying method. A pit was dug onsite for disposal of the faecal sludge.

MHHM practices at the mosque

When asked whether the existing latrine facility at the mosque supports girls and mothers when they are in their menstrual people cycle at mosque, the response was that it is taboo because the Islamic teaching does not allow a menstruating woman to come to the Mosque for prayers. Under the Islamic law a menstruating woman is supposed to pray from home.

Recommendations:

- GIZ S4M programme considers construction of toilet facilities and WASHaLots at each mainstream place of worship in each town, equip the religious leaders with skills to manage the sanitary facilities.
- Conduct training on S&H and messaging for the religious leaders and trigger them to lead by example and to influence their congregants to improve sanitation and change negative behaviours.

3.5 ASSESSMENT ON MENSTRUAL HEALTH & HYGIENE MANAGEMENT

Menstruation is an integral and normal part of human life, indeed of human existence. Menstrual Health & Hygiene Management (MHHM), therefore, has been identified as a specific priority for improving the health, welfare and dignity of women and girls. The assessment specifically focused on understanding the knowledge, attitude and practices on menstruation including access to information; access to materials for managing menstruation (including issues of availability and affordability); as well as access to sanitary facilities that provide privacy for changing, washing and drying menstrual materials. The assessment on MHHM was conducted in the HHs/communities, institutions (schools & HCFs), and at public spaces (e.g., markets).

Knowledge and information on menstruation

Access to information on menstruation is very important for women and girls, so that they do not get shocked especially before their first menstruation periods but also to help women keep clean and avoid infections; to manage pain and other discomforts; and also, to remove stigma particularly from boys and men. The assessment established that currently MHHM is a neglected area in communities and public places such as markets as women do not have any particular place or organization providing information on menstruation. Neither were there specific on-going projects or programmes on MHHM at the health centers.

For young adolescent girls, awareness on MHHM is relegated to schools (especially Senior Women Teachers & by programs of agencies such as Save the Children or Watoto), although this varies across schools. The implication of this is that out-of-school girls are left out. The assessment also established that currently focus on MHHM in schools is on the girl-child, leading to boys laughing at girls (stigmatization) when they are in their menstrual periods. Girls are also not adequately helped to manage menstrual pain.

Cultural practices, beliefs and taboos on menstruation

The assessment established that there are no very serious cultural practices, beliefs or taboos in the Anaka cluster of towns in relation to menstruation that specifically affect the health of women. However, women and girls are usually told not to leave the used pads or menstrual cloth in the open anyhow for anyone to see because someone can malice a woman or girl with it by doing witch craft. Some of the myths and taboos on menstruation that will need to be demystified include: if a woman is in her periods, she should not go to a tomato garden, groundnuts garden and pumpkin garden as these will shrink and dry up or start rotting; so the woman can first attend to other gardens until she is has stopped menstruating.

Access to menstrual materials to absorb/catch menstrual blood

The assessment established that some women and girls in Anaka cluster of towns use disposable pads, which are usually available at the shops but which are quite costly. One pack of 7-8 pads costs UGX 3,500-4,000 yet a woman or girl may need 1-3 of these packs, depending on how heavy the floor of blood is. Schools provide emergence disposable pads, while some HCFs in Koch Goma benefited from donations of pads by the Japanese government. However, some schools reported interventions by a social enterprise called "Lutino Adunu" who taught girls how to make reusable pads from cotton cloth. Generally, the women and girls who cannot afford pads use pieces of cloth. Information from key informants (health workers) indicates that generally women do not know how to use pads, and that their hygiene is very poor.

Access to sanitary facilities during menstruation

Private space and washrooms are very important for women and girls to wash and change menstrual materials during menstruation periods. Women and girls also need appropriate sanitary facilities for disposal of used menstrual materials especially for those who use disposal pads. They also need soap and water for washing during menstruation.

In the communities of Anaka cluster of towns, mothers or older women ensure that girls have their own sleeping room where they can have their privacy. For the bathroom and toilets, the girls use whatever facilities are available for use by everybody else in the family. On the other hand, toilets used by market vendors were found not be women-friendly because they have no changing rooms, which means women have to go back to their homes in case of need for washing or changing (e.g. during menstruation).

In schools, girls reported use of school toilets but which unfortunately were dirty and do not offer a conducive environment for girls to change; school toilets have no provision for washrooms. Schools and public places such as markets do not have incinerators, with the most common practice of girls and women market vendors dumping their used pads in the latrines, which makes girls' latrine facilities to fill-up faster (compared to the boys' latrines in schools) and pit emptying more difficult. As a result, schools resorted to manual pit emptying, because it is cheaper and more efficient.

Recommendations:

- One additional behaviour for adoption by the S4M programme is ***"proper menstrual hygiene management***"; develop or adopt BCC materials with messages such as "Don't throw pads into pits".

- Develop and implement a comprehensive MHHM program in communities, schools, HCFs and markets that covers:
  - awareness creation and provision of information on MHHM, targeting both boys and girls; and men and women.
  - demystifying the various taboos, myths and beliefs
  - male (boys & men) involvement- to fight stigma, for them to know that menstruation is normal and to be supportive of the girls and women during menstruation.
  - training on the different options/alternative materials for catching menstrual blood (including re-usable pads)
- Engage Latino Adunu Social Enterprise to implement MHHM programmes.
- Support construction of toilets in schools and public places with provisions for washrooms and incinerators for disposal of used menstrual pads.

3.6 FAECAL SLUDGE MANAGEMENT IN HOUSEHOLDS & INSTITUTIONS

The assessment considered the entire sanitation service chain which comprises of containment of faecal matter, emptying of the containment, collection for transportation, treatment of the Faecal Sludge (FS), and the end-use or disposal of FS end products. Each of these components of the FSM service chain forms a crucial component for the successful implementation of any sanitation programme. The assessment focused on understanding the existing practices related to pit emptying, availability of pit emptying services, and the willingness to pay for pit emptying services in the HHs and in institutions (schools, HCFs, churches).

Pit Emptying Practices in the HHs and institutions

With over 90% of town residents in the five towns using unlined traditional pit latrines, the study established that demand for pit emptying at HH level is limited; unlined pit latrines when emptied especially by cesspool trucks tend to collapse. Therefore, majority of pit latrines that fill-up are abandoned. Pit emptying in the Anaka cluster was found to be mainly practiced by schools, hotels and lower-level health care facilities (HCFs), who practice the unhygienic manual pit emptying because it is a cheaper, readily available option, and is more efficient than hiring a service provider from Gulu city, a distance of over 50 km away. The determinant for the pit emptying method chosen is availability of a service provider, standing at 76.9%; an interesting finding is that the cost of emptying latrines/toilets was not a key determining factor for choice of pit emptying method.

Existence of Pit Emptying Service Providers

Until recently when Umbrella Authority acquired a cesspool truck, the only cesspool emptying services available was from Gulu city. Therefore, lack of pit emptying service providers within the Anaka cluster of towns has contributed to schools and HCFs adopting the unhygienic practice of manual pit emptying. One of the biggest challenges reported facing schools & HCFs and is the high cost of draining pit latrines/toilets because: i) girls' latrines in schools fill-up faster than for boys; and ii) of dumping used menstrual pads by women and girls in the latrines. The other challenge with pit emptying in institutions is the type of anal cleansing materials used by learners, which ranges from grass, leaves, stones and maize cobs which negatively impact the pit emptying process by cesspool emptiers because of foreign materials (hard solids) introduced into the pits.

Faecal Sludge-FS Disposal Practices

Although towns such as Anaka are growing at a fast rate, it was established that there is no standard lagoon for treatment of faecal sludge. It is only Anaka GH that owns a small lagoon for the influent but O&M is a problem; there is a blockage in the drainage system and therefore raw untreated sewage flows into the environment i.e., into peoples' nearby gardens which is a health risk. The other existing treatment plant is in Gulu city, a distance of 70+ km from Anaka or Amuru towns. Therefore, manual pit emptiers practice onsite dumping whereby usually a hole is dug behind the toilets, and the FS poured in the hole and covered.

Recommendations:

- Support Northern Umbrella Utility to implement the FSM model developed with support from GIZ S4M programme which centres on scheduled emptying and leasing. Accompany it with a well thought-through marketing strategy for promoting safe pit emptying.
- Support the construction of a lagoon for treatment of FS in Anaka Cluster, while working closely with the Water and Sanitation Development Facility-North (WSDF-N).
- Support Anaka GH to rehabilitate the lagoon for treatment of faecal waste from the hospital.
- Focus project interventions to increase the target market size through promotion of emptiable HH toilets e.g., improved basic latrines (lined).
- Promote other pit emptying options/enterprises such as the Gulper (Long-term) which is more suitable for emptying the type of existing household toilets/latrines in the Anaka Cluster of towns; interest the manual pit emptiers to adopt the Gulper technology to improve their pit emptying services.

3.7 ACCESS TO FINANCIAL SERVICES FOR SANITATION

The study sought to understand the available of financing options, what challenges HHs have faced to access financial services; how access to financial services can be improved; prioritization of investment for WASH household level; and the monthly cost of water and sanitation to the households (be it on infrastructure or sanitation and hygiene).

Ownership of a bank account is one of the important requirements for clients to access loans. Overall, 34.7% of HHs had bank/mobile money accounts. Owning/accessing bank/mobile money was lowest in Amuru (13%) and highest in Koch Goma (68.4%). Anaka and Purongo/Olwiyo towns had 35.5% and 35.8% of its HHs with bank/mobile accounts.

Access to loans in the Anaka cluster varied substantially across towns. In Amuru and Purongo towns, only 2.9% and 3.6% of HHs had ever accessed loans, respectively; access to loans was highest in Anaka (15.8%) and Koch Goma (12.3%). Amuru town had relatively the lowest proportion of HHs accessing loans at 2.9%. Overall, only 8 % of the residents in Anaka Cluster of towns had ever accessed a loan. Majority of the loans accessed for WASH related expenses especially toilet/latrine construction/renovation, were obtained from the commercial banks (47.8%), followed by VSLAs (30.4%), money lenders (8.7%) and relatives/friends (2%).

Post Bank (the only bank in Anaka Cluster) provides WASH loans for both individuals and businesses. However, the manager at Post Bank in Anaka town indicated that the uptake of the WASH loans was not so good and probably stands at 10% domestic as majority who take these loans are commercial farmers. The reasons advanced by the bank for this

status quo included inadequate sensitization of communities about the loans, among others.

Recommendations:
- Identify local money lending institutions to partner with such as PostBank and VSLAs.
- Support the money lending organization to create awareness and market the loan products.
- Subsidize the costs e.g., capitation, so that this can contribution to reduction of the final costs of the loan for the HHs. There will also be need to know the impact of the loans through a proper monitoring system.
- Provide well targeted subsidies to households for toilet construction, especially targeting the most vulnerable HHs such as women-headed households.

3.8 WASH GOVERNANCE

Assessment on the legal & policy environment for WASH

The major policy document that guides implementation of S&H in the small towns is the Public Health Act (PHA), which is in place but not effective because it is not enforced. Other than that, the study established that the small towns in the cluster have no sanitation bye-laws. However, other policies and guidelines exist that the five town councils can benefit from and hence will need to be disseminated by GIZ S4M and the MWE regional structures. Examples include the FSM and the PHC Guidelines. Majority of towns were supported by GIZ to develop Town Sanitation Plans (TSPs), except Koch Goma which is a newly created town council. However, implementation of the TSPs is poor and needs follow-up. Allocation of a % of local revenue and/or PHC grant to S&H is also not adequately happening.

Stakeholders' coordination

According to the new structure by Ministry of Local Government, a small towns town is supposed to have a Principal Health Inspector, a Health Inspector, a Health Assistant, and an Environmental Officer in-charge of Natural Resources Management (NRM). However, the assessment established that not all these staff are on-board in the town councils; majority of town councils have only Health Inspectors and Health Assistants in place. The other second important stakeholders in the five small towns are the regional structures of Ministry of Water and Environment (i.e. WSDF, NWSC and Northern Umbrella), who are spearheading provision of WASH services. Others include development partners such as Save the Children, CEFORD and GIZ, Health Centers In-charges, private companies such as cesspool emptying company from Gulu; the political wing including the mayors and the RDCs. Overall, coordination of WASH is not very well streamlined in the five town councils, which could be improved the Sanitation Task Forces in each town can be reactivated to meet regularly, at least once a quarter.

Recommendations:
- The Northern Umbrella Utility and WSDF-North should support the Town Councils in Anaka cluster of towns to re-activate the Sanitation Task Forces (STFs) as coordination mechanism for S&H
- GIZ should support an exchange visit to Apac cluster for the Anaka Cluster of towns to appreciate how their counter parts managed to improve on S&H in their town councils.

1 INTRODUCTION

1.1 BACKGROUND

This report presents findings of an assessment titled: Water, Sanitation and Hygiene (WASH) Social Behaviours and Practices Assessment in Anaka Cluster of Towns (Anaka, Amuru, Purongo, Koch Goma and Olwiyo) under the GIZ "Sanitation for Millions" (S4M) Programme, Uganda. This follows a Contract signed between the GIZ S4M Project and the Consultant on the 1st June, 2023 for Provision of Consultancy Services to conduct the assessment. The social practices assessment was conducted in July 2023.

The social practices assessment report is organized in four (4) broad sub-sections: Section One provides background information, context and the purpose of the study; Section Two covers the methodology used to conduct the assessment and the persons met; Section Three focuses on discussing the findings; while the last Section Four highlights the conclusions, lessons learnt and recommendations for the future.

1.2 PROGRAMME OVERVIEW

The GIZ S4M programme objectives in Uganda is to provide improved access to adequate and equitable sanitation and hygiene services to vulnerable populations. The project builds upon the results from the previous phase of the implementation in Apac Cluster of towns (Apac Municipal Council, Aduku and Ibuje Town Councils) and Kampala Capital City Authority (KCCA). The demographic focus is on the urban disadvantaged and vulnerable population in the selected locations.

The project is currently supporting local authorities in Anaka cluster towns (Anaka, Amuru, Purongo, Koch Goma and Olwiyo) in their efforts towards improved and more equitable access to sustainable sanitation and hygiene at Health Care Facilities-HCFs, schools, religious institutions, public spaces, and households.

1.3 GENERAL OBJECTIVE OF THE ASSIGNMENT

To undertake a social behaviour and practice assessment to ascertain the existing WASH knowledge, attitude, behaviours, and practices at institutional and households in the Anaka cluster Towns of Anaka, Amuru, Purongo, Koch Goma and Olwiyo to inform implementation of awareness and mobilisation measures of the project.

1.4 SPECIFIC OBJECTIVES

- To undertake social practice assessment on the existing WASH behaviours and practices at all levels through interviews, observations, and focused group discussions.
- Describe the legal and policy environment for WASH in institutions and community level (regulations, guidelines, and standards). Make recommendations on the likely contribution by the project on improving the enabling environment.
- Identify gaps associated with WASH social behaviours and practices at governance (town council and district levels), institutional (Schools – existence of WASH clubs, its functionality, hygiene practices like toilet use other than open defecation, existence of

Operation and Maintenance (O&M) plans and budgets including Menstrual Health and Hygiene Management (MHHM) and hygiene routines such as toilet cleaning, handwashing, inspection etc.; Health Care Facilities (HCFs) – existence of Infection Prevention and Control (IPC) Committee, its functionality, existence of O&M plan and budget including MHHM and hygiene routines such as toilet cleaning, handwashing, inspection etc.) and household level (Toilet use other than open defecation, toilet cleaning, handwashing, solid waste disposal mechanisms etc.).

- Assess the existing knowledge and practices and identify major bottlenecks in the implementation of institutional and community WASH.
- Identify and make practical recommendations on how to address major factors like economic and social-cultural (e.g., taboos and beliefs) that may be affecting lack of sustainable improvement in the sanitation and hygiene situation in the region.
- Identify the existing Menstrual Health Management mechanisms at community and institutional level and recommend robust and sustainable actions to improve menstrual health management measures of the project.
- Undertake consultative engagements with the identified project implementation partners and GIZ technical officers to form a consensus on implementation of tasks, universal tools and methods, synergies for programming of awareness and mobilisation measures.
- Recommend appropriate knowledge, attitudes, and practices interventions (Behaviour Change Campaigns-BCC and trainings) in line with project results matrix and the 3-year operational plan for the project focus at institutions, community level and national level.

The results of the survey will provide the inputs needed for the review and refinement of the draft concepts and measures for WASH in Schools (WinS), WASH in HCFs and MHHM, so as for GIZ S4M to be able to implement an effective S4M programme in the Anaka cluster of towns. The assessment results will also inform the trainings and BCC strategy for sustained improvement in knowledge, attitude, and practices (KAPs) for improved WASH at institutions and communities in the Anaka cluster.

2 METHODOLOGY AND APPROACH

2.1 OVERALL DESIGN

The knowledge and social practices assessment adopted a mixed methods approach using both qualitative and quantitative approaches. The quantitative component involved structured interviews with project beneficiaries (households-HHs and managers of institutions) with a combination of a secondary data analysis of relevant data and information.

On the other hand, the qualitative component involved key informant interviews (KIIs) with project staff, local authorities' staff, and managers of GIZ's partner institutions (such as Makerere School of Public Health-MUSPH, Umbrella of Water and Sanitation-North, and Water and Sanitation Development Facility-North). These methods were supported by observations of WASH facilities in the HHs and at the various institutions (schools, health facilities, religious places and markets).

2.2 SAMPLE AND SAMPLING

2.2.1 Household (HH) Survey

For the HH survey component, the sample size was estimated with a 5% allowable error and a 95% confidence interval and assumed a maximum variability (p=0.5) for prevalence of the proportion of individuals with access to WASH among programme beneficiaries. The sample size calculation yielded a sample of **306** HHs. However, the HH sample size increased to 323 based on the increased in the number of villages/cells as ascertained and confirmed during the data collectors training. The 323 HHs were distributed proportionally across the 5 locations (small townships) based on their population sizes. Thus, a total of 21 cells/villages were included in the study.

2.3.2 Sampling plan for institutions

A take all strategy was applied for schools and health facilities such that all the 18 schools, the 10 health care facilities (HCFs) and 12 religious places were included in the study. However, for the markets, the Consultants sampled at least one market in each of the town councils.

For KIIs, key informants were chosen, selecting six at each level for national, regional, small town, institutions (Schools & HCFs) and community/HH level. The key informants were selected on the basis of their familiarity with WASH services at each of their levels and their anticipated roles in the project as well as their ability to articulate in detail, the challenges operating at different levels.

Focus Group Discussions (FGDs), were conducted in schools, markets, health facilities and communities. For each of the groups, between 6-8 respondents were included translating to a total sample size of up to 56 respondents for the FGDs.

2.3.4 Response rate

The response rate, provided as a percentage, was calculated as the number of eligible HHs for which an interview was completed, out of all HH structures listed/sampled excluding vacant HHs.

Table 2 1: Distribution of HHs across the 5 Cluster Towns

Town Council	Sample	Actual
Anaka Town Council	68	76
Amuru Town Council	68	69
Purongo Town Council	68	74
Koch Goma Town Council	68	69
Olwiyo Town Board	34	35
Total	**306**	**323**

2.3 DATA COLLECTION METHODS

2.3.1 Document and Literature Review

As a secondary source of data, thorough review of relevant literature and documents related to the water and sanitation programmes was conducted to understand the issues around WASH services delivery in the town councils and for purposes of gathering extra information which could otherwise not be gotten from the primary sources. Information gathered through the literature review supported the development and refinement of the methodology while at the same time providing key recommendations and lessons learnt at the end of the exercise. A list of all documents that were reviewed is included in Appendix 1.

2.3.2 Observations at Institutions and Public Places

Using tools such as observation checklists/guides embedded in the survey tools and camera, the Consultants observed and captured data on the as-is status of the existing WASH infrastructure and their condition/functionality in the selected HHs, Schools and HCFs as well as facilities and surrounding areas in markets and religious centres. Special attention was paid to capture information about the cleanliness of the toilets, bathrooms, and functionality of WASH facilities on the day(s) of the visit(s).

2.3.3 Key Informant Interviews (KIIs)

For each level (District Local Government/Town Council Authority and/or Community levels), key informant guides were developed to collect information about issues such as the implementation structure for Sanitation and Hygiene (S&H) and Solid Waste Management (SWM) in the small towns; the positive and negative S&H & SWM practices observed and/or experienced in communities/HHs and institutions (Schools & HCFs) and public spaces (markets & religious centres); the current social norms, taboos and beliefs, routine practices, perceptions and attitudes influencing behaviours around general S&H but with a specific focus on Menstrual Health and Hygiene Management-MHHM; and the Faecal Sludge (FS) disposal and treatment practices.

A total of 24 key informant interviews were conducted at the different levels (community, HCFs, town councils, district, schools, markets and churches). For each level, key informant guides were developed as presented in Appendix 2 to collect the required information.

2.3.4 Focus Group Discussions (FGDs)

In order to collect information during focus group discussions, FGD guides were developed and included information about the insights and knowledge about S&H and the current social norms, taboos and beliefs, routine practices, perceptions and attitudes influencing behaviours. Specifically, questions around MHHM were included to gain an understanding of the existing MHHM mechanisms; access to information on menstruation; access to menstrual products and materials; and the current menstrual hygiene practices and related cultural taboos and beliefs at the community level, among others. A total of 7 FGDs were conducted out of the planned 10 FGDs, representing 70% achievement. Copies of the FGD guides are included in Appendix 3.

2.3.5 Household-HH Survey Questionnaire

The questionnaire consisted of separate sections and modules covering generic topics (such as HH identification and informed consent) as well as specific information on the knowledge, attitudes and practices (KAPs) related to WASH. The HH survey questionnaire was developed in English and translated into the Luo language at the time of data collection for easy administration in the field. Pre-testing of the questionnaires was done in at least two villages/cells not selected as part of the survey within Anaka Town Council. The detailed HH survey tool that was used for the assessment is included in Appendix 4.

2.3.6 WASH in Schools (WinS) Assessment Tool

An assessment tool, as presented in Appendix 5, was developed to conduct WASH assessment in schools focusing on "software"/hygiene behaviours around three key behaviours: hand washing with water & soap (HWWS); proper & consistent use of toilets/latrines; and proper MHHM practices in the selected schools. Broadly, the survey captured generic data (e.g. name of schools; location of school; school level, learners' enrolment, # of teachers; and disabled learners' enrolment). In addition, the tool incorporated questions on the existence of key governance structures and individuals; knowledge of minimum WASH standards/policies; and awareness and use of Social Behaviour Change (SBC) materials and messages to aid learning on WinS.

2.3.7 Health Care Facility (HCF) Assessment Tool

The assessment in HCFs was conducted in three specific critical points of care: the Out-Patients Department/Ward; the Labour and Delivery Suits; and Post-natal care units. The Consultants adopted one of the most known tools for assessment on WASH in HCFs i.e., the WASHFit tool by WHO, while building on previous experiences of conducting similar assessments by agencies such as WaterAid Uganda, Engineers without Borders (USA), USAID-Uganda Sanitation for Health Activity (USHA); and Uganda Regional Health Integration to Enhance Services (RHITES-Acholi). The WASHFit tool covered four broad areas: water, sanitation (including health care waste management), hygiene (hand hygiene and environmental cleaning) and management. Each area included indicators and targets for achieving minimum standards for maintaining a safe and clean environment e.g. accessibility of toilets for persons with limited mobility such as women in labour or recently gave birth; women sanitation facility/menstrual hygiene equipment; general cleanliness of toilets and bathrooms; pit emptying practices; and healthcare & solid waste management. The HCF assessment tool is attached in Appendix 6.

2.4 FIELD PROCEDURES

2.4.1 Recruitment and training of Research Assistants (RAs)

For purposes of knowledge and skills transfer, individuals with experience in social research methods were identified and recruited as field data collectors in collaboration with the town councils and the GIZ Field team in Anaka Cluster. Preference was to work with data collectors identified from GIZ's partners (e.g. staff of the local government authorities'/town

councils such as Health Inspectors, Community Development Officers; and Inspectors of Schools). Preference was staff from the same targeted project areas because of their knowledge of local areas/context and local dynamics as well as knowledge of English and the local language (e.g. Luo/Acholi).
A total of 20 Research Assistants were recruited for this study and underwent a 2-days' training including field pretesting of data collection tools under the close supervision of the Consultant. Training included: i) extensive discussion of specific roles for each category of the research team; ii) data collection tools; iii) instructions on how to select respondents for each method of data collection; iv) the study design, population and sampling methodology; and v) common questions and answers.

After the training, the research team was divided into two teams: the team to assess WASH practices in the HHs and a team to conduct assessment in the institutions (schools, HCFs, and public spaces e.g. markets and religious centres). Two Supervisors were recruited, and their role was to supervise and ensure data is collected in the field; and to review data collected by each individual team on a daily basis for accuracy before uploading onto the server. Data collection took 15.5 working days in total.

2.4.2 Developing and testing the script on phones/tablets

For the HH and school survey interviews, the Consultant used Computer Aided Personal Interviews (CAPI). Using appropriate mobile data collection software, KoboCollect, the structured questionnaires were scripted by writing a program which facilitated interactive data capture during face-to-face interviews, ensuring that skip patterns were adhered to; and building appropriate validity and consistency checks into the questionnaire script. The Consultants and Supervisors had the rights to access the written programme and as such able to download data.

2.4.3 Quality Assurance

To ensure data quality, field data Consultant and the two supervisors held daily meetings to review the data collection process, to check data completeness and resolve any logistical or methodological issues. For HH and observation data at institutions, data quality was monitored in the field by the team supervisors, through sampling completed forms before they were uploaded to the server. In addition, the field supervisors made spot-checks with the data collectors while still in the field at the community or HH and institutional levels. Data validation (as for their completeness and quality) was performed before the analysis and checking a random sample of 5% of questionnaires during each day of data collection. A data manager/statistician was dedicated to this task.

2.5 DATA MANAGEMENT, ANALYSIS AND REPORTING

2.5.1 Quantitative data analysis and reporting

The Consultant used computer aided data collection for observations and HH surveys. HH and institutional observation data captured centrally was exported to STATA for checking and cleaning. Data cleaning instructions to guide the cleaning process was developed and a do file developed for this purpose. An analysis as well as a tabulation and report plan were

developed. Analysis took into account the different categories of the respondents and the different context of the 5 towns.

2.5.2 Qualitative data analysis and reporting

To analyse the qualitative data, the consultant used a blended approach of thematic and content analysis. A conceptual framework was developed, based on the assessment questions, to guide thematic analysis of the qualitative data. The framework specified the themes guiding the analysis, set out how the key assessment objectives would be addressed and enable analysis to be undertaken by variables such as category of respondent. Taking a grounded theory approach, the consultants undertook a content analysis, remaining open to unintended outcomes, themes, patterns and connections emerging from the data. The analysis involved drawing out key findings, identifying themes, patterns and issues relating to the focus of each assessment objective and project components.

3 FINDINGS OF THE STUDY

3.1 CHARACTERISTICS OF RESPONDENTS & HOUSEHOLDS

3.1.1 Characteristics of Respondent HHs

The survey included a total of 323 respondents in the Anaka Town Cluster. The number of participating HHs in each town council ranged from 35 in Olwiyo Town to 76 in Anaka Town Council. A HH was defined as a person or group of people who have been living and eating their meals together for at least 6 of the 12 months preceding the interview. The following categories of people were considered HH members even though they lived in the HHs for less than 6 months in the past 12 months: infants younger than 6 months old, newly married couples living together for less than six months, students and seasonal workers who have not been living in or as part of another HH, and persons living in the HH for less than 6 months who are expected to live in the HH permanently (or for a longer duration).

Figure 3.2 Distribution of Respondents by Sex

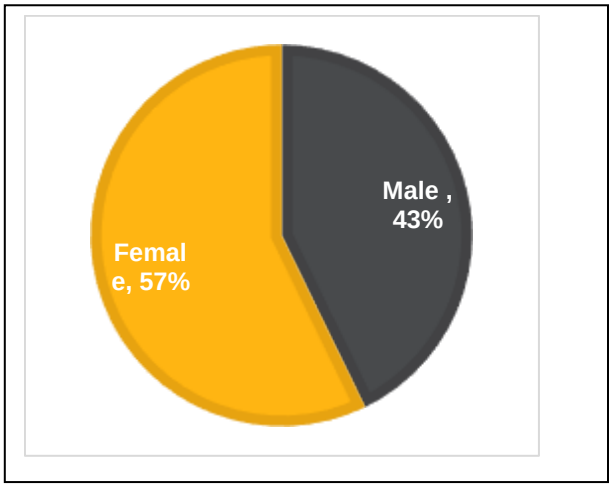
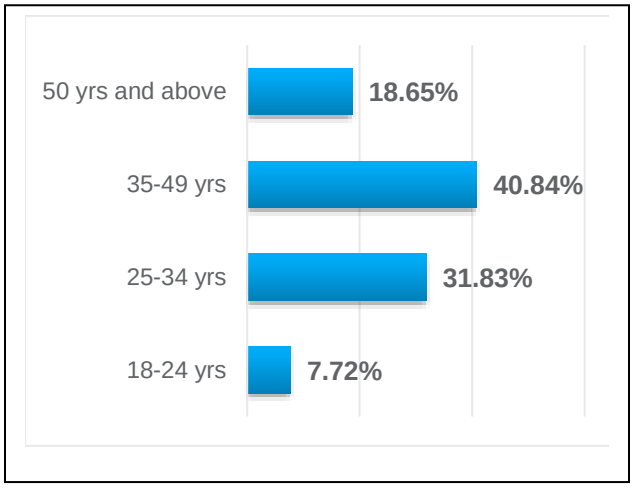


Figure 3.1 Distribution of Respondents by Age Group



Out of the 323 respondents reached by the study, female-respondents constituted 57.2% of the respondent HHs (see Figure 3.1 and Table 3.1). The highest proportion of respondents fell within the 35-49 years, with 40.8% (Figure 3.2). In many HHs (62.7%), primary school education was the highest level of education completed by the household heads, which may have an implication on the promotional approaches to be used by GIZ S4M programme to reach the target audience. The average HH size was 7.2 people, which is above the average HH size of 4.7 people in the country and 5.2 people in Northern Uganda as reported by the NPHC, (UBOS NHPC, 2017).

3.1.1 Household (HH) Characteristics

3.1.1.1 Household Occupancy Status

Most HHs in the Anaka Town Cluster are temporary (45.3%), while 32.2% of the HHs are permanent. Amuru town council has the highest proportion of HHs with permanent structures at 71%, followed by Purongo at 34% and Koch Goma at 30%. Interestingly, Anaka has only

12% of its HHs having permanent structures while Olwiyo has no HH with permanent structures.

Most of the HHs (90%) in Anaka cluster of towns own their houses and also own the land on which their houses are built (see Table 3.1). This means that utmost, only 10% of the populations are not at liberty to easily build latrines, as they do not own the land. In Amuru, ownership of the land stands at 96%, followed by Anaka at 91% of the HHs; the town councils of Purongo, Koch Goma and Olwiyo follow closely at 90%, 88% and 82%, in that order. Majority HHs (90%) ownership of land on which to build infrastructure is good finding for GIZ S4M programme because, unlike other towns where majority of residents are tenants, the HHs in the Anaka cluster can be targeted to build and use their own latrines on their own land.

Table 3.1 Household Occupancy Status

Household Occupancy Status						
%	**Amuru N=69**	**Anaka N=76**	**Koch Goma N=69**	**Olwiyo N=35**	**Purongo N=74**	**Overall**
Type of dwelling						
Permanent	71.0%	11.8%	29.8%	0.0%	33.8%	32.2%
Semi-Permanent	1.4%	31.6%	19.3%	5.7%	43.2%	22.5%
Temporary	27.5%	56.6%	50.9%	94.3%	23.0%	45.3%
Occupancy status						
Tenant/Rented	4.3%	9.2%	12.3%	17.6%	9.5%	9.7%
Owner/Landlord	95.7%	90.8%	87.7%	82.4%	90.5%	90.3%
Household Heads						
Female Head of HH	32%	33.5%	32.4%	32.9%	32.4%	32.6%
Mean Age of HH Head	46.4%	43.7%	41.6%	44.6%	43.1%	43.9%

3.1.1.2 Household Income

Overall, most HHs (87.8%) take farming (subsistence and commercial) as their main source of income. Specifically, the main source of income was subsistence farming (85.5%), with Non-agricultural practices at 4.5% and Commercial farming taking 2.3%. Only 1.6% of the targeted population are in wage employment. The relatively highest proportion of farmers is in Purongo town council (95%) and least in Anaka (75%). Olwiyo Town Board has over 93 % of its population engaged in Agriculture followed by Amuru (92%) and Koch Goma (82%). However, wages and non-agricultural enterprises were strong alternative sources, particularly in Anaka Town. Olwiyo had no HHs engaged in commercial farming and wage employment.

The majority of the targeted people (40.2%) earn below 50,000 UGX per month and only 10.9% earn above 500,000 UGX; only 15.8% of the HHs earn between UGX 100,000-500,000 (see Table 3.2). Olwiyo has the highest proportion of its HHs earning below 50,000 UGX at 77%, followed closely by Anaka at 66%. Purongo, Amuru and Koch Goma have 35%, 20% and 14% earning less than 50,000 UGX per month, in that order. Interesting to note is that

Purongo town council has relatively more HHs earning more than 500,000 UGX per month (11%).

The implication of the above statistics is that incomes of majority of HHs is seasonal, which may affect the rate of purchase of improved latrine options and services. The number of female-headed HHs was equally high, averagely 32% across the five cluster towns which points to possible vulnerability and hence the need for well-targeted subsidies by the GIZ S4M programme for some of the HHs.

Table 3.2: Household Income

Household source of income						
%	Amuru N=69	Anaka N=76	Koch Goma N=69	Olwiyo N=35	Purongo N=74	Overall
Agricultural Enterprises	1.5%	2.6%	1.8%	2.9%	0.0%	1.6%
Commercial farming	4.3%	1.3%	3.5%	0.0%	1.4%	2.3%
Non-agricultural enterprises	1.5%	9.2%	7.0%	2.9%	1.4%	4.5%
Organizational support	1.5%	1.3%	0.0%	0.0%	0.0%	0.6%
Others	0.0%	2.6%	1.8%	2.9%	0.0%	1.3%
Property income	0.0%	1.3%	0.0%	0.0%	0.0%	0.3%
Remittances	1.5%	1.3%	0.0%	0.0%	0.0%	0.6%
Subsistence farming	88.4%	75.0%	79.0%	91.4%	96%	85.5%
Transfers	0.0%	2.6%	5.3%	0.0%	0.0%	1.6%
Wage employment	1.5%	2.6%	1.8%	0.0%	1.4%	1.6%
Household Income in Uganda Shillings per month						
Below 50,000	20.3%	65.8%	14.0%	77.1%	35.1%	40.2%
50,000-100,000	60.9%	14.5%	31.6%	14.3%	36.5%	33.1%
100,000-500,000	17.4%	13.2%	31.6%	2.9%	10.8%	15.8%
Above 500,000	1.5%	6.58%	22.8%	5.7%	17.6%	10.9%

3.2 ACCESS TO HOUSEHOLDS WATER SERVICES

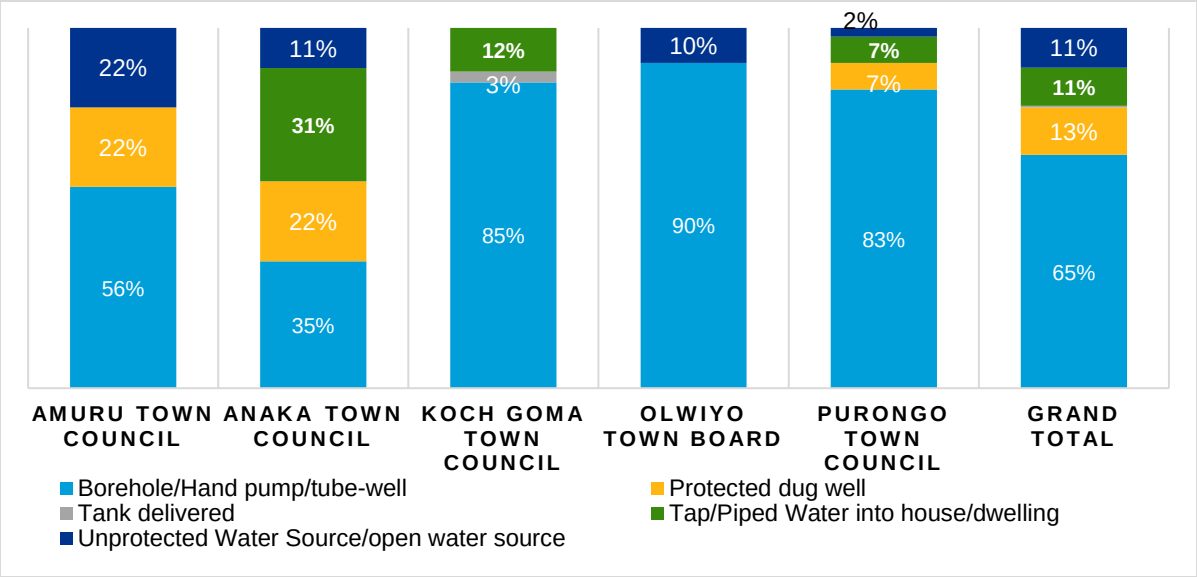
3.2.1 Brief Overview

Essential to enabling improved WASH behaviours is well functioning sanitation and water supply services. Access to water affects the quality of life of the people; use and maintenance of sanitation facilities, especially water-borne toilets (WBTs); as well as the practice of hand hygiene.

Overall, only 13.2% of HHs in the Anaka Cluster drink safely managed tap water from piped systems; 47.3% of HHs had access to basic drinking water majorly accessed from boreholes while 39.5% had limited drinking water sources; nearly all the five cluster towns had differing proportions of HHs with limited access to water.

All the four towns of Purongo, Olwiyo, Amuru and Koch Goma except Anaka rely heavily on boreholes, with 90% of the population of Olwiyo using this infrastructure type as its main source of drinking water as detailed in Figure 3.3.

Figure 3.3: Main sources of drinking water in Anaka Cluster of Towns



The above findings of the social practices assessment corroborate with the findings of the Situation Analysis Report (2022) by STROD Engineering Limited which showed that Amuru and Olwiyo were the least served towns with piped water supply systems.

3.2.2 Functionality of the Main Sources of Drinking Water

Functionality – the % of water sources functional at the time of spot check (rural) or the % of piped water service available (urban) – is very critical to ensure not only availability but also sustained use of water services. Over 97 % of the improved water sources in the Anaka cluster were functional, especially in Koch Goma and Amuru town councils, as compared to 83% functionality rate in urban areas nationally. However, to note is that Olwiyo Town Board had a relatively higher proportion of non-functional water sources which stood at 14.3 %, compared to the other remaining four towns.

Besides unreliability of most of the water supply systems, many boreholes were reported broken down and deliberately not repaired by the town council such as Purongo. This may be based on advice by the Umbrella utility to discourage use of boreholes and encourage use of piped water supply system, since point water sources are prone to contamination in densely populated areas.

Regarding making water safe for drinking, a total of 62.1 % of the population said they do not take deliberate efforts to make water safe for drinking, and consequently believe that it is not safe. The highest proportion of such HHs was found in Olwiyo (91.4 %), Koch Goma (80.7 %) and Purongo (64.9 %). The reverse is true in Amuru and Anaka towns where more of their populations reported to make water safer for drinking at 52.2 % and 55.3 % respectively.

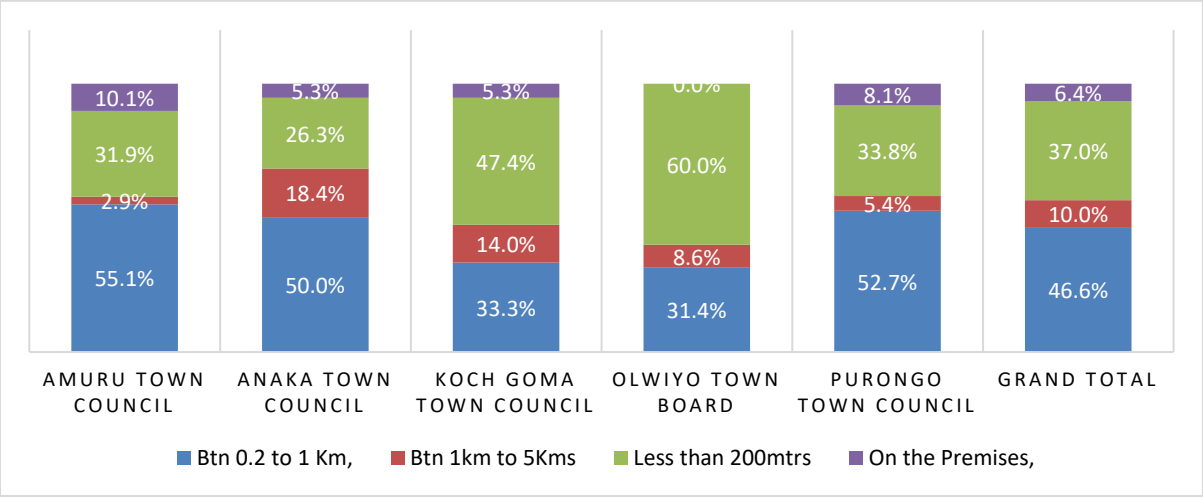
3.2.3 Drinking water service levels in the Anaka Cluster

Overall, access to safely managed water in Anaka cluster of towns is still very low with only 6.4% of the HHs having access to safe water within their premises with the majority (46.6%) having the water source between 1-5 kilometers (see Figure 3.4). No HH reported to be accessing water more than 5 kilometers from their dwelling. Olwiyo town has relatively the highest proportion (60%) of HHs having their main water source less than 200 meters from their premises; however, no HH in this town reported having water within their premises. Notably, Amuru town council has the highest number of HHs that reported having the main water source within their premises (10.1%), though this is an outlier since Amuru does not have piped water; followed by Purongo (8.1%), and Koch Goma and Anaka at 5.3% each respectively. These findings rhyme with the statement from one of the respondents from Koch Goma Town Council who reported that the current piped water supply system serves only 30 HHs within the town.

3.2.4 Water treatment methods

Due to the high likelihood of safe drinking water getting contaminated through handling, HHs are always advised to treat water before drinking it. The survey established that approximately 4.2% of the HHs in the Anaka cluster treat their drinking water with chlorine to make it safer, which is a lower proportion than desired (see Figure 3.4). No HHs in Olwiyo, Purongo and Koch Goma chlorinated their water, for example. Boiling of drinking water was reported to be the method or practice used most to treat water to make it safe, as reported by 23.2% of the HHs. The community health drives within the towns have contributed to this according to the key interview responses from the Health Assistants. 3.39% of the respondents did not know what method to use to make the water clean or safer. However, to note is that the results of 61.02% of HHs boiling drinking water contradicts the existing beliefs and practices related to drinking boiled water as highlighted in sub-section 3.2.5 below.

Figure 3. 4: Distance of Households from main source of drinking water



3.2.4 Major issues & concerns with water supply systems

The assessment established that the main concerns of the residents in the five towns with regard to water are varied: intermittent supply (e.g. Anaka and Purongo town councils); high cost of water; poor paying culture and behaviour leading to disconnection (Purongo); poor attitude and beliefs of residents towards piped water (e.g. in Anaka and Purongo town councils); poor Operation & Maintenance (O&M) of existing point water sources such as boreholes (Purongo); and town councils with inadequate improved water supply (such as Amuru and Olwiyo town board).

3.2.4.1 Koch Goma town council

Koch Goma has a water supply system constructed in 2013 with support from the Japanese International Cooperation Agency (JICA) targeting the population that lived in the camps. However, the connection is only in the center of town as its yield is low and its capacity (i.e. 40,000 liters) can only serve about 30 HHs in the town, and excludes institutions such as Koch Goma secondary schools and Koch Goma health care facility (HCF III). Besides limited supply, HHs with connections do not have adequate water while schools such as Koch Goma secondary school have no water completely and move far away distances to fetch water from boreholes. Water quality control and management of the piped system is also questionable the Water board that manages the system hardly conducts regular water quality testing.

3.2.4.2 Anaka town council

Anaka town council is supplied by National Water and Sewerage Corporation (NWSC) for between UGX 26-94 per 20 liter jerry-can, although the only existing source is inadequate to serve the entire town council. The water service, which basically covers the center of town, was reported to be intermittent especially in the morning hours and at night time. Consequently, a section of the residents in the center of the town and the outskirts rely on point water sources such as boreholes, and protected and unprotected springs and open wells, which were reported to be heavily contaminated with E.coli particularly in the rainy season. NWSC and Northern Umbrella conduct routine checks on water quality and share results with the town councils. However, the town council was reported not to act on the water quality testing results.

3.2.4.3 Purongo town council

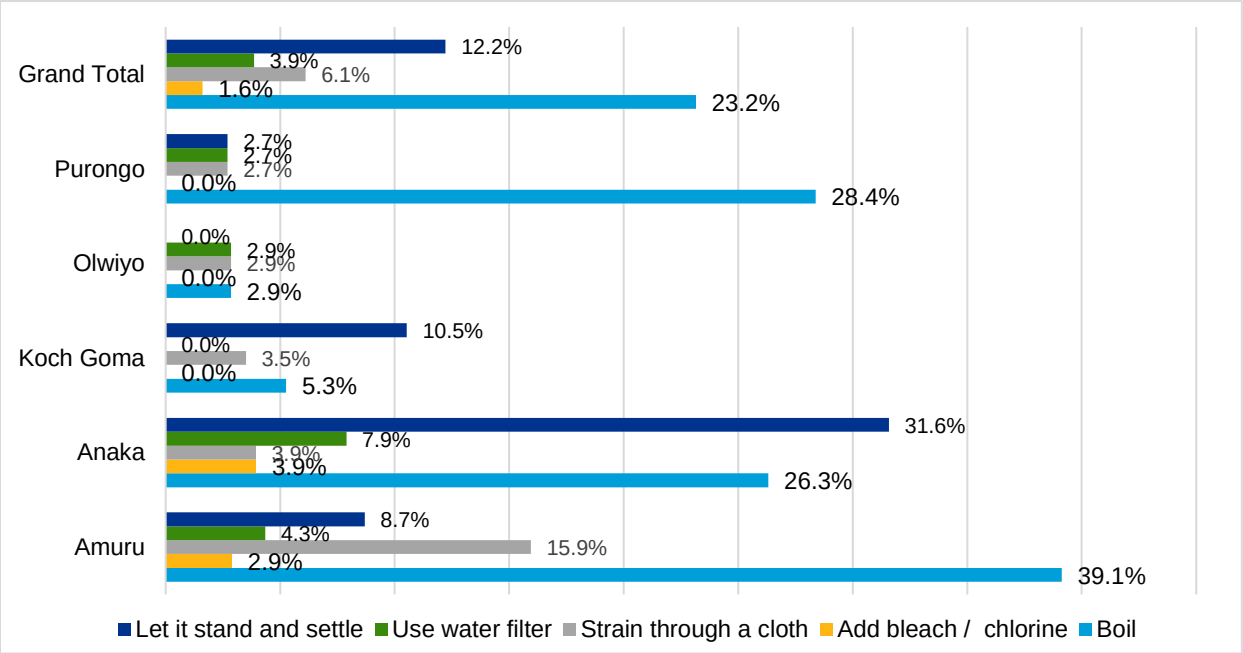
Purongo town council has a water supply system managed by the Northern Umbrella Utility of Ministry of Water and Environment (MWE) and has no major complaints except recent cutting of water pipes by the ongoing road works along Karuma - Pakwach road, to the extent that residents think they are currently consuming contaminated water. The other challenge reported on the system is the low yield as water was reported to sometimes disappear. With intermittent water supply, the respondents were of the view that speaking about S&H was impossible without clean water in place.

3.2.4.4 Amuru and Olwiyo towns

Amuru town council and Olwiyo town board have no piped water supply systems and mainly rely on a few protected point water sources such as boreholes, while majority of the communities' drink from unprotected sources (e.g. shallow wells, rivers, and open wells). However, there are plans in place by the MWE to construct a piped water supply in Amuru town Council (TC). Due to inadequate safe water, residents in Amuru town were reported to

buy water at UGX 500 per 20-liter jerry can which is quite expensive. Important to note is that the water crisis in the towns affects the adoption and use of waterborne toilets and other behaviours and practices.

Figure 3.5: Proportion of Households by Type of Water Treatment practiced



3.2.5 Current social beliefs & practices related to Water Use

The social practices assessment established that use of some of the existing point water sources such as boreholes in some of the towns is affected by negative practices such as witchcraft and poisoning that was reported in Amuru town council. Consequently, boreholes are left for one HH or family to use.

Overall, there is mindset and belief in use of unprotected sources of water by a section of the population and residents were reported to pay up to UGX 500 per 20-liter jerry can for such water, for example in Anaka town council, which is quite expensive. Hence there is need for mindset and attitudinal change towards piped water as some people were reported to detest piped water due to the test of residual chlorine. A section of the community has a belief that water from boreholes and unprotected sources tests sweeter; that boiled drinking water does not have freshness and therefore is not sweet to drink. Also, some people claim their thirst is not quenched when they drink boiled water. There is also a belief that some children in the community developed diarrhea because of drinking boiled or tap water, and that children cannot fall sick after consuming borehole water because it is considered safe while children cannot get sick from drinking unboiled water because they get used to drinking it directly right from childhood.

Recommendations:

1. The two water utilities (NWSC & Umbrella) need to provide reliable water services to motivate residents to make HHs connections and to pay for services.
2. WSDF/MWE needs to fast-track construction of water supply system for Amuru town
3. Umbrella Authority needs to take over Koch Goma town council and plan for a new source to augment the existing smaller system.
4. NWSC & Umbrella should conduct marketing of water services to the HHs (e.g., in Anaka and Purongo town councils) to counter the identified negative behaviours, attitudes and beliefs. This may also include use of radio programmes to sensitize HHs & communities.

3.3 ACCESS TO HOUSEHOLD SANITATION SERVICES

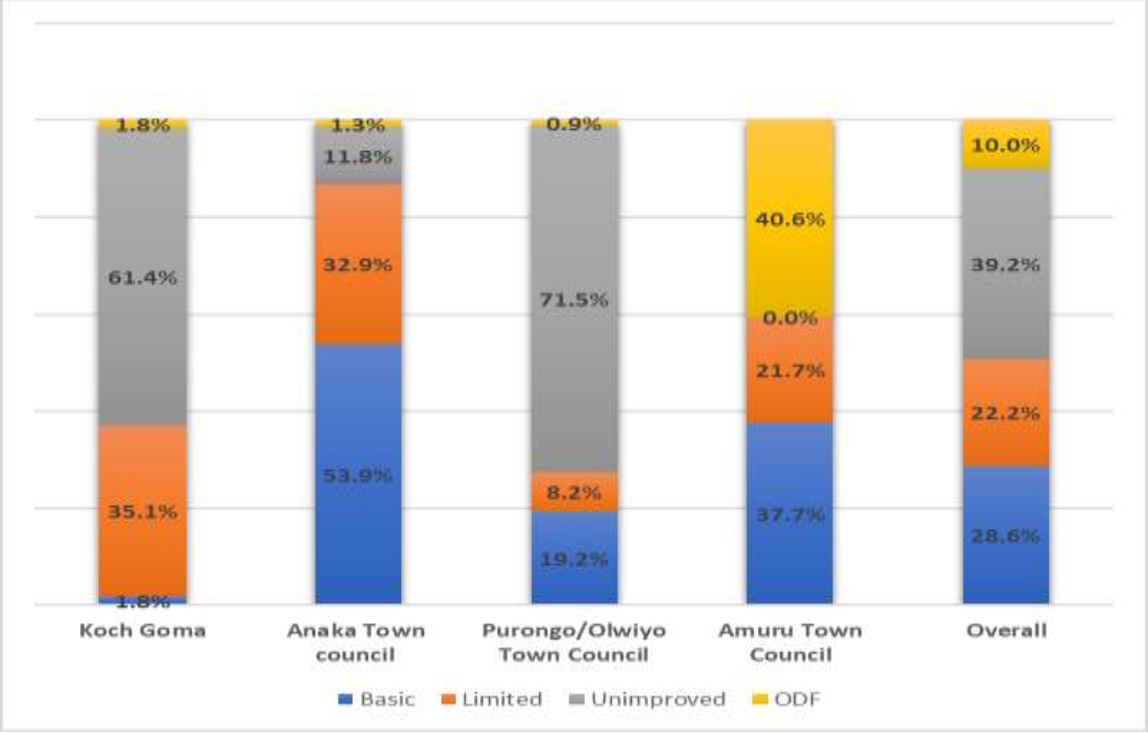
3.3.1 Brief overview

The survey assessed access to sanitation services according to the JMP definitions and standards. SDG target 6.2 aims for adequate and equitable sanitation and hygiene (S&H) for all. “Adequate” implies a system that safely separates excreta from human contact throughout the sanitation chain, either through safe containment and disposal in situ, or through safe transport and treatment/reuse off premises.

3.3.2 Household sanitation levels

The survey assessed access to sanitation services according to the JMP standards. In the five towns, access to sanitation services as per the JMP ladder was: Basic, 28.6%; Limited, 22.2%; Unimproved, 39.2%; and Open Defecation, 10% (see Figure 3.6). The town with the highest prevalence of Open Defecation was Amuru town (40.6%), Open Defecation was lowest in Purongo and Olwiyo at 0.9%, followed by Anaka Town at 1.3% (see Figure 3.6).

Figure 3.6: Sanitation service levels in the five cluster of towns



Purongo and Olwiyo have the highest proportion (71.5%) of HHs with unimproved sanitation services, followed by Koch Goma Town at 61.4%. To note is that Anaka town council has the highest proportion of HHs with basic sanitation services, owing to the fact that it is more developed than all the other towns in the cluster; while Koch Goma has the lowest proportion of HHs with basic sanitation services (1.8%), across all the towns in the cluster.

These results of the social practices survey are not far from the 2022 findings by STROD Engineering Limited, highlighting the sanitation service levels across the five Anaka Cluster towns based on the Shit Flow Diagrams (SFD) developed for the five towns. The STROD report showed that Amuru town had the highest rates of OD, standing at 50%; while safely managed across the 5 towns was averagely about 10%.

Recommendation:
Conduct targeted marketing of sanitation to facilitate HHs to move up the sanitation ladder and make improvements in their current sanitation status:

a. **HHs with unimproved sanitation**, are targeted to improve and/or upgrade their existing latrines to basic (based on an assessment by trained masons of the durability of the existing latrine sub-structure).
b. **HHs with limited sanitation**, are encouraged to construct and use their own improved individual basic latrines.
c. **HHs practicing OD** – more effort is put in ending OD, particularly in Amuru town council, by supporting HHs to construct basic or unimproved latrines (depending on the affordability of a specific HH).

Therefore, two of the priority behaviours for the Behaviour Change Campaign (BCC) should be:

- ***Build new/upgrade an improved, individual household toilet facility (HHs)***
- ***End the practice of open defecation (HHs)***

3.3.3 Toilet types, ownership and use

When access to sanitation services was examined by toilet type, a large proportion of HHs in Anaka cluster had pit latrines or open holes without slabs (57.2%). This was closely followed by pit latrines with slab (35.7%); only 1.9% of the HHs own flush toilets. With only 2% of HHs in the Anaka cluster of towns having access to flush toilets, over 90% of the HHs that own toilets predominantly use on-site sanitation systems i.e. ordinary traditional unlined or unimproved pit latrines, which has an implication on pit emptying.

By national standards, HHs in these small towns are supposed to use flush toilets/sewered sanitation, drainable pit latrines or septic tanks; the latter two types are currently a preserve for institutions such as schools. Only the business community and a few HHs were reported to have constructed improved pit latrines and septic tanks.

Several HHs (12.9%) did not have access to a toilet and therefore either shared latrines/toilets of other HHs or practiced OD. HHs owned the toilets in 87.1% of the cases, while toilets provided privacy in 82.4% of the cases (toilets with privacy being highest in Anaka and Purongo town councils). Koch Goma town had the highest number of HHs with latrines built with slabs (43.9%), followed by Purongo/Olwiyo (39.8%), Anaka (39.5%) and lastly Amuru (21.7%). Notably, Anaka town council has the highest proportion of HHs that do not own their own toilets/latrines, while Purongo has the least proportion (7.3%). Amuru town council had

the highest proportion of HHs with no latrines/toilets (7.2%), which correlates well with the town having the highest occurrence of OD among all the five towns in the cluster.

Important to note is that lack of or inadequate privacy and sharing of latrines has an impact on use of toilets because often shared toilets have unhygienic outcomes, with the survey data showing 37.6% of respondents were somewhat satisfied while 22.8% were unsatisfied with sharing of latrines.

The KIs interviewed at community level reported challenges of difficult and collapsing soils in town councils like Purongo that make it difficult for HHs to dig and construct latrines. Additionally, there were also reports of poor building materials such as logs that rot leading to collapse of latrines and lack of expertise on how to build better latrines as illustrated in the two quotes below.

"*The challenge we have with pit latrines is that our area here is water logged. Whether someone constructs a nice pit latrine or not, when it starts raining, peoples' pit latrines fall-in (read collapse) and when the rain stops, they have to reconstruct new pit latrines. The reason why our pit latrines fall-in is because of the logs we place on the slab. These logs rot because of the rain water and fall-in. So, this has made people not to care much about the quality of pit latrines constructed because they got tired of spending a lot of money yet the pit latrines will fall at the end of the day when it starts raining*" **– Participant, Community FGD Purongo Town Council**

Recommendations:
GIZ S4M & partners should target:
- the 87% individual HHs to construct basic latrines since these HHs own land on which their houses are built.
- the 13% Landlords in the five cluster towns to construct their own latrines and for their tenants. Liaise with NWSC or Umbrella-North (and the town councils*) that is willing to share with the programme partners the list of landlords who use water services.

3.3.4 Construction & maintenance of latrines/toilets

There were two issues the study assessed that affect adoption and use of improved toilets in communities, in terms of: who takes a decision at HH level to construct latrine/toilet; and secondly, who does the actual construction (owner Vs service provider). Decision-making as an important element in latrine construction and issues of gender roles were confirmed by some of the key informants as in the quote below.

"*Latrine construction at HH level is also about decision-making and definition of roles and responsibilities i.e. who is supposed to do what and where. Unclear roles leave the responsibility for construction of toilets hanging*" **– KII, Water & Sanitation Development Facility Staff-WSDF North, Ministry of Water and Environment (MWE).**

The assessment established that there is a tendency for men to look at women as tractors i.e. men do not help and leave everything including latrine construction to be done by women yet women have many other household chores to attend to. In the majority of the HHs within the cluster of towns (76.5%), the decision to construct the toilet was made by the men as heads of the HHs. Purongo/Olwiyo had the highest proportion (80.7%) of HH heads making

the decisions to construct a latrine, while Koch Goma had the least proportion (66.7%) of HH heads making the decision to construct toilets. Overall, only 8.4% of the decision to construct a latrine/toilet was jointly made by couples, with Amuru town having the highest proportion (11.6%) of HHs where the decision to construct a latrine was jointly made by a couple in the family and relatively lowest in Anaka town (6.6%).

Recommendation:
- GIZ S4M & partners should target selling/marketing improved toilets and hygiene services to the 68% of male-headed HHs to construct and use improved latrines/toilets. Male HH heads should be targeted as key decision-makers in latrine construction, which may involve either finding them at home, their places of work or their drinking joints.

Critical to note, however, is that men rarely attend sensitization meetings and when they do, often they want to be motivated through sitting allowances or snacks such as sodas. For future programming it will be very important, using a Behaviour Change Campaign (BCC) approach, for the GIZ S4M programme to target selling/marketing improved toilets and hygiene services to 68% male-headed HHs, if HHs are to construct and use improved latrines.

Regarding who constructs latrines, the study established that several HHs (70.8%) contracted professional services to assist with the construction of toilets. Amuru town had most HHs contracting professional service providers to construct toilets (86.4%), which may explain why the cost is higher to construct a latrine/toilet in this town. On the other hand, Anaka town had the least proportion (69.9%) of HHs contracting professional service providers to construct latrines. These statistics point to the fact that there exists some service providers for latrine construction that GIZ S4M will need to identify (with the help of the communities and local leaders), but whose capacity needs to be built to offer better services given the quality of latrines currently in use.

Most HHs (64%) reported adding chemical products to control the flies or the smell of the toilet, which is a sign of the desire to have cleaner and odour-free toilets. Adding ash and smoking of the latrines were the most common practices that were mentioned by the HHs surveyed, with the highest practice in Anaka town (72.4%) and lowest practice in Amuru town (47.8%). 70.2% of the HHs surveyed use mud/clay as the material surrounding the latrine drop hole, which makes latrines not washable (or easy to clean) as required by the SDGs. Health Assistants (H/As) and Health Inspectors (HIs)will need to guide households on the standards and the moulds to use.

Recommendations
- Select and build the capacity of local masons to offer better services and construct quality latrines (lined improved latrines with better slabs and stronger materials in accordance with onsite sanitation minimum standard); equip masons with the necessary tools (such as BoQs) to provide information to HHs on how to construct improved toilets and to market their services.
- Health Assistants (H/As) and Health Inspectors (HIs) will need to play a role to guide HHs on the required standards.

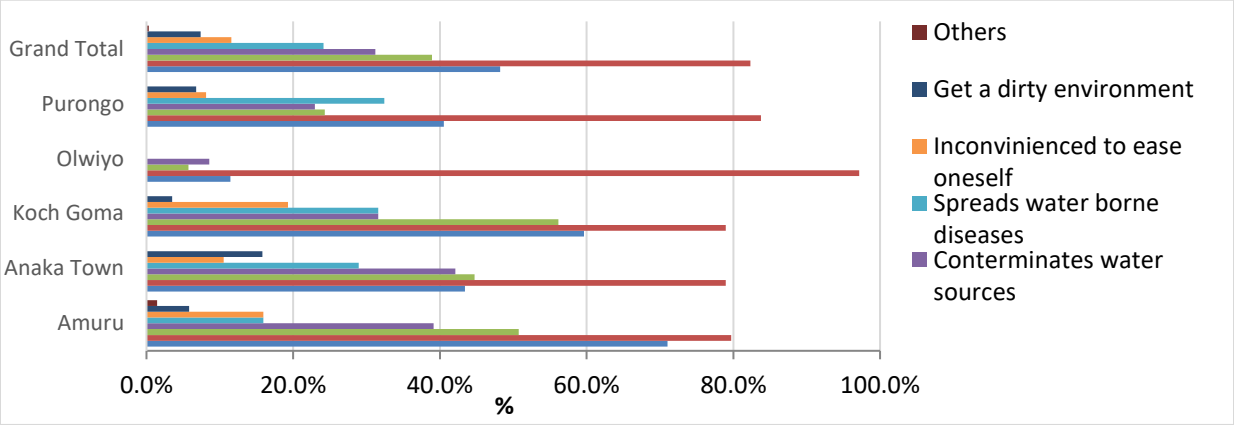
3.3.5 Current knowledge & awareness of households on WASH issues

Due to limited funding and hence limited outreach by the HIs and H/As, it was estimated by some of the KIs that only about 30% of HHs in Anaka cluster of towns are aware of WASH

issues. Knowledge and awareness is confined to those people who go to school and those who have been reached by the few community sensitizations conducted by the Health and Sanitation Infection Prevention and Control (IPC) committees at the health centers. The study established that a high number of HHs (82.3%) had knowledge that having no pit latrines leads to spread of diseases (Figure 3.7) but the practice is different as evidenced by the high levels of OD. Closer to half of the HHs (38.9%) said the neighbourhood or environment becomes dirty due to OD, while 31.2% HHs surveyed mentioned that not having a pit latrine contaminates water sources.

From Figure 3.7, it was evident that knowledge levels in Olwiyo, Purongo and Koch Goma towns is relatively lower than the other two towns of Anaka and Amuru, given the spread of the responses across the specific dangers listed. Based on the outcomes of the social assessment, GIZ S4M will develop a clear Behaviour Change Communication (BCC) Strategy to create awareness about the benefits of improved water and sanitation across all the five cluster towns. This strategy will also include use of innovative participatory approaches such use of local folk groups to conduct sensitizations and create awareness about the dangers of OD and to motivate HHs to construct and use improved latrines/toilets.

Figure 3.7: Knowledge of dangers of not having a pit latrine/toilet



Recommendation
Use innovative participatory approaches such use of local folk groups and radio programs to conduct sensitizations and create awareness about the dangers of OD and the benefits of improved WASH to motivate HHs to construct and use improved latrines/toilets. Therefore, the BCC campaign should:

- promote behaviours from a positive side (prestige, convenience, privacy, durability, safety, no smell, family pride, … as opposed to shame, disgust, …)
- focus on changing one additional priority behaviour around "***consistent and proper use and maintenance"*** and keeping latrines clean to keep away flies.

Regarding existing community level structures for awareness creation, the study established that there exists a Ministry of Health (MoH) structure of Village Health Teams (VHTs) at village/cell level that communities and HHs believe in. A FGD at community level in Purongo town council, for example, confirmed that communities love VHTs and have no problem listening to them and following their leadership because VHTs provide information that has helped HHs to improve on their living conditions. They sensitize communities on S&H and

how to keep homes hygienically clean. They ensure homes have pit latrines, bathrooms, and wires for hanging clothes. The quote below illustrates the role being played by VHTs.

"*People view these VHTs that come to educate us without hatred because the teaching and information they bring to us is for our own benefit. To see that homes are found in at least good shape has been the efforts of these VHTs. People welcome them properly to their homes and listen to what they have to say because these VHTs are born of the area, so people trust that they mean well and have no harm in all that they do. So, people love them, listen to them and make sure they follow their advice/ teaching/counselling*" **– Participant, Community FGD, Purongo Town Council.**

Recommendations:
For sustainability and continuity, GIZ S4M programme should consider working with VHTs particularly as Sanitation Promoters (SPs) or Sales Agents, to market and sell improved sanitation products and services at HH/community level. However, this will require specialized training for VHTs on WASH and on their roles as SPs, since previously VHTs have been so much involved in distribution of mosquito nets, malaria drugs and mobilisation of HHs to participate in immunization programmes of MoH.

3.3.6 Current Sanitation & Hygiene (S&H) Beliefs, Norms and Practices

Generally, sanitation and hygiene are a big concern in the Anaka cluster of towns with many of the HHs having no pit latrines, evidenced by the practice of OD especially in Amuru town council. Faeces were reported littering the streets and roads behind shops in the towns and especially in locations where there are temporal sites for garbage/solid waste storage before disposal. The unhygienic practice of use of polythene bags aka "kaveera" or "flying toilets" is rampart in the towns, which puts the health of residents at high risk of contracting diseases.

The practice of OD in the towns also raises question marks on the safety of the alternative sources of water such as boreholes. For example, NWSC conducts periodic random sampling of water points in Anaka town council for water quality testing and has found traces of E.coli in drinking water. However, these water quality testing results are not acted upon by concerned stakeholders such as Anaka town council.

The major reasons for the rampart practice of OD include ignorance about the dangers of OD by the HHs in towns such as Amuru town council; negative attitude and beliefs; few or no latrines (both household and public); and availability of bushes around the towns as an alternative option for defecation. Notably, besides the bushes, OD also takes places in peoples' compounds and the two quotes below illustrate the situation on the ground.

"One finds that these small towns are more rural than urban, with lots of bush around the towns. Therefore, people prefer and feel safer by using the bushes for defecation rather than use latrines which are short and like for kids" **– Senior Environment Sanitation Officer, WSDF, Ministry of Water & Environment (MWE)**.

Another poor hygiene practice that was found in the communities in the Anaka cluster of towns is poor disposal of childrens' faeces, coupled with lack of handwashing with water and soap (HWWS) after cleaning babies after they have defecated.

"*Communities in this town are naturally and generally very dirty. It is not uncommon to see a woman eat a fruit like a mango while a child is defecating nearby and a mother does not mind, after cleaning the baby she starts eating again without washing her hands; or to see a woman mingling food for the family, she removes a baby's faeces with leaves and takes behind the house and comes and continues with the mingling*" **– Technical staff, Amuru Town Council.**

Other poor S&H practices that are common in the Anaka cluster of towns which affect utilization of toilet facilities is the construction of poor-quality latrines; poor use and maintenance of existing latrines; and sharing of latrines between a number of households with no clear responsibilities for cleaning, hence misuse which leaves existing latrines dirty. All of these factors and practices affect motivation for use of latrines as expressed in the quote below from a KI.

"*The few existing pit latrines are misused; the biggest challenge is O&M. Latrines are in such a way that the roof is off; and the squat holes of the pits are soiled. Latrines have no anal cleansing materials; urine is all over the floor of the pit; pathways to the latrines are either not cleared or are littered with faecal matter*" – **Technical staff, Amuru Town Council**

Some cultural myths, beliefs and practices that the GIZ S4M programme will have to deal with were cited to affect adoption and use of improved S&H and these include the following: i) a pregnant woman does not use a toilet because they think they will deliver or drop the foetus in the pit when they use latrines or will most likely lose their baby if they use a toilet. Therefore, pregnant women were reported to be the biggest culprits of OD particularly at health centers; ii) belief that "You do not look where you have defecated"; iii) belief of not to disposing babies' faeces in the latrines because it is considered safe; iv) the belief that defecation in the bush (OD) is normal; and v) the belief that the more faeces one has in his/her compound, the wealthier or a sign of more food or ability to feed the family.

Recommendation

- GIZ S4M and partners should adopt use of MoH S&H Social Behaviour Change (SBC) materials under the "Living Freshi" Brand".
- Develop BCC campaign materials and focus messaging for the BCC campaign on changing the negative behaviours, beliefs and attitudes at HH and community level; consistently focus messaging around two key priority behaviours i.e. i) ***children's faeces management***; and ii) ***ending the unhygienic practice of use of polythene bags/"Kaveera" or "flying toilets***".

3.3.7 Factors limiting HHs from constructing & using improved latrines

The respondents at HH level as well as the regional and national level key informants were asked to identify and state the major factors that limit people in the Anaka cluster of small towns from constructing and using improved toilet facilities; these are listed below:

1. Low levels of education, coupled with limited knowledge of the benefits of improved sanitation hence sanitation is not a priority for investment at household level.
2. Cultural myths, beliefs and practices as highlighted in sub-section 3.3.6 above.
3. Poor attitude, as majority of town residents (including leaders such as Councillors) do not value having toilets and were reported to be hard-hearted, with strong beliefs and mind-set.

4. Lack of knowledge and information about other available or alternative toilet/latrine options, and that latrines can be cheap in the long-run, hence high prevalence of unlined pit latrines which cannot easily be emptied.
5. Lack of experts such as trained masons to provide information and guide households to construct better quality toilets, hence poor-quality toilets which do not motivate people to use them.
6. Inadequate water to facilitate adoption of waterborne (WBTs) or pour-flash toilets.
7. Inadequate capacity of town council authorities including:
    - weak enforcement of the Public Health Act (PHA) and other laws, because of fear since some people in the communities were reported to own guns.
    - inadequate understanding of many town council teams (both technical & political) on the innovative approaches for S&H promotion such as sanitation marketing.
    - the political leadership that are not adequately enlightened to support sanitation.
    - lack of town council bye-laws and when technical personnel use the Public Health Act (PHA) to enforce good sanitation, the politicians were reported to turn against them
8. Lack of or inadequate exemplary leadership particularly from the elected political leaders such as LC Is, LC IIs and LC IIIs/Mayors of town councils because quite often these do not have toilets in their own homes.
9. Problem of collapsing soils in some parts of Anaka town council, as pits of up to 12-20 ft were reported to collapse and water-logged soils in places such as Purongo town council.
10. Very limited on-going sanitation and hygiene sensitisation programmes, as no one is currently talking to communities about the importance of having toilets.
11. Limited allocations, in terms of funding, by town councils to support sanitation improvements in the towns, as S&H majorly uses local revenue. The Primary Health Care (PHC) grant, where a HCF III receives UGX 2-4 million a quarter, was reported to go mainly to immunization and addressing S&H within the HCFs
12. Low incomes of majority of small towns' residents, coupled with high costs of construction of latrines which makes affordability a challenge.
    - A fairly good 2-stance latrine was reported to cost between 1-2 million (digging pit – Ugx 100,000; Putting the slab – Ugx 70,000: labor, cement and bricks – 500,000; roofing with 2 iron sheets – Ugx 120,000); while construction of a septic tank alone was estimated to cost 1-4 million Uganda shillings.
    - Towns such as Anaka, for example, are former Internally Displaced Peoples' (IDP) camps, where some people failed to go back to their respective rural villages and yet they lack funds to survive in the town

Recommendations:

- Develop a clear delivery, sales and marketing model to achieving basic sanitation, while learning from previous projects (GIZ S4M-Apac Cluster; USAID-USHA)
- Aim at addressing/removing barriers to HH investment in sanitation (E.g. develop best-fit products for the target market, including options for difficult soils; train & mentor sales agents/SPs/VHTs; on-board local masons as sanitation entrepreneurs; unlock financing).
- Target triggering and changing the attitude of local leaders (e.g., cultural-Rwot Kweri, religious, political) who have influence on HHs and communities.
- Use a phased approach to reach HHs and communities because market-based sanitation takes time to develop in low-income or poor areas such as Olwiyo and Amuru towns, and so initially may serve only small population segments within the centers of the five towns. Other

approaches will be needed to reach the rest of the population, including a comprehensive and sustainable sanitation BCC campaign programme that can address the factors listed above and change social norms.

3.4 ACCESS TO HYGIENE SERVICES

3.4.1 Brief background

Hygiene refers to the conditions and practices that help maintain health and prevent spread of disease including handwashing, food hygiene, and menstrual health and hygiene management (MHHM)[1]. The presence of a handwashing facility with soap and water on-premises has been identified as the priority indicator for global monitoring of hygiene. HHs with a handwashing facility with soap and water available on-premises meet the criteria for a basic hygiene service. HHs that have a facility but lack water or soap are classified as having a limited service, and distinguished from HHs that have no facility at all (no service). In some cultures, ash, soil, sand, or other materials are used as handwashing agents, but these are less effective than soap and are therefore counted as limited hygiene services[2].

3.4.2 Handwashing devices and practices

Over 70% of the HHs in the Anaka cluster lacked designated HWFs and only 22% of the HHs had identifiable handwashing place; 9% of the HHs in the cluster responded that they had HWFs within their HHs, but these were not observed by the enumerators (see Table 3.3 and Figure 3.8). Koch Goma town had the highest number of homes with no HWFs standing at 89% while Purongo/Olwiyo had the least (60%). Amuru and Anaka towns had 61% and 73% with no HWFs within their HHs respectively, which is still negatively significant.

Table 3.3: Characteristics of Handwashing Services

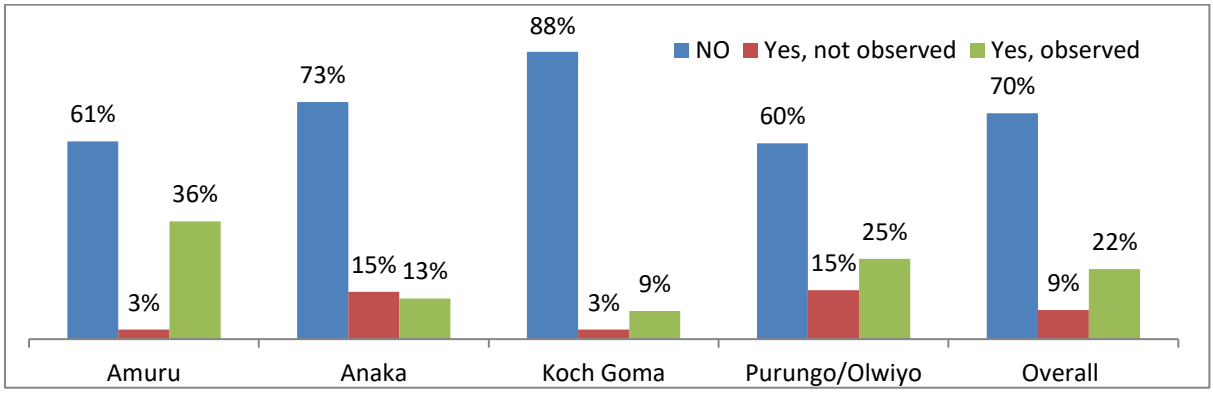
Characteristic	Koch Goma	Anaka	Purongo/ Olwiyo	Amuru	Overall
Households that have soap or ash at the hand washing facility or next to the toilet					
Yes	10.5%	7.9%	1.8%	34.8%	12.2%
No	89.5%	92.1%	98.2%	65.2%	87.8%
Presence of water at handwashing place					
Water available	12.35	9.2%	4.6%	62.3%	19.9%
Water not available	87.7%	90.8%	95.4%	37.7%	80.1%

Amuru town council, on their hand, had the highest proportion of HWFs within their HHs and observed at 36% while Koch Goma had the least proportion of HHs with observed HWFs within their HHs at9 %. Anaka and Purongo /Olwiyo town councils had 13% and 25% of their HHs with observable HWFs respectively. Amuru, Anaka, Koch Goma and Purongo/Olwiyo

[1] https://washdata.org/monitoring/hygiene
[2] Ibid

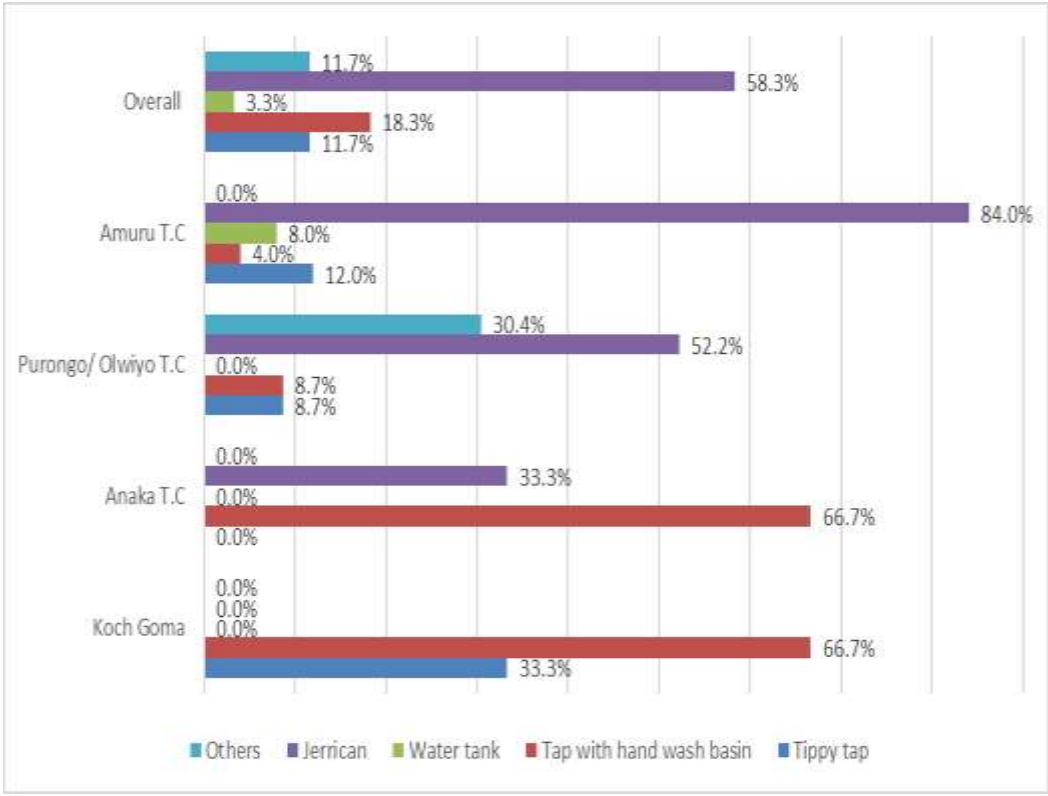
had 3%, 15%, 3% and 15% of their HHs reporting that they had HWFs but they were not observed by the enumerators, in that order.

Figure 3.8: Percentage of Households with handwashing facilities



Overall, many of the HHs had a movable container also known as “jerry-can” as the handwashing device (58.3%), especially in Amuru town council, where over 84% of the HHs had this device. As observed earlier, access to water impacts the practice of handwashing with water and soap (HWWS). Water from rainwater harvesting tanks was the least available in the cluster at 3.3% of the HHs; while only I8% of the HHs mainly access water from tap/piped water sources.

Figure 3.9: Percentage of Households by handwashing devices types used



Anaka and Koch Goma town councils had the highest access to tap/piped water hence with HWFs (66.67%), and also had 7.9% and 10.5% of their HHs with soap or ash present at or near the handwashing facilities, respectively (Table 3.4). The use of "tippy taps" were significantly common in Koch Goma (33.3%).

3.4.3 Use of soap or ash for hand washing

In Anaka cluster, only 12.2% of HHs surveyed had soap or ash soap available in their HHs at the hand washing facility-HWF (Table 3.4), compared to 61.1% access to handwashing in urban at national level (FY 2019/20)[3]. The HH heads were responsible for making the decision to buy soap at all times, regardless of gender of the HH head as revealed during the FGDs. Amuru town council had the majority of HHs with soap at the HWF (34.8%) while Purongo and Olwiyo towns had the least proportion of HHs with soap or ash at the HWF or next to the toilet (1.8%).

Table 3.4: Percentage of households with Soap or ash at their HWF

Characteristic	Koch Goma	Anaka	Purongo/ Olwiyo	Amuru	Overall
Available	10.5	7.9	1.8	34.8	12.2
Not available	89.5	92.1	98.2	65.2	80.1

3.4.4 Knowledge of critical times when to wash hands with soap

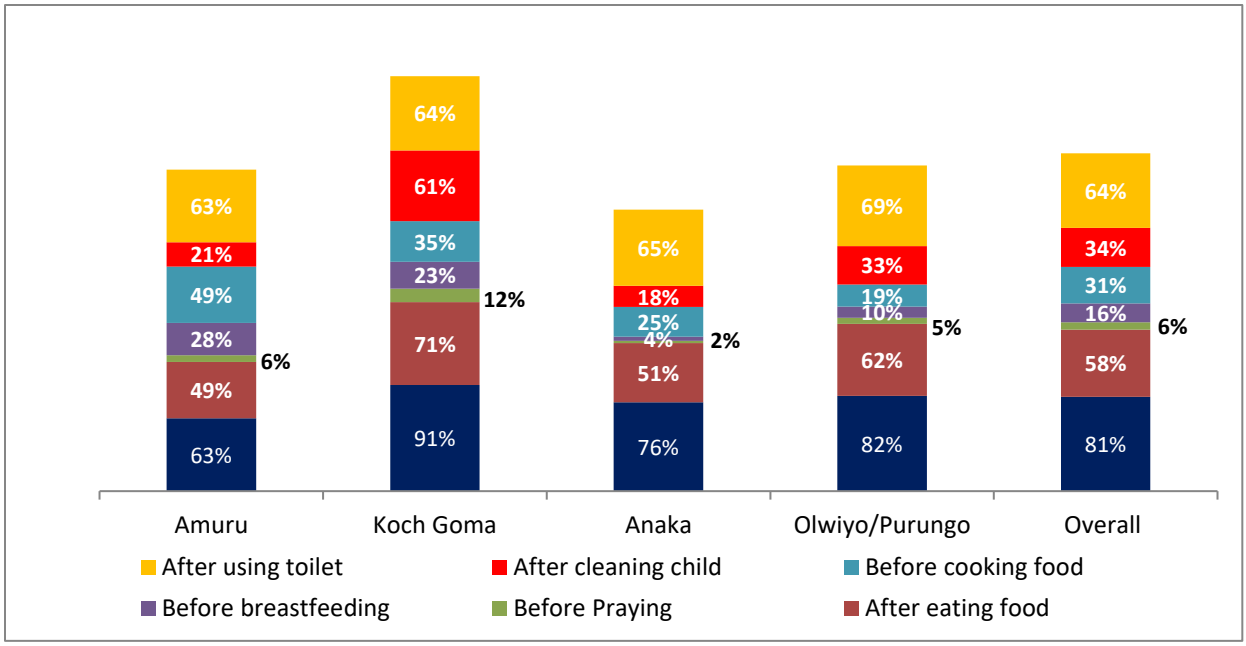
The majority of HHs (55.9%) had knowledge that hands need to be critically washed before eating food, while 64 % had knowledge that hands are to be washed after using the toilet (see Figure 3.10). This means that close to about 33% of the population do not know that hands are to be washed after using the toilet and this trend was similar across the five towns. Again, as observed earlier about knowledge in relation to the practice of OD, knowledge and awareness on the need for hand washing at critical times was found to be quite high, but the practice is very low.

Recommendations

- Adopt one additional priority behaviour for the BCC campaign i.e., ***"hand washing with soap and water in HHs and communities***
- Develop clear and consistent messages on HWWS to include critical times when to WASH hands with water and soap including:
  - Before eating food
  - Before feeding a baby
  - After using the toilet
  - After cleaning the baby who has defecated
- Development BCC materials on HWWS, to be informed by the above messages.
- Demonstrate cheaper options of hand washing devices for HHs but also the "how to properly wash hands".

[3] Water & Environment Sector Performance Report 2020

Figure 3.10: Knowledge of handwashing at critical moments by town



3.4.5 On-going sanitation and hygiene programmes

Despite the challenges cited above regarding the practice of hand washing, on a positive note there are some on-going initiatives to help HHs and communities to change their status quo; therefore, the GIZ S4M programme can build on these. For example, at town councils' level, with support from GIZ all the five small towns in Anaka cluster developed long-term Town Sanitation Plans (TSP). TSP have helped politicians realize that sanitation is good and important and to develop interest and demand for improved services.

The four cluster towns of Olwiyo, Amuru, Purongo and Anaka were facilitated to form Sanitation Task Forces (STFs), which were created during the Town Sanitation Planning (TSP) processes. The STFs is multi-disciplinary and constitutes of both the technical staff/head of departments[4] and the political leadership of town councils. The STFs work hand-in-hand with the Sanitation Forum-SF; and conduct monitoring and reporting on sanitation e.g. to the SF. The-TSP are implemented by the Town councils themselves but can also approach development partners such as GIZ for support. STFs can be good coordination mechanisms for WASH in town councils.

The assessment established that STFs were inactive. As opposed to the step-by-step process that was followed in Apac cluster of towns, GIZ used a Consultant in the Anaka Cluster who trained the STFs for only one day which was inadequate. Therefore, the STFs may benefit from capacity building initiatives including exposure visits to towns with similar structures (e.g. in Apac cluster) so as to strengthen them to play their role.

Health Inspectors (HIs) and Health Assistants (H/As) were also reported to provide information to HHs and communities on S&H mostly through routine home visits and

[4] These include the Town Clerk-TC, the Community Development Officer-CDO, the Physical Planner, Enforcement Officers, Town Agents, and the Health Inspector who is the Secretary)

inspections, which helps to remind communities about their roles and responsibilities. They do inspections on school hygiene; market hygiene; sensitize residents about vector control and sexual reproductive health; and conduct routine data collection and analysis on WASH including water quality testing. However, due to limited funding, HIs and HAs as well as the IPC committees conduct sensitizations on WASH issues but only to a few communities in and around the Health Centers thus no impact is being seen by these initiatives.

In Amuru town council, village or cell and Ward competitions are periodically organised and winners of such competitions are awarded prizes such as jerry cans and soap. Other initiatives include participation in and celebration of internationally recognized days such as the World Water Day and the Sanitation Week, by both the town councils and the districts. Institutions such as schools, the police, prisons, the army and the churches are invited to participate and attend. The TC also organizes general cleaning days on a monthly basis, but is limited due to limited resources to buy biscuits and soda during the cleaning days.

The study also established there exists the regional structures of the Ministry of Water and Environment (MWE) based in Lira i.e. the Water and Sanitation Development Facility (WSDF-North), that is responsible for WASH infrastructure development (including water supply and Faecal Sludge Management-FSM systems) and the Northern Umbrella Utility that is responsible management of WASH infrastructure and provision of pit emptying services. Both WSDF and the Umbrella utility also provide capacity building support to town councils where they operate, outside the jurisdiction of NWSC.

Health Promotion International – is a consultancy firm implementing a 3-year Tilenga project on behalf of TotalEnergies in the Tilenga area (covering Buliisa, Kikuube, Pakwach, Hoima, and Nwoya (only in Gotapoyo parish in Purongo town council). The project that started in November 2022 has components on HIV/AIDS prevention/awareness and testing, and awareness on non-communicable diseases as well as TB prevention. The project also implements WASH activities, focusing on S&H software activities such as community coordination, school WASH programme, formation of School Health Clubs-SHC, and sensitization of communities using SHC.

Recommendation:
Use Anaka cluster as a second pilot for the WSDF-North and Umbrella Utility to provide hands-on capacity support to the five town councils and to their respective communities with a view to learn and scale up these experiences to other small towns in the Northern region and beyond.

3.5 EXPOSURE TO INFORMATION ABOUT WASH

3.5.1 Access to information on WASH

Overall, in the Anaka cluster, the survey showed that radios were the most frequent used source of information on WASH (30.2%), followed by health workers (23.8%; see Figure 3.11) especially at the health centers. The third most common frequent source of information was through community health volunteers/VHTs (18%). Notably, using print media to relay WASH information was non-existent, while use of TV and social media was very low. The GIZ S4M

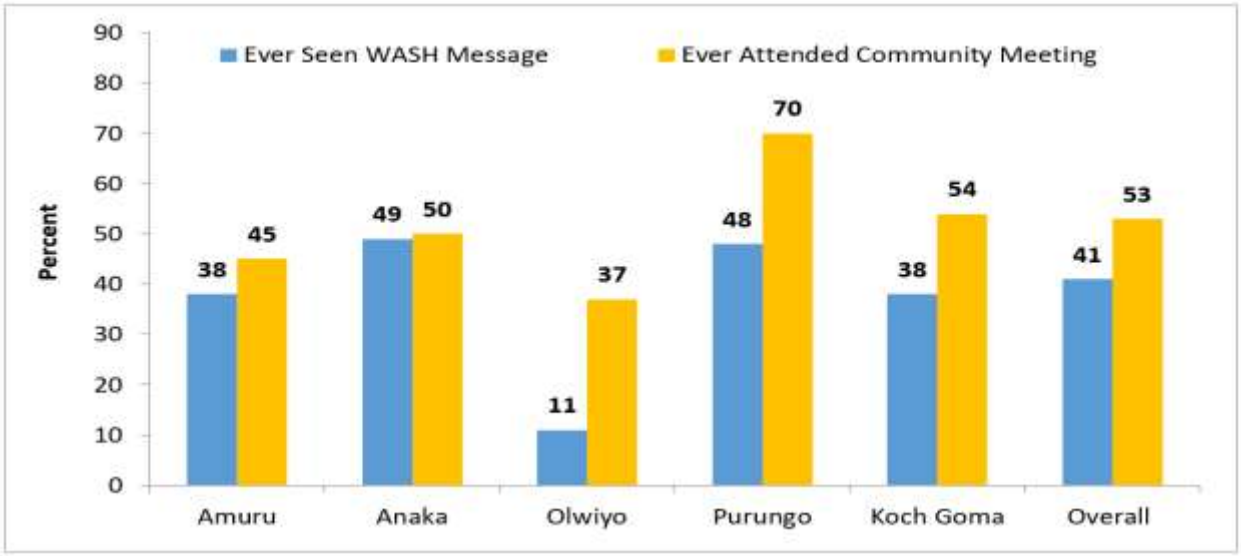
programme needs to take note of these 3-4 important and frequently used channels through which communities and HHs readily get information on WASH for future BCC.

Figure 3.11 shows the distribution of the frequency of different sources of information by town council, showing differences and variations on the sources of information across the five small towns. Uniquely, most HHs in Purongo town council mentioned that they receive their sanitation and hygiene information from posters and community health volunteers (28.4% in both cases). In Olwiyo, it is community health volunteers (31.4%), family and friends (25.7%) and radio (17%), in that order. Since radio is the most used media to disseminate sanitation and hygiene information, we will analyse it more closely in sub-section 3.5.4 that follows below.

3.5.2 Exposure to WASH messages

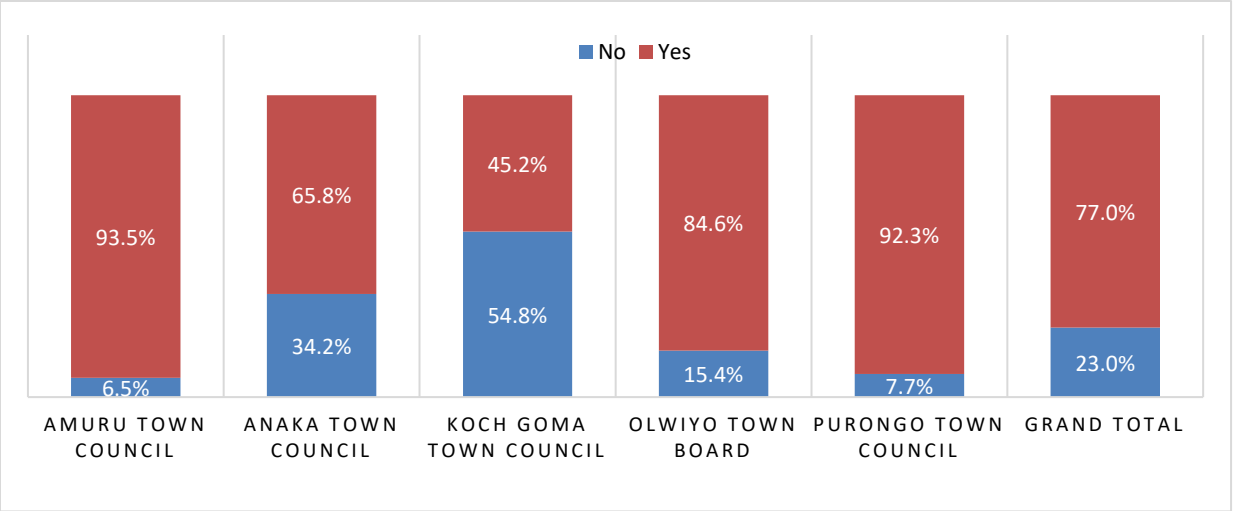
On the other hand, a smaller proportion of HHs in the Anaka cluster were exposed to some form of information on WASH, either through seeing WASH messages (e.g. on posters) or through attendance of community meetings (Figure 3.11). Overall, about 36% of HHs interviewed in the cluster reported to have seen WASH messages within the last 12 months, while 53% of HHs were exposed to messages on WASH through participation in and attendance of community meetings.

Figure 3.11: Percentage of respondents that have ever attended community meetings and seen WASH messages by Town



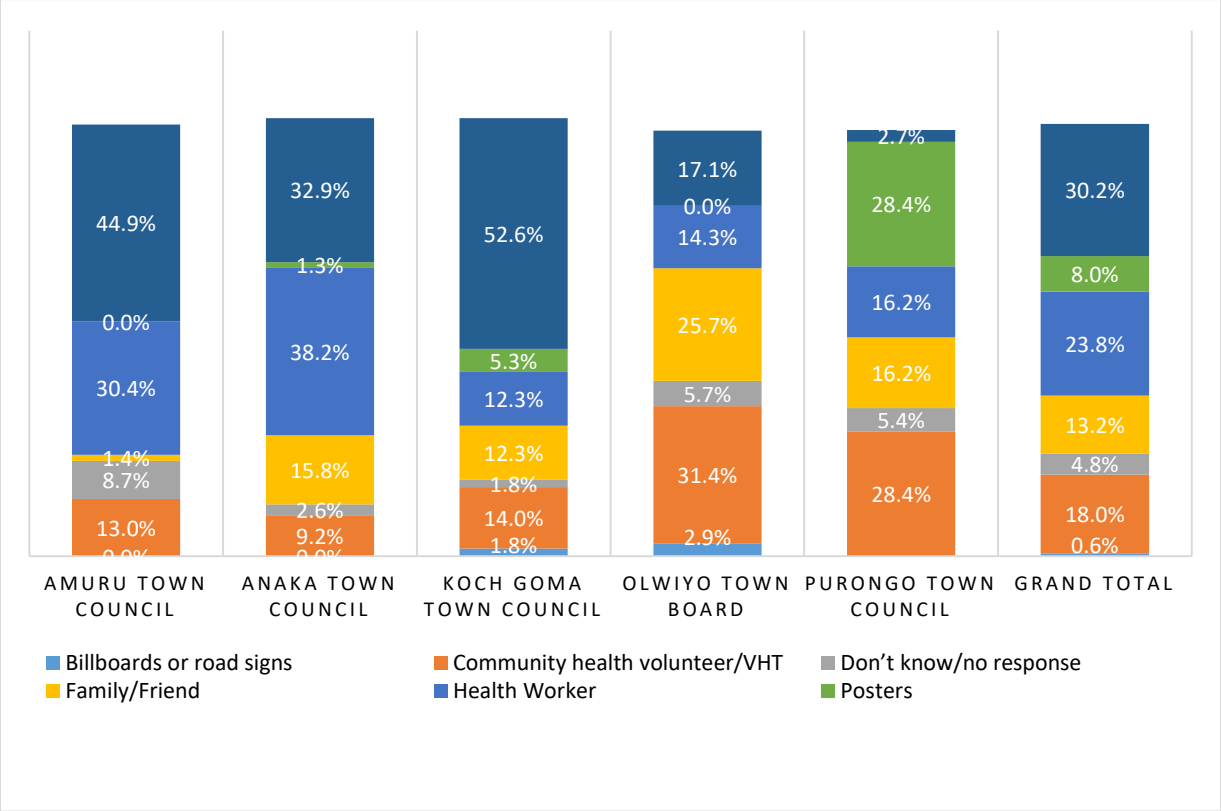
Of those that attended the community meetings, water and sanitation issues were discussed at 77 % of the meetings (Figure 3.12). Amuru reported that 93 % of the community meetings attended discussed WASH, followed by Purongo (92.3%). Koch Goma had the least proportion of HHs attending these meetings and discussing sanitation related issues (45 %).

Figure 3.12: Whether Sanitation issues were discussed during community meetings



Further analysis showed that overall, 53% of the population in Anaka cluster had ever attended a community meeting, while 41% said they saw a WASH message in the past 12 months. Respondents from Purongo town council were more likely to attend community meetings (70%) and see a WASH message (48%) within the Anaka Cluster.

Figure 3.13: Proportion of households by their source of WASH related information



On the other hand, respondents from Olwiyo were the least likely to attend a %community meeting (37%) and get exposed to WASH messages (11%). Community drives that were instituted by VHTs led by the Health Assistants, as mandated by PHC policy, were reported to have led to these results. For future programming, therefore, one of the strategies that the GIZ S4M programme needs to adopt is use of community meetings in towns such as Purongo to pass on WASH messages and information, since the study indicates the fact that 77% of HHs interviewed said sanitation issues were discussed during the community meetings attended.

3.5.3 Sources of information about latrine/toilet construction

As seen from Table 3.5 below, VHTs, Health Inspectors and LC1s are the most common source of information in the community and HHs about latrine/toilet construction and use, pit emptying and hand washing, within the cluster, across board. In Koch Goma, almost all the HHs received information from VHTs about latrine/toilet use (95%), pit emptying (98%) and handwashing with water and soap (100%). This is unlike Anaka where the VHT information dissemination model is weakest, among all the towns in the cluster.

Table 3.5: Sources of information on various WASH services

	Amuru	Anaka	Koch Goma	Olwiyo	Purongo	Total
Source of information about latrine / toilet construction and use						
Health Inspector	50.7%	57.9%	49.1%	22.9%	29.7%	44.1%
LC 1	34.8%	43.4%	28.1%	22.9%	56.8%	39.5%
Sanitation Committee	5.8%	5.3%	14.0%	0.0%	1.4%	5.5%
Mason	5.8%	0.0%	1.8%	0.0%	0.0%	1.6%
VHT	63.8%	30.3%	94.7%	60.0%	54.1%	58.5%
Pit Diggers	34.8%	6.6%	1.8%	2.9%	0.0%	10%
Others	14.5%	3.9%	5.3%	11.4%	0.0%	6.4%
Source of information about pit emptying						
Health Inspector at town council	60.9%	56.6%	54.4%	54.3%	32.4%	51.3%
LC I	31.9%	27.6%	22.8%	17.1%	55.4%	33.1%
Mason	1.4%	1.3%	7.0%	2.9%	0.0%	2.3%
VHT	63.8%	26.3%	98.2%	34.3%	56.8%	55.9%
Pit diggers	37.7%	1.3%	5.3%	0.0%	0.0%	9.7%
Other	14.5%	3.9%	5.3%	11.4%	0.0%	10%

The least source of information are masons yet they play a critical role in toilet construction; therefore, there will be need for the GIZ S4M programme to identify and train masons from

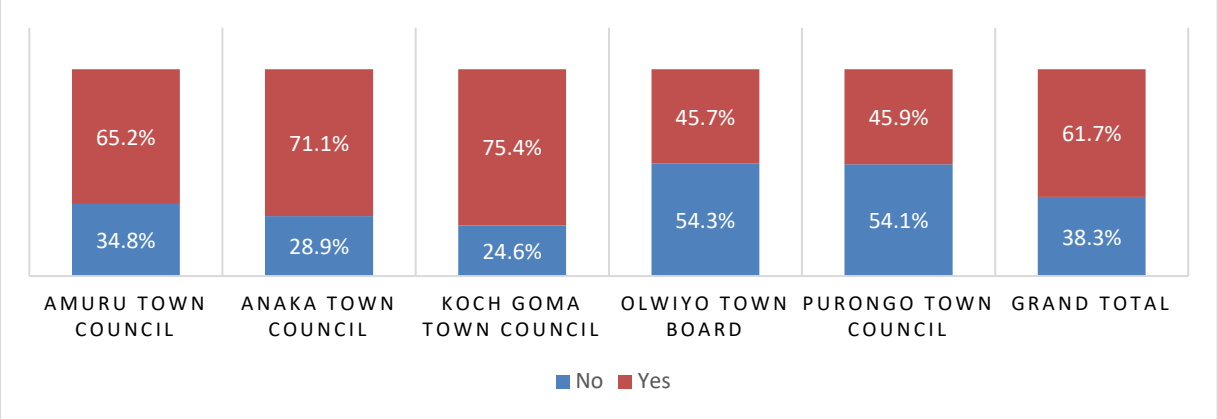
each of the five towns and equip them with the necessary tools (such as BoQs) to provide information on how to construct improved toilets to HHs and to market their services.

3.5.4 Use of Radio as a source of information

Overall, over 61.7 % of the HHs in Anaka's cluster of towns listen to radio (see Figure 3.14). Koch Goma had the highest proportion of HHs who listen to radio at 75 %, followed by Anaka and Amuru at 71 % and 65 % respectively. Unfortunately, the reverse is true in Olwiyo and Purongo with about 54 % of the HHs who do not listen to radio, in both cases.

In terms of listenership to radio (see Table 3.12) Mega FM, Rupiny and Voice of Nwoya FM are the most listened to radios. Mega FM102 is the most listened to radio station (42 %), followed by Rupiny FM (34.7 %) and Nwoya FM (31.8 %). To note is that these radios appeal to different audiences as Favour FM was said to appeal to Born Again Christians; Rupiny, is listened to majorly by young people; Mega FM appeals to older people; while Voice of Nwoya is listened to by everyone.

Figure 3.14: Percentage of Households who listen to radio



The least listened to Radios are Mega FM 100, Gulu FM and Radio Maria with 5% of the respondents mentioning these radios respectively. In terms of the preferred language, as expected, Luo is by far the most preferred language for listening (96%) and reading (75%), among the respondents.

In conclusion, when asked about how best to engage communities and HHs to improve on their sanitation status, the use of radio came up time and again as a tool that can be utilized by the GIZ S4M programme to sensitize communities so as to bring about mind-set change. Therefore, GIZ S4M programme needs to take note of these 3-4 important frequently used channels through which communities and HHs readily get information on WASH for future BCC and other engagements.

Table 3.6: Exposure to sanitation and hygiene information

Radio listened to most (frequency)						
	Amuru	Anaka	Koch Goma	Olwiyo	Purongo	Total
Voice of Nwoya FM	10.1%	52.6%	21.1%	34.3%	37.8%	31.8%
Mega FM 102	53.6%	38.2%	66.7%	20.0%	25.7%	41.8%
Mega FM 100	7.2%	3.9%	10.5%	0.0%	2.7%	5.1%
Favour FM	23.2%	18.4%	26.3%	25.7%	21.6%	22.5%
Rupiny FM	47.8%	18.4%	57.9%	28.6%	24.3%	34.7%
Radio Maria	2.9%	3.9%	14.0%	2.9%	1.4%	4.8%
ABS	20.3%	1.3%	3.5%	0.0%	6.8%	7.1%
Gulu FM	20.3%	2.6%	0.0%	0.0%	0.0%	5.1%

GIZ S4M programme needs to put in place a strong BCC strategy to communicate what the communities and HHs need to hear and to prepare them to receive sanitation facilities. The programme will need to package the S&H messages well, in order to change the current negative attitude and social behaviours of communities and their leaders. Radio should be used as a communication and sensitization tool while being mindful of the different radios that appeals to different audiences.

Recommendations

- GIZ S4M & partners should use radio as a tool of communication to sensitize communities so as to bring about mind-set change, while being mindful of the different radios that appeal to different audiences.
- Develop a BCC strategy to provide knowledge and reinforce awareness, so that people know and buy into the promoted improved latrines and behaviour(s).
- Adopt the use of community meetings in towns such as Purongo as a strategy to pass on WASH messages and information.

3.6 ASSESSMENT ON WASH IN INSTITUTIONS

The social practices assessment covered mainly two types of institutions: schools (both primary and secondary government aided schools); and healthcare facilities-HCFs (i.e. HCF IIs and HCFs IIIs) including one general hospital located in Anaka town council.

3.6.1 Assessment on WASH practices in schools

3.6.1.1 Background characteristics of schools

Majority of the schools accessed are in Anaka Town Council (6), 3 in Koch Goma, another 3 in Amuru, 4 in Purongo, and only one assessed in Olwiyo town. A total of 11 out of 17 schools assessed were primary schools. Only 36 % (6,082) of the learners were females with majority

of the learners being males (64 %; 10,956). There were no refugee pupils registered in the assessed cluster schools.

3.6.1.2 Access to water services in schools

The study established that schools in town councils without piped water such as Olwiyo and Amuru depend on point water sources such as boreholes, while schools in town councils with piped water systems such as Anaka and Purongo use both point water sources and tap water. However, the water from the piped systems was reported to be unreliable. A total of 16 schools out of the 17 assessed have safely managed water on their premises and with water available at the time of the visit. A total of 12 (70.5%) schools had access to boreholes, while 5 (29.4%) schools had access to tap/piped water outside dwelling. Fortunately, only two schools shared facilities with communities, as sharing of water points between schools and communities increases the time for fetching water for students. Only one school had access to water off premise, over 500 m away.

Some few schools e.g. in Anaka and Purongo town councils reported use of rainwater harvesting tanks but which run dry during the dry season. Even where piped water exists, due to increased bills, school managers or head teachers had the tendency to limit use and direct it to only critical areas such as kitchens and not to latrines/toilets.

With high enrolment rates, sharing of water points between schools and communities also raise challenges for the schools as water is not enough, and secondly, is the challenge related to O&M for the schools. When boreholes break down, as reported in Amuru, it is the schools to do repairs. The community simply abandons the water points and fetches water from open wells, until when repairs are completed by the schools.

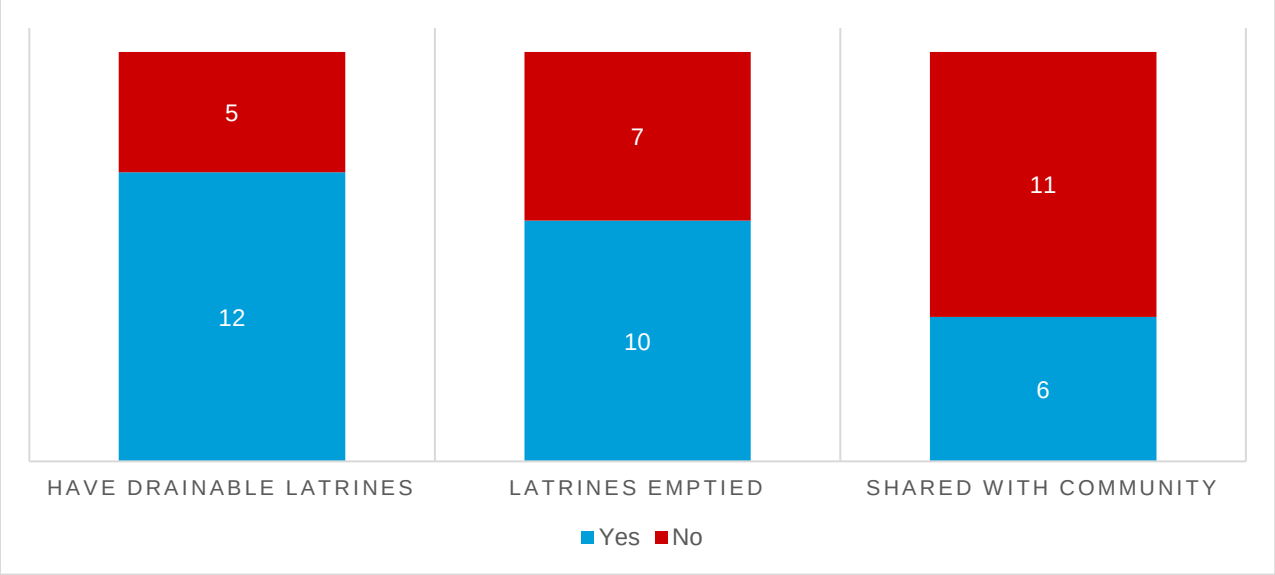
Recommendation:
School Management Committees (SMC), PTAs, and Parents should be sensitized on their roles and responsibilities in the management of school WASH facilities, especially water sources. This will also involve supporting each school to develop O&M plans and budgets for incorporation in the overall schools' work plans and budgets on an annual basis.

3.6.1.3 Sanitation service levels and practices

The assessment established that although GoU and development partners have tried to ensure latrine facilities are constructed in schools, with provisions of stances for learners living with disabilities, generally public schools in the Anaka cluster of towns do not to have adequate improved toilet facilities as evidenced from the pupil; stance ratio. Schools are overwhelmed and facilities overused due to high enrolment rates i.e. number of students Vs. available stances of latrines. Consequently, compared to rural schools whose toilets may take up to two years to fill, urban schools need to be drained on a termly basis because usability is quite high hence high depreciation levels.

A total of 12 (70.6%) schools had access to and were using VIP drainable latrines, while the pupil: stance ratio was 60:1 for boys and 81: 1 for girls; the overall Pupil: stance ratio for all schools was 73:1 which is quite high compared to the national standard, which is 40:1. This means children wait for 1-5 minutes to access latrines; children's lining up to use toilets was reported to affect learning because children's valuable time is wasted. School latrines were found to be shared with communities in six (35.2%) out of 17 schools (see Figure 3,15), while OD was found practiced in 4 (23.5%) out of the 17 schools. Sharing of school toilets with neighbouring communities quite often negatively impacts use and maintenance of toilets and should be discouraged. A total of 10 (58.8%) of the 17 schools assessed had ever emptied their latrines/toilets.

Figure 3.15: Access to latrines and pit emptying practices in the schools



Important to note is that a few schools, for example in Koch Goma town council, were reported not to have drainable toilets, probably because of the high cost of building quality drainable latrines. Contractors for drainable toilets were reported mainly obtained from Gulu city, a distance of more that 40km away from the Koch Goma town and further away from the remaining cluster towns. One of the schools in Anaka town council has a biogas toilet which has become a public nuisance because the biogas system is not working effectively.

Recommendation:
GIZ S4M & partners should support the construction and/or rehabilitation of toilets in schools with inadequate facilities, especially those without drainable toilets; and urgently support schools to address the issue of disposal of used menstrual pads through construction of incinerators.

3.6.1.4 Knowledge and Awareness of Schools about WASH

Regarding awareness on WASH, overall learners in the assessed schools in the Anaka cluster were reported to be aware and knowledgeable about S&H issues. This is because majority of schools have appointed teachers concerned with WASH issues who have also

received some training in some of the towns e.g. in Anaka town council. A total of 16 schools (94%) reported having in place a teacher in charge of WASH, while only 10 schools (59%) reported having access to WASH educational materials. Teachers talk to learners about health and sanitation.

However, to note is that though schools are armed with some information on WASH, it is not adequate or being put in practice as evidenced by poor management of the sanitary facilities which is exacerbated by lack of adequate water in the schools. Therefore, the reasons for poor S&H practices in schools are varied but are within the means of the town councils and schools to address.

3.6.1.5 Challenges experienced on sanitation in schools

School toilets were reported to suffer from vandalism from community members, due to limited number of toilet facilities in the HHs. Poor workmanship was a challenge as well, particularly evidenced through poor quality of construction of facilities and contractors doing shoddy work due to inadequate supervision by the town council and district authorities. Some schools such as Anaka P7 School regularly host sports tournaments, hence outsiders, access, use and contribute to filling up of school toilets. Quality of construction of toilets was expressed by one head teacher of a secondary school as per the quote below:

"*We have functional toilets in place. The only challenge is with the doors that are already falling out so the latrines remain open without doors. Looks like the work that was done with fixing the doors was substandard because the school is only seven (7) years old but we always have a task of re-fixing the toilet doors for both students and teachers. We, however, use them like that whether the doors have been fixed or not because we are most times limited by finances*" **– Head Teacher of a Secondary School, Purongo Town Council.**

The study also found the practice of locking up some of the toilets in some of the schools especially schools with both boarding and day sections, such as Anaka primary school. The implication of this is that some of the toilets are not accessible by learners during the day despite the high enrolment rates. The toilets are locked up and preserved for boarding students to use late evening and in the night leading to overuse and misuse of the few accessible day-time latrines.

3.6.1.6 Proper and Consistent Use and Maintenance of toilets

Overall, O&M of latrines is a neglected area by all public schools in Anaka Cluster of towns, because interesting Head Teachers (H/Ts) on WASH in schools is a challenge. Due to poor use and maintenance mechanisms, the majority of toilets in public schools are filthy and stinking with cleaning of toilets used as a punishment for learners. Access to adequate water was repeatedly reported as a big challenge for schools, especially to help keep latrine facilities clean. However, some teachers were of the view that schools try their best to encourage students to apply the recommended hygienic practices but the issues stem from children's homes where a lot of behaviour change is needed. One specific respondent said the reason why the latrines were dirty was because of the poor hygienic practices that learners adopt from their homes.

Dirty latrines are most likely encouraging the practice of OD, which was observed to happen behind toilets in schools. Privacy for some of the latrines is compromised, especially for

female learners; for example, one of the schools in Amuru town council was reported to have a 4-stance toilet block and 3 out of the 4 stances did not have doors.

Due to poor design, it was also common to find facilities flooded with waste water (urine) inside the toilets. Although 13 schools reported use of toilets paper, there were reports in some schools of learners using stones, grass and remains of maize for anal cleansing; this means solid waste (including used menstrual pads) is commonly introduced into the pits which affects pit emptying. Out of curiosity and wanting to "taste", able learners sometimes use the toilets for those living with disability and soil them with faecal matter.

Recommendations:

- Develop and implement a comprehensive Schools WASH approach with a clear end-in-mind, which focuses on software measures and changing the bad practices identified by the study. Consider promotion of three priority behaviours & messages in schools:
  - ***Consistent and proper use of toilets***
  - ***Practice of hand washing with water and soap at critical junctures***
  - ***Proper menstrual hygiene management***
- Develop and/or print BCC campaign materials, while borrowing a leaf from previous projects such as S4M Phase I (Apac Cluster) and the USAID funded Uganda Sanitation for Health Activity (USAID-USHA). Examples of BCC materials include Snakes & Ladders games, jingles, behaviour calendars, posters, champion badges, etc.
- Train teachers on BCC and how to use these materials to engage learners to change behaviour
- Involve all key stakeholders at school level: the head teachers and teachers; the SMC; PTAs; the Learners and Parents so they are aware of their roles and responsibilities on WASH in schools.

3.6.1.7 Handwashing with water and soap (HWWS) in schools

The study sought to assess knowledge about the benefits of HWWS; knowledge about the critical times when to wash hands; availability of handwashing facilities; the practice itself of hand washing with water and soap by learners and teachers; and availability of water and soap.

Regarding knowledge and awareness, the teachers interviewed from selected schools said an estimate of 60%-80% of pupils were aware about good WASH and hygienic practices such as the need to wash hands with soap and water. However, this is not uniform across board, as some schools put it as low as 22%. Some teachers were of the view that they take students through issues concerning sanitation but when they observe the things that students do after, it proves that they have the theoretical knowledge but lack the practice.

Teachers said they emphasize to the students to wash their hands after visiting the toilets, after picking rubbish from the school compound and before eating meals. As shown by the data from the study, 88.2% of schools reported having installed hand washing facilities around the schools to be frequently used by learners for hand washing; and that learners wash because they have adopted the culture and know that the hands always pick up dirt so there's need to wash them after such activities or before eating so that they do not fall sick.

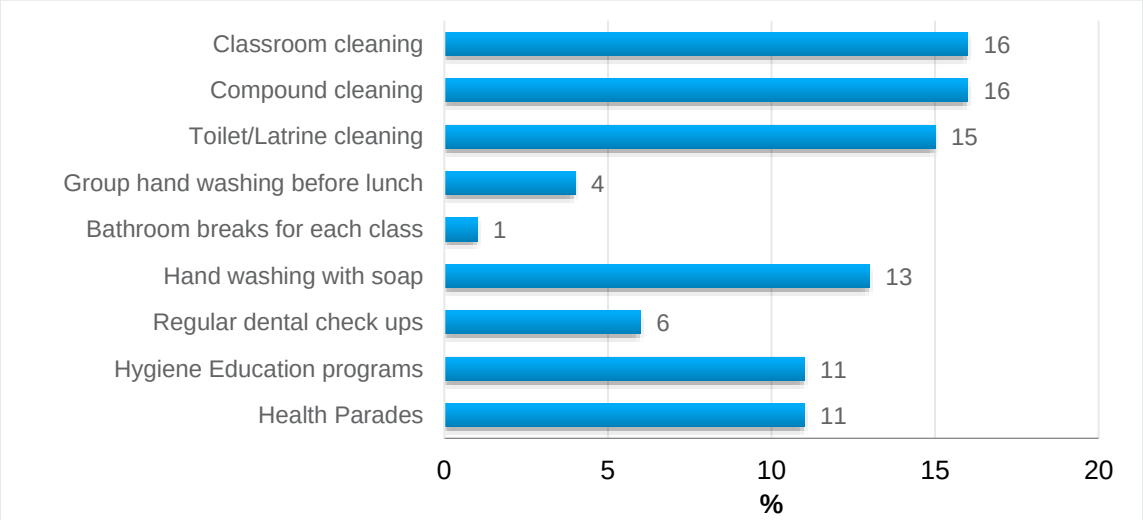
However, much as about half of the schools were aware about HWWS, the actual practice of HWWS is very low. As in the HHs, HWWS in schools seemed to have been practiced only

when threatened by diseases such as the COVID-19 pandemic because then teachers and learners attached the practice to their health and safety. Pupils were also reported to contribute to vandalism of portable hand washing facilities installed in the schools.

Overall, the study established that handwashing facilities were either not available or inadequate in almost all schools assessed, hence negatively impacting the practice of HWWS. This is exacerbated in majority of schools by inadequate access to water. Where schools have handwashing stations, the practice is to pour liquid soap into the hand washing container/facility because of the tendency for the learners to steal bar soap.

The assessment also established that the location of existing handwashing facilities in the schools is not strategic to aid the practice of hand washing at critical times. Learners in all targeted will need to be sensitized with well-targeted messages on the critical moments for handwashing with water and soap, with demonstrations and illustrations on the proper handwashing techniques in the schools. Figure 3.16 shows the different hygiene related practices in the schools.

Figure 3.16: Current Hygiene Practices at the Schools



Recommendation:

- GIZ S4M & partners should support schools to install adequate HWFs in strategic locations in each school e.g., near the toilets, and next to the dining and/or eating areas; and use the BCC approach to promote HWWS in schools, with clear messages, for example: to sensitize learners, so they all know the critical times when to WASH hands
- Paint nudges in strategic places such as toilet walls with key hygiene messages for sensitization but also to promote positive behaviours and reinforce or keep learners reminded of hygiene messages.

3.6.1.8 Solid waste management in schools

Majorly schools produce three types of waste: food/biodegradable waste, paper waste and plastics (e.g. plastic bottles and polythene bags. With regard to SWM, some schools have employed compound cleaners; however, the school administration and teachers sometimes

engage the learners to pick up rubbish around the school. Learners in one of the FGDs in Anaka Town Council had this to say:

Majority of the schools practice collection of rubbish, which they take away to be burnt on the premises. The main practice in the schools, therefore, is to dig rubbish pits which are used for solid waste disposal, where the rubbish is either left to rot or is burnt. Some schools collect solid waste in bins placed at each classroom; these are then collected and carried by the responsible class members to the rubbish pits for burning. Only two (2) schools reported to have their rubbish/waste collected by a private waste collection service provider.

3.6.1.9 Existing structures and systems to promote WASH in Schools

Existence in schools of individuals such as Senior Women and Senior Men teachers and existence and functionality of structures such as School Management Committees-SMC, Parents Teachers Associations-PTAs and School Health Clubs-SHC can support improvements on WASH in schools and adoption of hygiene behaviour and practices. Hence the study sought to assess the existence of such individuals and structures in the schools.

All the head teachers interviewed as KIs from five schools across four small towns (Purongo, Anaka, Amuru and Koch Goma) were knowledgeable about WASH and understood their roles in supervision, monitoring and provision of the necessary requirements needed to facilitate improvements on S&H in the schools. They take part by talking to students about WASH and also encourage the teachers to physically participate in activities such as cleaning, they do not look at it like a punishment. Therefore, Head teachers will be instrumental in supporting improvements on sanitation and hygiene practices in their schools.

Schools also reported to have Senior Women and Men teachers as well as sanitation teachers, key individuals who can be targeted by the GIZ S4M program to spearhead S&H improvements in their schools, while working closely with the head teachers and other teaching and non-teaching staff. The sanitation teachers, together with the H/Ts, do planning and budgeting for S&H in the schools, while the Senior Woman Teachers (SWT) are responsible for menstrual health of girls while in school. A few schools such as Anaka P7 school in Anaka town council and Purongo Seed School in Purongo town council reported to have had their teachers trained on WASH, who in return pass on the information to students. However, training of teachers may not have been uniform across all schools.

Some schools reported to have in place a committee in charge of health and sanitation with both male and female leadership, besides the sanitation teachers. For example, one school in Koch Goma reported to have a Health and Sanitation Club consisting of 14 executive student members, with 215 student members overall; however, this committee was not trained on its roles and responsibilities.

A total of 14 out of 17 schools assessed reported to have School Health Clubs (SHC); of these, only 10 were reported to be functional. The composition of these SHC was 374 learners (172 males; 202 females). The GIZ S4M will need to strengthen SHC to play their role in changing behaviours among peers in schools.

The Head Teachers, together with SMC, are responsible for overall planning and budgeting for the school including WASH using either Universal Primary Education-UPE or Universal Secondary Education-USE funds or resources generated from parents' contributions. However, with the situation with "village" schools, parents do not pay promptly so it makes it very hard and costly for schools to pay for some of the services. Head teachers also observed that UPE & USE funds are conditional grants, and so the component for utilities that comes with it is very little and often goes to paying utility bills.

Recommendation:
GIZ & partners should strengthen school-level structures such as SHC and their patrons in the 10 schools assessed and found with existing SHC; and support formation and training of SHC in the remaining schools, for engaging fellow students in peer-to-peer learning and change of behaviours (e.g. through music, dance and drama).

3.6.1.10 Some Good Practices on WASH in schools

The study found some isolated reports of good practices going on in schools. For example, health inspectorate staff in Anaka town council reported to have established WASH Movements in schools where learners in lower and upper classes are involved. WASH movements were taught how to develop school cleaning rota, which they discuss in their Clubs so that cleaning becomes a routine". In Koch Goma town council, Koch Goma Central P.7 primary school was able to allocate and use the Universal Primary Education (UPE) funds provided by the Ministry of Education & sports (through the district) to take care of WASH (E.g. construction of a boy's latrine).

Purongo Seed Secondary School has staff who were trained on WASH at the sub county, and as a result supported installation of hand washing facilities in the school. The head teacher (H/T) is involved in monitoring the cleanliness and hygiene in the toilets and bathrooms as well talking to students about their hygiene, keeping clean and smartness and had improved a lot. The H/T was aware of his role in supervision, monitoring and provision of the necessary requirements needed to facilitate the improvement of hygiene in the school. He takes part in talking to the students about WASH, gives them practical examples of how to do certain activities, and encourages his teachers to always be in a place physically as the students are doing cleaning and if possible, take part in what the students are doing so that they do not look at it like a punishment.

3.6.1.11 Ongoing WASH in Schools Programmes

The study established that some schools, for example in Anaka town council, reported to have received support on MHHM from a company called "Lutino Adunu", whose lady teaches the girls how to make reusable pads. She teaches both school children and women groups in the community. She also gives them health talks on how to manage and remain clean as women during and after these periods. She currently gives services for free of charge. *Details about Lutino Adunu can be found in the sub-section on MHHM of this report*.

The Sisters of the Holy Cross (USA) were reported to have supported Koch Goma Central P.7 school in Koch Goma town council by funding the construction of a borehole that is currently being used by the school. In addition, using SFG, the head teacher of the same schools facilitated the renovation of one of the latrines for the teachers. The SFG initiative

under the MoES also provides some funds for construction of latrines in schools for learners, for both boys and girls.

Watoto Church (Gulu), on a monthly basis, usually provides menstrual pads to some schools for the girls to use e.g. in Koch Goma town council. They also participate in providing health education drives that involve hygiene talks given to the girls and boys in the schools. The menstrual pads are usually stored by the Senior Women Teachers (SWTs) who distribute them to the girls in need, within the schools. SWTs were reported to provide health education topics to the girls on a periodic and regular basis. The head teachers supervise the SWTs in their role related to menstruation. Some schools have also established Health and Sanitation Clubs, although these clubs need strengthening to play their roles.

Schools in Anaka town council reported to have participated in sanitation and hygiene programmes with the most recent with the GIZ staff who came to launch the S4M programme. Schools also reported participation in the sanitation day celebrations by sending learners and the sanitation teachers to go for sanitation programmes that were organised by the town councils. They were sensitized about hygiene and also participated in cleaning around the hospital and town.

Save the Children also had on-going programme called “Leave No one Behind” and specifically had some interventions on MHHM, for example in the schools in Anaka small town; however, the programme ended in March 2023.

Overall Recommendation on WASH in Schools:
Develop a clear Concept or Step-by-Step Guide for WASH in Schools to guide all interventions by GIZ S4M programme and partners, with clear:

- End in mind, what does the WASH in schools programme wish to achieve in schools
- Strategies for engagement of stakeholders (SMC, teachers, learners, parents, …)
- A menu of activities to be implemented from entry into a school until exit/endline.
- BCC messages on S&H and MHHM to trigger change in behaviours in schools.

3.6.2 Assessment of WASH practices in Health Care Facilities-HCFs

The assessment focused on understanding and appreciating the existing practices on water, sanitation, hygiene; healthcare waste management systems and environmental cleanliness as per the JMP service ladder for monitoring WASH in HCFs as well as the Ministry of Health’s National Guideline for WASH in Health Care Facilities-HCFs (2021).

3.6.2.1 Access to water services in HCFs

a) **Water supply in Anaka General Hospital-GH**

Anaka GH has its own piped water system with two production wells: a smaller motorized solar powered system, which can pump up to 2,000 litres of water a day; and second source which is powered by a Generator. However, the GH currently has intermittent water supply due to inadequate planning and budgeting for O&M. consequently, all the departments in the GH were found connected to the water supply system but had no running water because the system was not working effectively. The system is broken down and foreign material was reported to be entering into the system which could be the cause of the blockage experienced.

The GH was reported to have no qualified technical personnel to help run the system but instead is using Plumbers who conducted an assessment but were not able to rectify the problem. The Hospital may benefit from employing an Estates Manager to help take care of their water supply system.

b) Water supply in other lower-level Health Care Facilities (HCFs)

A total of six (6) HCFs were sampled for assessment, excluding three (3) private not for profit facilities. The rest of HCF IIIs and IIs that were sampled and assessed for example in Koch Goma, Purongo and Amuru town councils use point water sources such as boreholes which are located on the HCF premises. However, this was viewed as a big challenge because in a HCF III, for example, there is need for running water especially in the laboratories, the maternity wards and in the examination rooms. Some of HCFs have rainwater harvesting systems for their Out-Patients Departments-OPDs, but which run dry when there is no rain leaving the facility with no water. Besides, in some of the HCFs, wards such as maternity which require running water are not connected to any system.

Regarding maintenance, like happens with many institutions, the communities around the health facilities share the water facilities with the health centers but once the boreholes break down, the community members tend not to contribute towards repairs. This may explain why some HCFs such as Purongo HCF III lock their borehole and deny community members water. Figure 3.17 shows a summary of access to water services across the HCFs assessed against the stated indicators or parameters. A total of 2 HCFs did not meet target against some of the indicators, while 2 HCFs did not have a management and operational plan in place.

Figure 3.17: Water service levels in the HCFs

Characteristic	# of Health Care Facilities assessed & Performance			Remarks
	Yes meets target	Yes, partially meets target	No, does not meet target	
ACCESS TO IMPROVED WATER SERVICES				
Improved primary water sources	6 (100%)			All the 6 assessed facilities had access to improved water
Availability of water on the facility premises	5 (83.7%)	1 (16.7%)		One HCF has water off premises, Less that 500m from the HCF
Functionality of water source	6 (100%)			All the 6 HCFs assessed had functional water sources
Water is available all the time	5 (83.7%)	1 (16.7%)		One HCF, yes, had water every day but not sufficient quantity
Availability of a Management and Operations plan	3 (50%)	1 (16.7%)	2 (33.3%)	Two HCFs assessed did not have a management & operational plan seen.

Recommendations:

- Facilitate formation of a small committee of 5-6 people to discuss and agree on the way forward regarding the water system in Anaka GH (which, once rectified, will facilitate re-opening of the sanitary facilities in the wards).
- Train the GH management & IPCs of HCF IIIs and IIs on O&M of the WASH facilities; encourage management of the GH to employ an Estates Manager.
- Extend water services to the HCFs that partially met target and ensure all HCFs have O&M plans and budgets in place. Part of the PHC funds received at HCF level should be utilised for O&M of WASH facilities.

3.6.2.2 Sanitation Service Levels in HCFs

Anaka GH

Currently the hospital has two (2) blocks of latrines of two stances each: one for OPD and one for in-patients but for a hospital which receives on average 300 patients a day, these facilities are inadequate. All buildings (departments and wards) were reported to have flush toilets but these were closed due to lack of water and high volume of patients, except for hospital staff who use pour-flush system. A beautiful washing facility for clothes provided for in the hospital is non-functional and the toilets close to this facility were also closed due to lack of running water.

One of the KIs was of the view that what is lacking majorly are adequate outside pit latrines for patients and ensuring provision for people living with disability. However, the recommendation is for the current blockage in the water system to be rectified, to facilitate the flush toilets to function effectively. Once this is addressed, flush toilets will be re-opened for use by patients and caregivers. However, there will be need for on-going support by the IPC committee to sensitize clients/patients, their visitors and care-takers on how to use the flush toilets.

HCF III and IIs

Majority of the lower level HCFs that were assessed have drainable latrines which were all functional, except three (3) HCFs assessed had less than 50% of the required number of stances. The toilets are accessible to all patients, their visitors and attendants and they are available at all times during the day and night, except one HCF has a facility for PWD but in disrepair while another HCF did not have any provisions for PWD at all. Also, the HCFs reported lack of proper bathing or washing facilities for the general wards, besides the in-patient and OPD toilets.

Regarding pit emptying all the HCFs, except Anaka GH, practice manual pit emptying of latrines because it is the cheaper option available but is unhygienic. In Koch Goma town council, HCFs are charged UGX 800,000 for manual pit emptying. Disposal of FS is onsite, by digging burying the faecal sludge behind the pit latrines which may be a health risk. Most of the HCF IIIs reported to have incinerators; however, they do not have ash pits.

The girls and women have access to latrines and toilets; however, one HCF assessed did not have clearly demarcated toilet facility for females. Majority of the toilet facilities have no provision for buckets inside the toilets for disposal of menstrual pads; there are no inadequate incinerators; and no changing rooms besides the toilets to take care of the needs of women. There are no washing places and bathrooms close to the in-patient and OPD toilets. Some

HCFs have one toilet facility being shared by both maternity and in-patients, yet there should be separate facilities used by both the in-patients and the out-patients. Figure 3.18 below shows a summary of access to sanitation services across the HCFs assessed against the stated indicators or parameters. Almost half of the facilities assessed either partially met target or did not meet the target at all.

Figure 3.18: Access to sanitation services in the HCFs

ACCESS TO SANITATION / TOILETS				
Type of toilet	5 (83.7%)	1 (16.7%)		One HCF assessed has an unimproved toilet.
Number of toilets available	3 (50%)		3 (50%)	3 HCFs assessed has less than 50% of required number
Separation of Toilets (Staff & Patients	3 (50%)		3 (50%)	3 HCFs assessed did not have separate facilities for staff & patients
Separation of Toilets (Male & Female)	3 (50%)	2 (33.3%)	1 (16.7%)	2 HCFs assessed had toilets but not clearly separated; one did not have clearly separated facilities
Availability for people with disability	4 (66.7%)	1 (16.7%)	1 (16.7%)	One HFC assessed had a facility for PWD but in disrepair; one HCF had a toilet but with no provision for PWD
Toilets provide Privacy	5 (83.7%)		1 (16.7%)	One HCF assessed did not offer privacy
Emptying of toilet	5 (83.7%)		1 (16.7%)	3 HCFs used a municipal truck, 2 HCFs used a private truck, one HCF used manual emptying

Recommendations:

- Urgently support Anaka GH and the lower level HCFs to address gaps in hardware e.g. support the GH to rehabilitate the hospital lagoon for treatment of FS and construction of new or rehabilitation of existing sanitary facilities in HCFs and ensure provision for washrooms and incinerators for women (patients and caregivers); consider these facilities for critical points of care e.g., OPD and Maternity Wards.

3.6.2.3 Use and Maintenance of Sanitary Facilities in HCFs

Anaka GH

The hospital employees a cleaner for toilets; the cleaners who clean buildings also clean toilets. However, nurses also help with keeping the place clean.

HCF IIIs and IIs.

Koch Goma HC III in Koch Goma town Council and Otwee HC III in Amuru town council were visited for KIIs. The study established that despite employing cleaners who clean the toilets on a daily basis in these HCFs, majority of the healthcare sanitary facilities were in a very sorry state due to misuse. Misuse of the latrines by the patients was observed as toilets were

found dirty; patients were also reported not to use the right anal cleaning materials. Most of the latrines save for some recently constructed facilities (e.g. by the Japan Government in Koch Goma HC III) are in a sorry state to the extent that men sneak to *use the newly constructed maternity ward latrines.*

The HCFs also expressed the prevalent delay in the receipt of cleaning products as well as disinfectants, because of delayed disbursement of funds by GoU to the National Medical Stores for purchase and distribution of the necessary supplies and products to HCFs around the country.

Recommendation:
1. Use the O&M Training Manual on WASH in HCFs (MoH, 2022) to enhance O&M capacity of WASH facilities for all HCFs, but also facilitate HCFs to develop and implement O&M plans and budgets, per HCF.
2. Develop & implement a scalable model to improve and maintain infrastructure in HCFs.
3. Follow-up the use of PHC funds in the HCFs to facilitate the Health Assistants to conduct sensitizations of patients and care-givers and communities within a radius of 5 kms from the HCFs.

3.6.2.4 Hand Hygiene in the HCFs

Anaka GH.

Regarding awareness, it was established that majority of patients who come to the hospital are aware about the importance of washing hands, but people do not put knowledge into practice. The assessment established that the GH was flooded with hand washing stations during the Covid-19 pandemic but since the pandemic ended, there are very few as there are no hand washing facilities right from the main gate or entrance into the hospital. There is need, therefore, to support installation of handwashing facilities which are not movable from place to place, not only one but several of them, for example, near the main gate, near the administration block, near the kitchen, near OPD and near the toilets.

HCF III & II.

In 2018, there was support on improving hand washing in HCFs by the RHITES North under University Research Council (URC) that was funded by USAID that provided hand washing facilities to the Health Centers e.g. in Koch Goma town council in 2018. The project also trained VHTs to promote community health including hand washing and other hygiene practices. However, despite having guards who work either during the day or nighttime, majority of the hand washing stations donated by RHITES-North were reported to have been stolen from the facilities. Generally, there was reported misuse of the hand washing facilities at the HCFs; patients were found not practicing hand washing with water and soap as recommended.

Figure 3.19: Access to hygiene services in the HCFs

ACCESS TO HAND WASHING SERVICES				
Availability of hand washing facilities near the toilets	3 (50%)	2 (33.3%)	1 (16.7%)	2 HCFs assessed had handwashing facilities with no water and soap; one HCF had no hand washing facilities
Handwashing facilities at all points of care	2 (33.3%)	3 (50%)	1 (16.7%)	3 HCFs had handwashing facilities but with no water or soap; one HCF did not have any handwashing facilities
Availability of disinfectant and sterilisers at HCF	5 (83.7%)	1 (16.7%)		One HFC assessed had sterilizers but inadequate.
Hand washing facilities at all points of waste disposal	2 (33.3%)	1 (16.7%)	3 (50%)	One HCF assessed had hand washing facilities but with no water & soap; while 3 HCFs did not have at all.
Availability of hand washing and hygiene promotion materials	3 (50%)	2 (33.3%)	1 (16.7%)	3 HCFs had visible materials; 2 HCFs had partially visible materials; one HCF did not have materials at all.
Availability of awareness sessions on hand washing and MHM	4 (66.7%)		2 (33.3%)	4 HCFs assessed had adequate sessions; 2 HCFs did not have any handwashing and hygiene sessions.

Recommendations:

- Support HCFs to construct WASHaLots at strategic locations within each HCFs.
- Work with the H/As, HIs and VHTs in each town council to engage clients in and around HCFs on WASH. Put to use the training manual for IPC and One Health as well as the simplified User Guide that were developed by Makerere School of Public Health (MUSPH) for use by VHTs for the WASHFit process in each HCF.

3.6.2.5 Solid Waste Management in the HCFs (including medical waste)

Anaka GH.

Anaka GH has a garbage bank for temporal solid waste storage outside the main gate of the hospital. However, solid waste was reported to take long in the hospital before it is collected and hauled away for disposal by the town council; usually the tractor takes waste after every two days. The hospital has no substantive incinerator for burning waste; however, there was one under construction. The hospital also has a placenta pit but not well maintained and hence was stinking, and an ash pit and other pits where to dispose of infectious waste.

HCF III & II

The H/As and/or HIs are responsible for the establishment of waste bins in and around the Health Centers and ensuring that the cleaners collect these regularly and burn them in the pit. The Cleaners dispose of the solid waste at the rubbish pits regularly, where it is burnt. All the HCFs practice sorting of medical waste at the generation point, where these are sorted into highly infectious, infectious, sharps, etc. However, the current practice is that these are

mixed at the time of disposal. Figure 3.20 below shows a summary of the solid waste management practices especially for medical waste.

Figure 3.20: Solid & Medical Waste Handling Practices in the HCFs

MEDICAL WASTE DISPOSAL PRACTICES				
Segregation of waste in 3 coloured containers and clearly labelled	4 (66.7%)		2 (33.3%)	4 HCFs had color coded bins, clearly labelled; 2 HCFs did not have any color coded bins
Use of appropriate sterile equipment	5 (83.7%)		1 (16.7%)	5 HCFs had sterile equipment available for all staff; one HCF did not have any equipment available.
Availability of disinfectant and sterilisers at HCF	5 (83.7%)		1 (16.7%)	5 HCFs assessed had disinfectants & sterilizers; one HCF did not have any
Use of waste disposal protocols	3 (50%)		3 (50%)	3 HCFs assessed has waste disposal protocols; 3 HCFs did not have any.
Availability of incinerator or other alternative technology	2 (33.3%)		4 (66.7%)	Only 2 HCFs assessed has incinerators; 4 HCFs did not have incinerators or alternative technology

3.6.2.6 Governance/Existence of IPC Committees

Anaka GH

The hospital has an IPC comprising of nine (9) members (Chairperson, Secretary and members). Its role is to: i) sensitize staff, community and patients about infection prevention including in the wards and at home; and including WASH ii) Continuous Medical Education (CME) to remind staff; iii) support lower-level facilities e.g. HCF IIs and IIIs; and iv) Contact tracing (hand hygiene, how to prevent coughing/technique of coughing, waste disposal, rubbish pits including distance of rubbish pit from home), etc. However, the IPC was reported to be inactive after its chairperson was transferred and promoted to a District Health Officer-DHO in one of the districts in the region. Secondly, the hospital does not have resources to buy refreshments (e.g., tea or soda and bites/snacks), and so the committee members are not motivated to hold monthly meetings. Thirdly, IPC committee members were reported not have the time to conduct meetings.

With regard to Primary Health Care (PHC) funding, the study established that Anaka GH receives PHC funding but the guideline on how it is supposed to be utilized, how much is planned and budgeted for, and how much is received was not clear to the team, yet this would be one of the sources of funding to support the work of IPC committees. Usually, the Medical Superintendent of the hospital is mandated and requests for the PHC resources.

HCF III & II

The H/As and/or HIs are in-charge of WASH issues at the HCF II and IIIs as well as in-charge of IPC Committees. The IPC committees oversee the sanitation issues of the HCFs. H/As and HIs are also in-charge of the Town Councils Sanitation Committees. IPCs are responsible

for spearheading WASH activities in the HCFs and also do community health sensitization outreaches, among other things. In some towns, the Town Clerks have asked the IPC committees to extend their mandate to the Town Council and communities around it. All the HCFs assessed had IPC committees (except one), which is a result of the intervention by GIZ in partnership with MUSPH.

Figure 3.21: Existence of IPC structures at HCF level

GOVERNANCE				
Availability of a functional WASH/infection control committee	5 (83.7%)		1 (16.7)%	5 HCF assessed had functional IPC committees; one HCF did not have IPC Committee.
Availability of WASH Focal person/officer	**6 (100%)**			All the 6 assessed HCF had IPC committees.
Inclusion of sanitation and hygiene in annual budget	6 (100%)			All the 6 HCFs assessed, each S&H included in the budget.

3.6.2.7 On-going Sanitation & Hygiene (S&H) programmes in HCFs

HCF III & II level

Using funds from the PHC, the H/As undertake health-related community outreaches within a radius of 5km from the health center. These outreaches are done together with VHTs under the supervision of the H/A, where they promote hygiene and good sanitation practices at the HH level. However, it was noted that this is according to the MoH policy but in reality, the activities are not well-done because PHC funds are insufficient and many times they come late. Instead, for community, the HCFs normally conduct health education when patients come for services at the facility.

In some town councils such as Koch Goma, the Japanese Government supported the construction of a new maternity ward with in-house toilets and a drainable latrine at the health centre. The HCFs are also aware about the on-going S4M programme by GIZ that is working on WASH issues in the community.

The HCFs also do repairs of HCF level water points such as boreholes when there are break-downs, so that the health facilities have running water. The In-charges, together with the H/As also organise for pit emptying when the pit latrines are full. They also ensure that there are hand washing facilities at the HCFs to aid the practice of hand washing facilities, although these were reported either broken down or stolen from some of the HCFs.

GIZ and Makerere School of Public Health (MUSPH) Partnership Programme

GIZ had a partnership with MUSPH between May and July 2023 with three objectives: i) to assess WASH and IPC status in HCFs; ii) to check the functionality of IPC committees, so that they are given WASHFit to improve on services; and iii) to see if there are gaps in IEC materials. The situation analysis by MUSPH revealed gaps in service provision e.g., there

was limited supply of water in the HCFs, hence affecting the quality and use and maintenance of sanitary facilities, and practice of hand hygiene. There was a lot of OD observed resulting from poor O&M of existing sanitary facilities. MUSPH supported the re-establishment and reactivation of the IPC Committees in all the targeted HCFs, conducted trainings for Health Workers and VHTs, developed a training manual for IPC and One Health; simplified IEC materials; and a simplified User Guide that VHTs could use for the WASHFit process. For sustainability, MSPH worked with local stakeholders such as the ADHO-EH and Health Inspectors, who were involved in the supervision and monitoring, so that the process is locally owned for follow-up and institutionalization.

Recommendation:

- The H/As and HIs as well as IPC members should target clients during clinic days to pass on WASH messages (e.g. clinic days for clients with chronic illnesses such as TB and HIV/AIDS; and/or antenatal clinics).
- Put to use the training manual for IPC and One Health as well as the simplified User Guide that were developed by MUSPH for use by VHTs for the WASHFit process in each HCF.
- Consider adoption of GIZ's "Toilet Make Grades-TMG" and tailor it to HCFs, to encourage competitions between healthcare facilities (see conclusion & recommendations for details).

3.7 ASSESSMENT ON WASH IN PUBLIC PLACES

Public sanitation facilities are always found on highways, markets, and taxis and/or bus parks majorly meant to help the residents as well as the transient population. The biggest challenges with public sanitation in the five Anaka cluster of towns are five: one, is that facilities are inadequate; secondly, is that existing management structures do not know their roles and responsibilities, ; thirdly, is limited knowledge especially on how to use waterborne toilets-WBTs (e.g. in Anaka town council market); fourthly, is the poor use and management of the existing latrines; and lastly is lack of water. With the exception of Purongo town council that has a public latrine constructed along the Karuma-Pakwach-Nebbi-Arua highway and managed by Umbrella utility, all the five towns do not have adequate public latrines except in the town council markets.

3.7.1 Status of WASH in the markets

3.7.1.1 Access to water in the markets

With regard to access to water services, all key stakeholders interviewed at market level observed that for S&H to be improved, the markets must have access to water. Unfortunately, all markets in the five small towns do not have any source of water inside the markets. The assessment established that the former Tenderer for Anaka market, for example, left an uncleared water bill of about UGX 60,000 which was hard for the current Tenderer[5] to start working with and so the water was disconnected by NWSC. The Town Clerk promised to clear that bill so that the current Tenderer can have a fresh start, but this has not been effected, which is sheer negligence. With the resources generated by markets, town councils can liaise with NWSC and Umbrella to extend water services/connections inside the markets

[5] The current Tenderer of Anaka Market started working in the market in November 2022.

While in Purongo town council market, the closest water source is located at the nearest health facility but is unreliable because it is usually locked up which means market vendors have to look for other alternative sources of water. Overall, reasons for inadequate access to water in the markets is more administrative but unfortunately has kept the hygiene of the markets very poor.

3.7.1.2 Access to sanitation in the markets

The assessment established that there are existing latrines in each market; however, besides being inadequate, the facilities are not in good working conditions due to poor O&M and are not sex-segregated. The desired size of the public latrines would be at least 3-4 stance with a bathroom attached. While Amuru town council market has two latrine facilities (one old; and a new one), Anaka town council market has a 7-stance latrine facility but because of poor management by the former tenderer, only two stances are in working condition and currently in use; promises to do repairs by the town council are not forthcoming.

Overall, all the five (5) small towns lack adequate public sanitary facilities; the few existing one serve mainly markets and are not well maintained. They also lack hand washing facilities with soap and/or water. The ideal is that town councils should have flush toilets but only about 1% of residents have them. Town councils are believed not to be doing enough to provide public toilets especially in the markets and yet these markets e.g. in Anaka town council accommodate more than 1,000 vendors in the market who pay market dues.

Recommendations

- Support the construction of adequate sex-segregated drainable public toilets (pour flush) in the markets and other public spaces such as taxi parks and/or rehabilitate existing toilets, and ensure provision of facilities/stances for the disabled, washrooms for women, bathrooms and incinerators.

3.7.1.3 Use and maintenance of toilets in the markets

Overall, market leaders and vendors are not satisfied with the current toilet facilities because they are too few for the daily traffic/population that uses them. Due to few stances, the market leaders feel there is no way they can segregate for the different sexes; hence males or females use the available stances interchangeably. This applies to the few existing bathrooms as well, hence no privacy especially for women. Neither do the current toilet facilities have provisions for people living with disability (PWDs).

There are also concerns about the location of toilets, for example, in Anaka town council the market toilet is located outside the market which contributes to its misuse and being dirty, and the sharing of toilets with nearby communities as in the case of Purongo town council market which also poses challenges with use and maintenance.
One of the most common bad practices is disposal of used menstrual pads and/or bottles of water into the toilets, hence making it difficult for the cesspool emptiers to empty and remove sludge from the pit latrines.

Recommendations:

- Conduct Training of Trainers (ToT) for the Market leadership and town councils on proper O&M of sanitary facilities; and develop and share with them the BCC materials on the “dos” and “don’ts” of public toilets (in local language).

3.7.1.4 Current management models for public latrines

The management model adopted for the existing public latrines is either by the Town Councils (TCs), who tender out management to private operators/market masters/Tenderers, or by utility companies such as Umbrella organizations (e.g., for Purongo town council highway sanitation facility). Overall, despite generation of adequate revenue all the public latrines in the town council markets currently suffer from O&M challenges, for example, the latrine at Purongo highway was reported always closed due to challenges with its plumbing system.

Although the TCs lease out the market toilets to private operators, it was noted that the lease agreements have been abused or do not cover O&M costs such as paying for water bills, doing repairs of toilets and pit emptying. Additionally, the private operators do not provide hand washing facilities with water and soap to aid the practice of HWWS after toilet use.

Recommendations:

- Umbrella should support the town councils to review agreements with Tenderers and to breakdown the roles and responsibilities of the Market stakeholders i.e. Town council and Market Operators/Masters/Tenderers.
- Consider the option of tendering management of public toilets to private operators, independent of Market Masters/Tenderers, so that toilets become a source of revenue for the town councils; training the private operators on the basics of managing public toilets and how to plan and budget for recurrent costs such as consumables and toilet emptying.

3.7.1.5 Hand hygiene services and practices the markets

It is assumed that the number of people who are knowledgeable about good hygiene practices in the markets (e.g. Anaka market) is high, estimated at about 60%. However, the practice of hand washing with soap and water at critical times is very low. It was reported that it is not common for people in the markets to use soap and water for washing hands after toilet use because the facilities or service is non-existent at the toilets; therefore, it is simply a culture that market vendors have not developed.

However, on the other hand, the most common practice of market vendors is to wash their hands before and after eating food because it is a norm or culture they have built over time and are used to doing every day. Important to note is that absence of water in the markets makes it hard for vendors to regularly wash their hands.

Recommendations:

- Construct WASHaLots closer to the public sanitary facilities in the markets to aid the practice of handwashing with water and soap by market vendors.
- Develop and share with the market leadership BCC materials on HWWS.

3.7.1.6 Willingness and ability to pay for use of public toilets

The assessment established that there is willingness to pay for use of public toilet and bathroom services as long as the facilities are functional and offering a good service. For example, it was noted that people in Elegu in Amuru district pay Ugx 500 for bathing and the facility receives over 150 users per day while in Purongo, the community is being charged Ugx 300 for toilet use and Ugx 500 for bathing. In Anaka town council market, on ordinary days, users pay UGX 200/= per use while on the big market/auction days they pay UGX 500/= to use the toilet.

3.7.1.7 Governance of Town Council Markets

All markets in the Anaka cluster of towns are managed by Town Councils, who tender out day-to-day management to private operators aka Market Masters or Managers or Tenderers. The sole responsibility of Tenderers is basically to collect daily revenue from market vendors. The expectation is that a certain amount of funds is paid to the town councils per month i.e., UGX 1.2m per month to Anaka Town Council. Amounts charged per market vendor depend on what one has brought for sale, for example, in Anaka market UGX 500/= is charged for one selling tomatoes and UGX 2,000 per sack for those selling cassava since this is brought in sacks. However, Tenderers are willing to play an additional role in improving WASH in the markets, only if access to services can be improved. The Tenderers also welcome hygiene promotional programs to sensitize market vendors on improve practices. As suggested earlier, town council need to be supported to clearly demarcate roles for management of public toilets in the markets, between the councils and tenderers.

Recommendations

- Town councils need to be supported to clearly demarcate roles for management of public toilets in the markets, between the councils and tenderers; or consider tendering the management of pubic toilets to private service providers.

3.7.2 Status of WASH in The Religious Places of Worship

The study selected sites for assessment on WASH to represent the mainstream churches and mosques and thus selected three sites: a mosque in Koch Goma town council, a Catholic Church in Anaka town council and an Anglican church in Purongo town council. Unfortunately, Anaka Catholic church did not have a toilet facility as the only available toilet was inside the Parish Priest's residence; Christians use a toilet located at the nearest Library. On the other hand, Purongo Church of Uganda (CoU) also did not have a toilet as Christians were reported to use the facility at a nearby school. Therefore, the information included here was basically picked from an interaction with a Key Informant at a mosque in Koch Goma town council.

3.7.2.1 Access to water at the mosque

The study established that the mosque has access to piped water supply. Aware that Muslims need to use water before prayers are held, water was extended and a meter installed at the mosque. Management of the water system periodically serve the mosque with the water bills, to which the Muslim community that pray at the mosque make contributions. The Muslim leader reported that once the bill is received, an announcement of the total amount is made for contributions to clear the bill.

The mosque has no management structure in place for managing the water services; however, the mosque devised a mechanism where the tap is lock especially when the community is bust praying to avoid children from playing at the tap. Regarding O&M funds, there was no specific money put aside in advance for paying the water bill but instead funds are collected only when the bill is received and payment made depending on the actual amount on the bill. The leadership of the mosque has intentions to put some gutter to begin harvesting rain water to supplement the tap water at the mosque.

3.7.2.2 Access to sanitation at the mosque

Koch Goma mosque has a 2-stance drainable toilet, which is inadequate hence the need for another toilet facility. The KI interviewed reported that a potential partner came and informed the leadership of the mosque that they had intentions to construct a latrine at the mosque, and so the Muslim community is still waiting. The leadership of the mosque expressed willingness to maintain such a facility to ensure that it is kept clean. At the time of assessment, there was written information on the toilet walls, encouraging people to pay at least Ugx. 200= for using the toilet (see above), to raise funds for painting but also to empty the toilet which was reported to have been last emptied around April 2023 but it was not emptied fully.

It was also established that although the community has people with mobility problem who come to pray at the mosque, there was no provision of stances for people living with disability. Such people were reported to use the same existing toilet as-is. However, they have designed the toilet in a way that at least the people with mobility challenges can use the facility comfortably since the toilet is always clean because Muslims use water all the time.

3.7.2.3 Knowledge and awareness of the Muslim community on WASH

The KI said that to Muslims the issue of water, sanitation and hygiene is obvious, as the community knows it very well as one of the principles in Islam. However, the Muslim leaders at the mosque only play a role of reminding the community about it.

3.7.2.4 Hand washing with soap practices

Regarding HWWS, the KI reported that hand washing was the order of the day in Islam; however, when asked whether the Muslim community washes hands with soap, the response was that no, they do wash without soap although when one has soap, then they can wash their hands with it. Overall, very few people were reported to wash their hands, as it is not a very common practice especially among the non-Muslims.

3.7.2.5 Pit emptying practices

On pit emptying, the study established that manual pit emptying was used in Koch Goma Mosque since it was too expensive for the leadership to hire a cesspool truck. The KI reported that some years back a cesspool truck emptier was used and it cost the mosque around Ugx. 800,000=. Due to limited resources, the mosque took a decision in 2023 to use the manual pit emptying method, which is unhygienic. A pit was dug onsite for disposal of the faecal sludge.

3.7.2.6 MHHM practices at the mosque

When asked whether the existing latrine facility at the mosque supports girls and mothers when they are in their menstrual people cycle at mosque, the response was that it is taboo because the Islamic teaching does not allow a menstruating woman to come to the Mosque for prayers. Under the Islamic law a menstruating woman is supposed to pray from home.

Recommendations:

- GIZ S4M programme considers construction of toilet facilities and WASHaLots at each mainstream place of worship in each town, equip the religious leaders with skills to manage the sanitary facilities.
- Conduct training on S&H and messaging for the religious leaders and trigger them to lead by example and to influence their congregants to improve sanitation and change negative behaviours.

3.8 ASSESSMENT ON MENSTRUAL HEALTH & HYGIENE MANAGEMENT

Menstruation is an integral and normal part of human life, indeed of human existence. MHHM, therefore, has been identified as a specific priority for improving the health, welfare and dignity of women and girls. The assessment specifically focused on understanding the knowledge, attitude and practices on menstruation including access to information; access to materials for managing menstruation (including issues of availability and affordability); as well as access to sanitary facilities that provide privacy for changing, washing and drying menstrual materials.

3.8.1 Menstrual Health & Hygiene Management in Communities

3.8.1.1 Knowledge and information on menstruation

Access to information on menstruation is very important for women and girls, so that they do not get shocked especially before their first menstruation periods but also to help women keep clean and avoid infections; to manage pain and other discomforts; and also, to remove stigma particularly from boys and men. The assessment established that currently MHHM is a neglected area in communities as women do not have any particular place or organization providing information on menstruation unless one has gone for maternity care in HCFs and chances that menstruation is part of the topics of discussion.

Information about menstruation for young adolescent girls is relegated to schools and is now more of a school affair, as the majority of school-going girls tend to get information on menstruation from schools. However, some of the women talked to during the FGD meeting were of the view that some schools do not do much on menstruation and so it is not a balanced affair for all the girls. Since this information is given to the girls in school, the implication is that out-of-school girls are left out.

Due to lack of on-going MHHM programmes or poor supportive environment from local structures such as VHTs, women and girls continue to suffer in silence from menstruation discomfort and disorders such as painful periods, as per the quote below.

"*The gap that is there could be in getting information concerning the appropriate way to deal with the menstrual pain because I have a daughter who goes through a lot of pain but when I consulted with an elderly woman on how I can help her with the pain, she told me not to give her any pain killers that because they will spoil her; so she instead told me to keep giving her local herbs but these do not help with the pain at all*" **– Participant, Purongo Community Women Only FGD**

3.8.1.2 Cultural practices, beliefs and taboos on menstruation

The assessment established that there are no very serious cultural practices, beliefs or taboos in the Anaka cluster of towns in relation to menstruation that specifically affect the health of women. However, women and girls are usually told not to leave the used pads in the open anyhow for anyone to see because someone can malice a woman or girl with it by doing witch craft. Additionally, women are told to wash themselves and their menstrual cloths very clean and there after keep the pieces of menstrual cloths away from the eyes of any other person. Women are also told that menstrual cloth is not supposed to be shared.

Some of the myths and taboos on menstruation that will need to be demystified by GIZ and partners include: if a woman is in her periods, she should not go to a tomato garden, groundnuts garden and pumpkin garden as these will shrink and dry up. If the tomatoes and pumpkins were big, they will start rotting so the woman can first attend to other gardens until she is okay. However, the head of her home can prevent this from happening by burying the skin of a hippopotamus in the garden at the time of planting these particular crops. If not, he needs to put on car tyre shoes (aka "Lugabire") while planting these crops and nothing will happen to the crops in the garden even if a number of women in their menstruation periods work in the garden.

3.8.1.3 Access to menstrual materials to absorb/catch menstrual blood

Women and girls need menstrual materials such as pads to catch or absorb menstrual blood during menstruation periods and to be able to change as often as they may wish depending on availability. Women and girls may also have preferences, depending on affordability. The assessment set out to establish what materials women and girls have access to; their availability, accessibility and affordability; as well as challenges faced and possible solutions.

The study established that some women and girls in Anaka cluster of towns use disposable pads, which are usually available at the shops. However, the only challenge experienced is that some women lack funds to buy the disposal pads because they are costly i.e. UGX 3,500-4,000 a pack of 7-8 pads. A woman or girl may need 1-3 of these packs, depending on how heavy the floor of blood is. The women and girls who cannot afford pads use pieces of cloth which they always wash very well and keep for the next month after they have completed their menstrual periods for the current month.

In terms of choice, majority of women prefer disposable pads because they are easy to use while some women prefer to use pieces of cloth because it is affordable. To note is that there are also girls who were reported to have refused the use of disposable pads because they were told that they have their own side effects; such girls prefer using a certain type of soft and comfortable handkerchiefs that are sold on the open market. They buy enough of such handkerchiefs and use them instead of any other pieces of cloth, which has helped them because they can be reused. One Health Unit In-charge had the following to say about women, menstrual materials and their hygiene.

"*For materials, most women use pieces of cloth. Others do not use anything by the way. Actually, the support for menstrual hygiene is very poor because most women do not know how to use pads. Their hygiene is very poor really because when a woman comes and you would want to examine her, you find their under wear wanting*" **– Health Unit In-charge, Purongo Town Council.**

3.8.1.4 Access to sanitary facilities during menstruation

Private space and washrooms are very important for women and girls to wash and change menstrual materials during menstruation periods. Women and girls also need appropriate sanitary facilities for disposal of used menstrual materials especially for those who use disposal pads. They also need soap and water for washing during menstruation.

In the communities of Anaka cluster of towns, mothers or older women ensure that girls have their own sleeping room where they can have their privacy. These places are cleaned by the girls themselves. For the bathroom and toilets, the girls use whatever facilities are available for use by everybody else in the family. The women reported that water and soap are always available because the girls themselves know that they will need water during these moments, to clean themselves up.

Since the girls have their private rooms/huts, the practice is for the girls to hang their menstrual cloths inside their private rooms; therefore, they are not concerned about being seen by someone else since they have their own private space. However, to note is that this practice needs to be discouraged because it may be unhygienic depending on where the cloth is spread. To note also, is that menstruation is private and usually women and girls do not wish men and boys to know about it, hence the different names used for it.

Regarding disposal, the used menstrual materials are disposed of in the pit latrines, as these are the only places regarded as safe for keeping the used pads away from the public's eye. Women requested for continuous sensitisation so that women and girls maintain and improve the standard of privacy not only when changing their materials but during the entire menstruation period.

3.8.2 Menstrual Health & Hygiene Management in Schools

3.8.2.1 Access to knowledge and information on menstruation

As seen from the discussion above with women in the communities, menstruation is something rarely talked about at home, and that most school-going girls get information on menstruation from schools. The above assertion was confirmed during interaction with learners in schools who reported that information on MHHM is majorly provided by Senior Women Teachers-SWTs. SWTs advise young girls wash regularly and wash their underwear frequently and change them, because they will have bad smell if they do not wash. Some information on menstruation was also provided by Save the Children programme in schools, which ended in March 2023.

However, to note is that focus for the SWTs is provision of information to the girl-child. Consequently, it is not surprising that interaction with learners in schools indicated that some of the boys laugh at girls when they realize that girls are menstruating. Inadequate MHHM practices and less involvement of boys was reported to lead to stigmatization of the girls when they are in their menstrual periods hence leading to girls not attending school during menstruation periods. Additionally, there was almost no mention of provision of information to young adolescent girls on how to manage pain and other discomfort related to menstruation. Otherwise, there were no cultural practices, beliefs and taboos on menstruation in schools.

3.8.2.2 Access to sanitary facilities during menstruation

The biggest MHHM challenges faced by schools is lack of enough proper toilets for girls, lack of incinerators and inadequate water in some schools particularly during dry seasons when water from some of the borehole reduces. MHHM facilities were reported to be absent in almost across all the government-aided schools that were assessed in the Anaka cluster of towns. However, most existing latrines were very dirty and do not offer a conducive environment for girls to change their menstrual materials such as pads while at school.

Due to lack of incinerators, the most common practice in schools is for girls to dump their used pads in the latrines, which tends to make girls' latrine facilities to fill-up quicker than latrines for boys. Majority of head teachers interviewed reported the challenge of emptying girls' latrines because of the practice of dumping used menstrual pads in the pits, which becomes costly for the schools to empty toilets and when the cesspool emptiers fail to empty the latrines, the schools' resort to manual emptying. Out of desperacy in Koch Goma, for example, one head teacher advised girls to use polythene bags to wrap their filled-pads and dump them in the rubbish pit for burning. This practice may not be very healthy and hygienic depending on how long the girls need to stay with their used or filled-up menstrual pads.

3.8.2.3 Access to menstrual materials to absorb/catch menstrual blood

Majority of girls in schools were reported to mostly use disposable menstrual pads because it is most comfortable and easy to use. Schools also tend to buy disposable pads for emergency, as majority of schools reported provision of emergency pads to the girls. Some schools also provide emergency changing dresses/attires to the girls, and it is easy for the girls to access and these materials because they are talked to and given prior information by the SWTs. However, some schools reported interventions by a lady from a social enterprise called "Lutino Adunu" who went to schools and taught girls how to make reusable pads from cotton cloth.

Recommendations:

- One additional behaviour for adoption by the S4M programme is ***"proper menstrual hygiene management***"; develop or adopt BCC materials with messages such as "Don't throw pads into pits".
- Develop and implement a comprehensive MHHM program in communities, schools, HCFs and markets that covers:
  - awareness creation and provision of information on MHHM, targeting both boys and girls; and men and women.
  - demystifying the various taboos, myths and beliefs
  - male (boys & men) involvement- to fight stigma, for them to know that menstruation is normal and to be supportive of the girls and women during menstruation.
  - training on the different options/alternative materials for catching menstrual blood (including re-usable pads)
- Support construction of toilets in schools and public places with provisions for washrooms and incinerators for disposal of used menstrual pads.

3.8.3.4 Latino Adunu Social Enterprise

"Latino Adunu-LA" is s local Community Based Organization-CBO or Social Enterprise that has previously received institutional capacity building support from GIZ CUSP project, which ended in 2022. LA moved to all schools, both public and private, with support from agencies such as Save the Children, Food for the Hungry, Child Fund, African Revival, and other

smaller donors supporting majorly the youth. The major focus of LA is training of women in communities and girls in schools to make Re-Usable Menstrual Pads (RUMPs), including both the theory and the practical.

“One of the major challenges faced by LA is access to quality materials as there is no 100% pure cotton on the local Ugandan market. Therefore, LA partners with Days for Girls to helps import good cotton material from Kenya.

The second challenge LA has faced is attitude and mind-set change, whereby LA recommends that a lot of sensitization is needed which LA is missing. Such sensitization drives should target local leaders that people listen to e.g., LC Is, LC IIIs, Councillors, Opinion leaders and cultural leaders e.g. Rwot-Kweri. There is also need for a clear engagement strategy for the communities; Koch Goma will need a lot of support since LA has not done any work in that town council or sub county.

With regard to schools, LA recommends mind-set change involving parents, teachers, and learners in schools as well as local leaders and hold them accountable; and use of the media especially radio to reach out to communities.

Recommendations:

- Engage LA Social Enterprise to implement a comprehensive MHHM program in schools as suggested above. Such a program should not only focus on training on re-usable pads but should cover other aspects such as provision of vital information and ensuring male engagement (both boys and male teachers) to fight stigma and ensure males are supportive of the MHHM for the girl-child in schools.
- Support schools with construction of incinerators for disposal of used menstrual pads.

3.8.3 Menstrual Health & Hygiene Management in Public Spaces

Regarding gender and attending to the needs of women and girls, the public toilets especially in the markets were reported not to be women-friendly because they have no changing rooms, which means women have to go back to their homes in case of need for washing or changing (e.g., during menstruation), which is inconveniencing. The assessment also established that there is limited and scanty information on menstrual hygiene for women in markets because menstruation is a taboo, and not to be talked about in public. There is also a belief that men should not know about menstruation, yet male involvement is very critical. The quote below demonstrates the various negative menstrual hygiene practices that will need to be addressed by the S4M programme in the future.

“*The latrines are full of solid waste. Women in their periods suffer a lot because there is no water for washing. The only available borehole is a distance away from the market and is shared with the community. As a result, women dispose their used menstrual cloth or rugs directly into the latrines since there is no water. There is no provision of buckets for disposal of used menstrual pads. All these contribute to filling up of the latrines and difficulties in emptying. Markets are worse than schools*” **– Technical *staffs, Amuru Town Council*.**

Generally, women market vendors were reported to lack general information on WASH, hence women (and men) misuse toilet facilities such as Water Borne Toilets (WBTs) because

of lack of knowledge on how to use such facilities and about proper disposal of used menstrual pads. The sanitary facilities also lack buckets and incinerators for disposal of used menstrual pads.

Regarding participation in community activities during menstruation, it was established that majority of men in town now know that it's normal for the women to undergo menstruation so they don't really have any negative attitude toward them and because of this, women are free to go on with their activities with ease. The problem probably may still exist with the young boys in primary schools who still stigmatise girls.

As for service providers, specific MHHM providers in the markets or towns are not known except for the shops that sell disposable menstrual pads. Regarding menstrual materials, women were reported to use mostly disposable pads which can be bought from shops around towns; however, there may also be some women who use other materials such as pieces of clothes.

3.8.4 Menstrual Health & Hygiene Management in Health Care Facilities

There were no specific service providers for menstrual hygiene in the communities around the HCFs, save for the nurses and mid-wives who provide menstrual health information and services to girls and women who ask for it at the Health Center. They provide information to women and girls on the proper use and disposal of pads as well as proper hygiene.

In some of the HCFs (e.g. in Koch Goma HC III), girls and women have access to pads provided recently through support from the Japanese Government, but these are believed not to be adequate for the targeted populations. Generally, there are no specific projects or programmes on MHHM at the health centers. However, nurses were reported to be well trained to handle patients in case of need for this topic on MHHM to be discussed with patients and care-givers.

Recommendations:

- Conduct Training of Trainers for H/As, Health Inspectors (HIs), HCF In-charges and VHTs on WASH, focusing on O&M (including development of HCF plans and budgets that integrate WASH), MHHM and Handwashing with water and soap (HWWS).
- Use the training opportunity to disseminate the National Guideline for WASH in HCFs, by Ministry of Health-MoH.
- Follow-up usage of the PHC funds for WASH in HCFs.

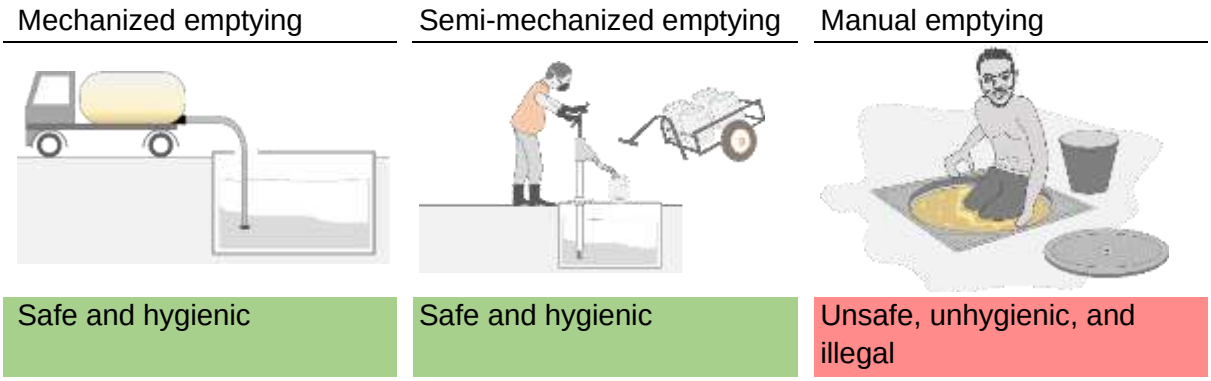
3.9 FAECAL SLUDGE MANAGEMENT IN HOUSEHOLDS & INSTITUTIONS

When referring to faecal sludge management (FSM), the assessment considered the entire sanitation service chain which comprises of containment of faecal matter, emptying of the containment, collection for transportation, treatment of the Faecal Sludge (FS), and the end-use or disposal of FS end products. Each of these components of the FSM service chain forms a crucial component for the successful implementation of FSM. The assessment focused on the practices related to pit emptying, availability of pit emptying services, and the willingness to pay for pit emptying services.

In Uganda, FSM services are provided mainly by the private sector, and generally fall into one of three types (please see Figure 3.22).

- *Cesspool truck emptiers (CTEs)* – FSM Enterprises (FSMEs) that provide fully mechanized emptying using vacuum trucks (typically 3,500 – 10,000 litres in volume) equipped with motorized pumps.
- *Gulper emptiers (GPEs)* – FSMEs that provide semi-mechanized emptying using hand-operated pumps to extract sludge into barrels (typically 200 litres in volume).
- *Manual emptying* – FSMEs that scoop out the sludge by entering the pit or tunnel into the side of the pit and allow the sludge to flow out. Though it is a common practice, manual emptying is unsafe and is illegal in Uganda.

Figure 3.22: Types of FSM services available in urban Uganda



3.9.1 Pit Emptying Practices in the Households

With over 90% of town residents in the five towns using unlined traditional pit latrines, the study established that demand for pit emptying at HH level is limited with only 10.2% of respondents indicating availability of services, which could be due to low prevalence of emptiable toilets. The current type of HH toilets predominantly used in the Anaka has an implication on pit emptying services for the filled-up toilets: i) unlined pit latrines when emptied especially by cesspool trucks quite often tend to collapse; and ii) use of cesspool emptiers may not be the best method for pit emptying because of the type of Faecal Sludge (FS).

Overall, the five cluster towns are small; FS collection and transportation is hardly practiced and is very low at HH level as majority of pit latrines that fill-up are abandoned. With regard to method of pit emptying, HHs that reported self-emptying stood at 61.5%, followed by use of manual emptiers at 23.1%. A small percentage (8%) of HHs reported emptying their latrines at least once, (Figure 3.23). In Olwiyo, no HH reported emptying their latrines/toilets and only 2% reported emptying their latrines in Purongo town council. Koch Goma and Amuru towns were the two towns with the highest proportion of respondents emptying their latrines/toilets at 25% and 23% respectively.

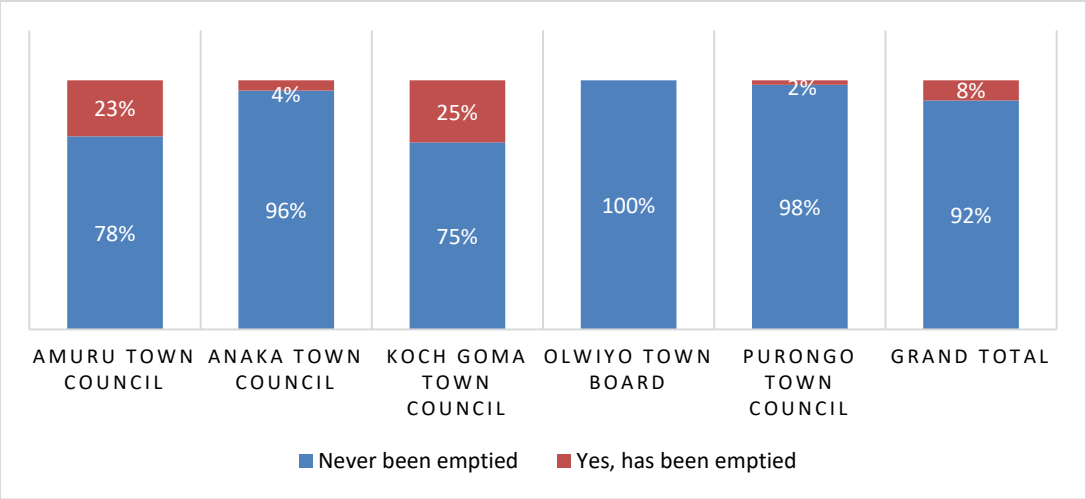
Overall, 61.5% of respondents were satisfied with the pit emptying services offered, followed by 23.1% of respondents who said they were fully satisfied with the service offered. The average price paid for pit emptying by a HH was UGX 262,308.

3.9.2 Pit Emptying Practices in Institutions

Pit emptying is mainly practiced by schools, hotels and lower-level health care facilities (HCFs), who practice the unhygienic manual pit emptying because it is a cheaper, readily available option, and is more efficient than hiring a service provider from Gulu city. The

determinant for the pit emptying method chosen is availability of a service provider, standing at 76.9%; an interesting finding is that the cost of emptying latrines/toilets was not a key determining factor for choice of pit emptying method.

Figure 3.23: Households emptying latrines / toilets once filled up



One of the biggest challenges reported facing schools and HCFs in the five small towns is the high cost of draining pit latrines/toilets. Pit emptying is costly especially as the girls' latrines keep getting filled-up because of dumping used menstrual pads in the latrines. Dumping of used menstrual pads by girls in the pit latrines was reported by schools to make it very hard and expensive to empty school latrines/toilets using Cesspool trucks. As an example, Koch Goma Central P.7 school reported to have recently emptied a girls' latrine/toilet at UGX 1.3m, using UPE funds from the school; while Anaka P.7 primary school in Anaka town council paid over UGX 3m for pit emptying.

Due to difficulties in emptying the entire pits, schools resort to engaging manual pit emptiers who practice on-site dumping of FS in holes dug and covered up behind the toilets. Out of desperacy and lack of incinerators in schools, one of the teachers has devised alternative means of disposal of used pads whereby girls are asked to wrap their used pads for disposal in the rubbish pit for burning, which practice may not be very healthy for the girls (depending on how long the girls have to keep the used pads).

The other challenge is the type of anal cleansing materials used by learners. Although toilet paper is the major anal cleaning material used by pupils in majority of schools, there were also reports of use of grass, leaves, stones and maize cobs which negatively impact the pit emptying process because of foreign materials (hard solids) introduced into the pits other than urine, faeces and toilet paper. A total of 10 out of 17 schools assessed reported to have emptied their latrines in the previous 2 years.

Interviews with key informants showed that getting a schedule from Gulu cesspool emptiers is difficult because the trucks are highly engaged. Experiences on manual pit emptying in schools and HCFs and the belief in its efficiency is summarized in the quote below:

"*Manual pit emptiers first start by pouring some chemicals in the pits to disinfect the pits. The chemical is also believed to aid with the removal of the FS. Manual pit emptying is more efficient for schools because they empty and remove everything and almost sweep the bottom of the toilet, as compared to cesspool/mechanical emptiers that remove but end up leaving some FS at the bottom of the pit*" **– District Education Official, Anaka District Local Government.**

3.9.3 Existence of Pit Emptying Service Providers

Of the HHs that emptied their latrines/toilets/septic tanks, most HHs (61.5%) emptied the latrines by themselves, using HH members. No cesspool was used to empty latrines/toilets by the HHs. In Anaka, all HHs sampled reported that they use HH members for free to empty their latrines when full. In Koch Goma, all HHs reported use of other local persons around to assist in emptying their latrines. Availability of pit emptying service providers was the biggest determinant for choosing the emptying method amongst the HHs. In the Anaka cluster, 7.7% of HHs were very unsatisfied with the quality of services used for emptying their toilets, 35.5% were somewhat unsatisfied, 7.7% were somewhat unsatisfied, and 23.1% were very satisfied. A total of 61.5% of the HHs were satisfied.

Table 3.7: Availability of Faecal Sludge services

Method of emptying					
	Amuru	**Anaka**	**Koch Goma**	**Purongo**	**Grand Total**
Cesspool services	0.0%	0.0%	0.0%	0.0%	0%
Self/Household member (free)	78%	100%	0.0%	0.0%	67%
Someone else (manual emptying)	22%	0.0%	100%	0.0%	25%
Gulper services	0.0%	0.0%	0.0%	100%	18%
Determinants for choosing emptying method					
Advertising	0%	50%	0%	0%	7.7%
Availability	100%	0%	100%	0%	76.9%
Can't afford	0%	50%	0%	0%	7.7%
Reputation / quality of service	0%	0%	0%	100%	7.7%
Satisfaction with quality of services					
Completely unsatisfied	0.0%	50.0%	0.0%	0.0%	7.7%
Fully satisfied	11.1%	50.0%	0.0%	100.0%	23.1%
Not satisfied	0.0%	0.0%	100.0%	0.0%	7.7%
Satisfied	88.9%	0.0%	0.0%	0.0%	61.5%
Average price paid for emptying in UGX	262,308				
Proportion who perceive that emptying services are affordable					
No	44.4%	100.0%	0.0%	0.0%	46.2%
Yes	55.6%	0.0%	100.0%	100.0%	53.8%

Lack of pit emptying service providers within the five Anaka cluster of towns has also contributed to schools adopting the unhygienic practice of manual pit emptying. Therefore, schools (and HCFs) in the five towns were found to be the biggest culprits of manual pit emptying.

3.9.4 Faecal Sludge-FS Disposal Practices

The assessment established that, with regard to FS disposal after pit emptying, the manual pit emptiers practice onsite dumping whereby usually a hole is dug behind the toilets, and the FS poured in the hole and covered.

Although towns such as Anaka are growing at a fast rate, it was established that there is no standard lagoon for treatment of faecal sludge. It is only Anaka General Hospital (GH) that owns a treatment plant for the influent but O&M is a problem. The GH uses a three (3) pond system: first pond is anaerobic; the second pond is facultative; and the third pond is an aerobic (maturation) pond. The assessment established that there is a blockage in the drainage system and therefore raw untreated sewage flows into the environment i.e., into peoples' nearby gardens which is a health hazard.

For disposal of FS, the survey data indicates the current methods as use of gazetted treatment plant standing at 61.5%, followed by open disposal standing at 53.9%, buried on an open pit on the property at 46.2% and burning or used for decomposting at 30.8%.

3.9.5 Knowledge of the Dangers of not Safely Emptying Toilets/Latrines

Majority of the HHs (74.6%) interviewed associated not emptying toilets/latrines when full with a bad odour or smell affecting the HH and surrounding neighbourhood negatively. Only 14.8% of the HHs associated not safely emptying the latrines/toilets with contamination of water and the environment and disease prevalence.

Regarding perceptions about selected sanitation practices, 52.7% of the populations strongly perceive open defecation as being irresponsible, with about 9% of the populations disagreeing, with that perception; 47.6% agreed that they were willing to pay for prestige and 51.8% for convenience, and so these are the motivating factors that the GIZ S4M programme should use to sell latrines to the target market.

3.9.6 Umbrella Utility as a Service Provider for Safe Pit Emptying Services

There seems to be light at the end of the tunnel regarding pit emptying in the Anaka cluster as Umbrella utility has started to offer pit emptying services to the institutions, both schools and HCFs. The schools acknowledged that as part of advertising and marketing their services, the utility provided a discount of between UGX 30,000-45,000 for emptying one pit, as compared to UGX 500,000 charged by private manual emptiers for the same volume of FS.

The Umbrella utility is of the view that if a Faecal Sludge (FS) treatment plant could be developed for the five cluster towns in Anaka town council, the cost of treatment will go down to below UGX 100,000 for schools in Purongo town council, while Amuru town council may need its own truck or Gulpers for emptying toilets given its distance from Anaka town.

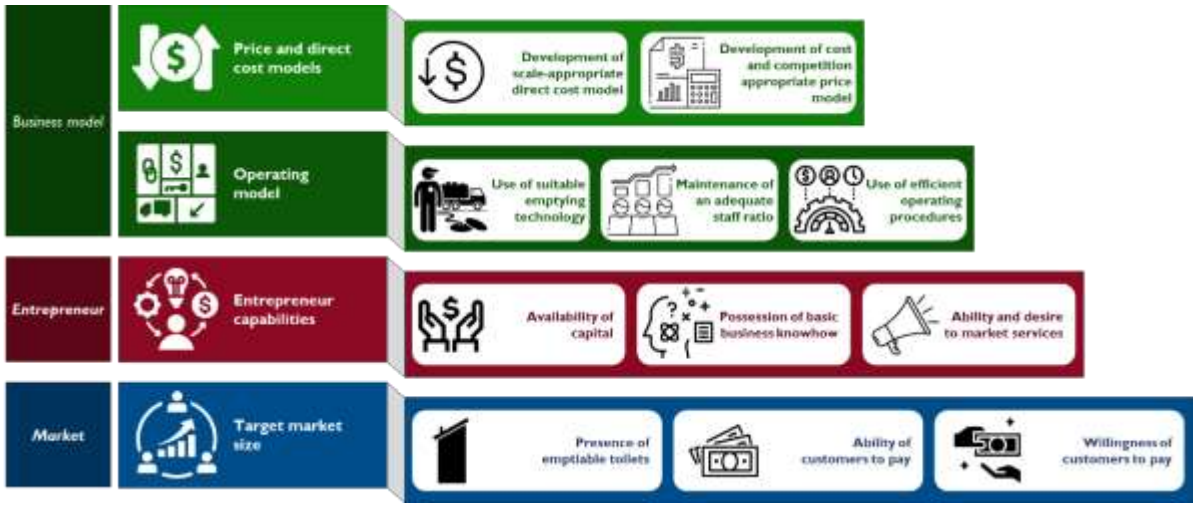
Brief Case Study (Northern Umbrella Utility)

"The Umbrella Utility owns a 8m³ truck and conducted some promotional activities on pit emptying. Anaka town is a distance of 54 Kms away from Gulu city. Considering fuel of between 5-21 liters, a trip would cost approximately UGX 200,000 to cater for the costs of small operations such as detergents, water and dumping fees. For Purongo, which is 76 kms away from Gulu city, the cost would not go beyond UGX 300,000. However, on the open market (private operators from Gulu city), the cost of pit emptying goes in Anaka town for between UGX 250,000-300,000 or even UGX 500,000 based on the distance travelled by the Cesspool emptier and the amount of sludge to be emptied (depending also on the number of stances, if it is a school)"
– Environment & Sanitation officer, Northern Umbrella, MWE.

3.9.7 Proposed Framework for developing viable FSM Businesses

The viability of FSM businesses depends on four key elements: (i) a critical mass of potential customers (i.e., institutions and households); (ii) entrepreneurs with the capabilities to establish and run FSM businesses; (iii) an efficient and effective operating model; and (iv) price and cost models that are appropriate given the scale of the business and competition. GIZ S4M will need to develop viable FSM business in the Anaka cluster based on this framework, which helps to assess existing and potential FSM businesses against these four elements (Figure 3.24).

Figure 3.24: Framework for developing viable safe FSM businesses



Source: USAID-USHA FSM Draft Learning Brief (2023)

The four elements are organized in a pyramid based on an understanding of one's ability, as an implementer, to intervene and influence these four elements, particularly in the short-to-medium term. Based on experiences of other projects such as USAID-USHA and GIZ's project in Apac cluster, in the short project period, GIZ S4M project may have limited ability to influence elements at the bottom of the pyramid, but with the ability to influence elements increasingly as they moved towards the top of the pyramid.

Recommendations:

- Support Northern Umbrella Utility to implement the FSM model developed with support from GIZ S4M programme which centres on scheduled emptying and leasing. This has to be accompanied by a well thought-through marketing strategy for promoting the practice of safe pit emptying.
- Support the construction of a lagoon for treatment of FS in Anaka Cluster, while working closely with the Water and Sanitation Development Facility-North (WSDF-N).
- Support Anaka GH to rehabilitate the lagoon for treatment of faecal waste from the hospital.
- Focus project interventions to increase the target market size through promotion of emptiable HH toilets e.g., improved basic latrines (lined).
- Promote other pit emptying options/enterprises such as the Gulper (Long-term) which is more suitable for emptying the type of existing household toilets/latrines in the Anaka Cluster of towns; interest the manual pit emptiers to adopt the Gulper technology to improve their pit emptying services.

3.10 ACCESS TO FINANCIAL SERVICES FOR SANITATION

The study sought to understand the available of financing options, what challenges HHs have faced to access financial services; how access to financial services can be improved; prioritization of investment for WASH household level; and the monthly cost of water and sanitation to the households (be it on infrastructure or sanitation and hygiene).

3.10.1 Access to financial Services

Ownership of a bank account is one of the important requirements for clients to access loans. Overall, 34.7% of HHs had bank/mobile money accounts (Figure 3.25). Owning/accessing bank/mobile money was lowest in Amuru (13%) and highest in Koch Goma (68.4%). Anaka and Purongo/Olwiyo towns had 35.5% and 35.8% of its HHs with bank/mobile accounts.

Access to loans in the Anaka cluster varied substantially, as shown in Figure 3.25. In Amuru and Purongo towns, only 2.9% and 3.6% of HHs had ever accessed loans, respectively. Access to loans was highest in Anaka (15.8%) and Koch Goma (12.3%). This could be because Anaka has more financial institutions, including a commercial bank and the fact that Koch Goma is close to Anaka too, compared to any other towns in the cluster. Amuru had relatively the lowest proportion of HHs accessing loans at 2.9%. There is a very big difference between those that accessed loans and those that own bank accounts. Overall, the gap was about 26 % but it was highest in Koch Goma by over 55%; only 8% of the residents in Anaka Cluster of towns had ever accessed a loan.

Majority of the loans accessed for WASH related expenses especially toilet/latrine construction/renovation, were obtained from the commercial banks (47.8%), as seen in Table 3.8. This was followed by loans accessed from the VSLAs (30.4 %), money lenders (8.7%) and relatives/friends (2%).

Figure 3.25: Proportion of Households that own financial accounts and accessed loan for WASH related expenses

Note: The "Overall" column is an average of the entire cluster. This report aimed to present town-specific variation

Regarding cost of construction, it was estimated to cost on average about UGX 760,000 shillings to construct a basic 4-stance latrine/toilet in the Anaka cluster of towns. It is more expensive to construct in Purongo/Olwiyo town council (i.e. UGX 2.3 million on average) probably because of the water-logged nature of the soils, and least costly to construct in Amuru town council (UGX 93,000 on average). These are very wide deviations that can be explained by the availability of service providers to construct in the towns as well as availability of materials predominantly used for construction within the towns. In Anaka and Koch Goma town councils, it costs on average UGX 373,000 and UGX 276,000 respectively. 63% of the population perceive accessing finance from institutions for WASH related expenses as not being easy (see Table 3.8).

8.10.2 Prioritization of Household expenditure

Respondents were asked to prioritize expenditure on selected HH items including sanitation (toilet construction, cleaning, maintenance etc.) and water for a total of nine items. HHs were asked to assign a rank of 1 through 9 for the nine items such that the one they prioritized first is 1, the second is 2 and so on. To determine the overall ranking order, average scores for

the nine ranked items were computed such that the item with lowest score is the best ranked while that with the highest average score was the worst ranked.

Table 3.8: Percentage distribution of source of loan for Households by town

Town Council	Koch Goma	Anaka	Purongo/ Olwiyo	Amuru	Overall
Source of Loans					
Commercial Banks	20.0	41.7	100.0	100.0	47.8
Micro-Finance Institutions	20.0	16.7	0.0	0.0	13.0
Credit Institutions not in data	0.00	0.00	0.0	0.0	0.0
SACCOs	20.0	8.3	0.0	0.0	13.0
Informal providers VSLA	20.0	50.0	0.0	0.0	30.4
Money lenders	40.	0.0	0.0	0.0	8.7
Relative or friend	40.0	0.0	0.0	0.0	8.7
Mobile Money	20.0	0.0	0.0	0.0	4.4
Average Cost of Toilet Construction					
Average amount paid for toilet construction in UGX	276,667	372,947	2,310,578	93,261	763,363
Easiness of accessing sanitation financing					
Yes	8.8	32.9	3.7	13	13.8
No	71.9	51.3	71.5	51.1	63.0
Don't know	19.3	15.8	24.7	19.3	23.2

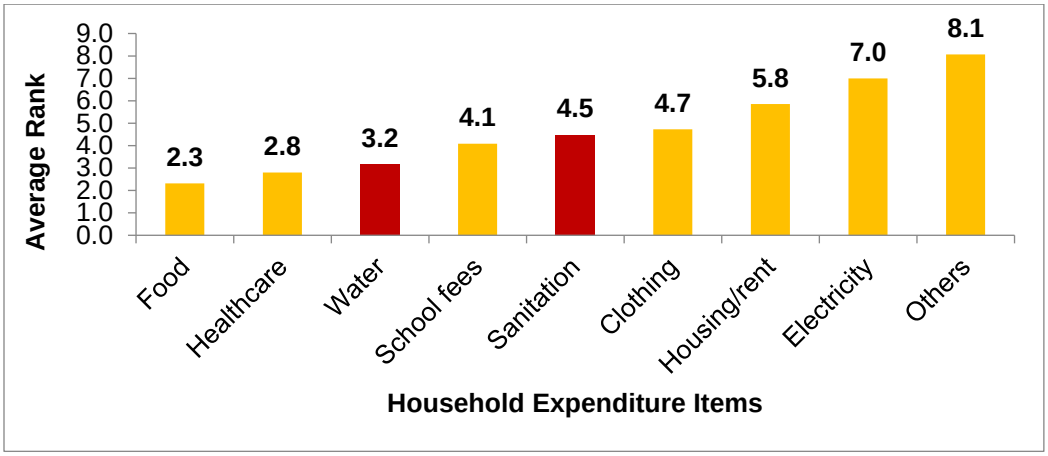
Overall, results indicator that HHs ranked food as the first item (2.3), followed by healthcare (2.8) and water (3.2). The least prioritized item by the HHs was electricity followed by housing/rent. Sanitation was ranked as the fifth most important item in terms of HH expenditure with water being ranked as the third. By towns, Anaka and Koch Goma respondents ranked food as the first item and electricity as the least item. Respondents in Amuru ranked water as the first item and housing/rent as the least item; those from Purongo ranked Healthcare as the first and electricity as the last. Those from Olwiyo ranked school fees as the first and clothing as the last. See table 3.9 and figure 3.26 below for details.

Table 3.9: Average rank of household expenditure on selected items

Town Council	Food	Electricity	Water	Sanitation	Housing	Healthcare	School fees	Clothing
Amuru	2.0	5.4	1.7	3.2	5.6	2.4	3.6	3.8
Anaka	1.5	7.4	4.1	5.7	5.9	2.8	4.0	4.5
Koch Goma	1.6	7.7	3.4	5.7	5.7	3.3	4.3	4.5
Olwiyo	5.3	6.1	3.3	3.1	4.4	3.3	1.9	6.7

Purongo	2.9	7.9	3.8	4.2	6.5	2.6	4.9	5.5
Average Ranking	**2.3**	**7.0**	**3.2**	**4.5**	**5.8**	**2.8**	**4.1**	**4.7**

Figure 3. 26: Overall ranking of expenditures on selected household items



8.10.3 Provision of WASH Loans by Post Bank

Under community banking, Post Bank (U) Ltd. offers financing in form of water and sanitation loans for clean, safe water and construction/improvements of sanitation facilities for both individuals and businesses. Post Bank offers loans to improve access to water in the homes, construction of pit latrines, water harvesting tanks, drilling (especially for farms), purchase of water pumps, and to institutions such as schools (institutional loans), which are a bit bigger.

The requirements include: an active Post Bank account; registered business with clear and verifiable income source; valid trading license for the business that is accessing a WASH loan; a contract with a service provider; bills of quantities (BoQs/Quotations), pro-forma invoice from materials suppliers, collateral and guarantors.

However, the manager at Post Bank in Anaka town indicated that the uptake of the WASH loans was not so good and probably stands at 10% domestic as majority who take these loans are commercial farmers. The reasons advanced by the bank for this status quo included: i) inadequate sensitization of communities about the loans; ii) lack of technical expertise on the type of appropriate toilets for construction; iii) lack of appropriate toilet products for individuals to appreciate alternatives; and iv) unclarity of who the service provider(s) is/are. The question put forward by Postbank was if GIZ can help with BoQs and identification and recommendation of service providers.

Otherwise, overall, the WASH loans are supposedly cheap with an interest rate of 20%-23% as compared to commercial loans which stand at 42% (with an interest rate of 3.5% per month).

Recommendations:

1. Identify local money lending institutions to partner with such as PostBank and SACCOs.
2. Support the money lending organization to create awareness and market the loan products.
3. Subsidize the costs e.g. capitation, so that this can contribution to reduction of the final costs of the loan for the HHs. There will also be need to know the impact of the loans through a proper monitoring system.
4. Provide well targeted subsidies to households for toilet construction, especially targeting the most vulnerable HHs such as women-headed households.

3.11 WASH GOVERNANCE

3.11.1 Assessment on the legal & policy environment for WASH

The major policy document that guides implementation of S&H in the small towns is the Public Health Act (PHA), which is in place but not effective because it is not enforced. The PHA requires that each HH and business in a town should have a waste bin and a toilet. Also, there is a PHC policy that mandates the health centers to do community sensitization drives targeting communities and HHs within a 5 Km radius of the Health Centre. Other than that, the study established that the small towns in the cluster have no sanitation bye-laws hence the need to support towns to develop S&H by-laws.

Important to note is that there are other policies and guidelines that the five town councils can benefit from and hence will need to be disseminated by GIZ S4M and the MWE Regional Structures. These include, among others: The National Sanitation Marketing Guideline for Basic Sanitation (March, 2022); FSM Guidelines; Training Manual for Operation & Maintenance of WASH Facilities in HCFs; and the National Guideline for WASH in Health Care Facilities in Uganda (MoH, 2022).

Majority of towns were supported by GIZ to develop Town Sanitation Plans (TSPs), except Koch Goma which is a newly created town council. However, implementation of the TSPs is poor and needs follow-up. Town councils use Health Assistants and Health Inspectors as staff responsible for WASH, because there are no staff specifically responsible for WASH activities within the Town Council set-up. Up to 10% of the PHC funds are allocated to S&H activities within a Town Council; additionally, town councils are also expected to allocate % of local revenue to S&H but this is not adequately happening. There is need, therefore, for keen to follow up the utilization of these funds to ensure they are put to proper use.

3.11.2 Stakeholders' coordination

According to the new structure by Ministry of Local Government, a small towns town is supposed to have a Principal Health Inspector, a Health Inspector, a Health Assistant, and an Environmental Officer in-charge of Natural Resources Management (NRM). However, the assessment established that not all these staff are on-board in the town councils; majority of town councils have only Health Inspectors and Health Assistants in place.

The first critical stakeholder in any town council is the Town Clerk-TC, who oversees the implementation of GoU programmes in the town which include WASH service provision plus public health. The Town Clerk is the Accounting Officer of the Town Council and therefore is responsible for the cleanliness of the town, on a day-to-day basis. A TC is supposed to create infrastructure for waste management in the town and allocate resources for waste collection

and disposal. S/he also recruits cleaners on a contractual basis to clean the town when it is dirty. Town clerks also work with a technical team including town agents, Community Development Officers-CDOs, and H/As and HIs. When needed, the town councils can also call for support from the districts for example, from the Assistant District Health Officer-Environmental Health (ADHO-EH), who is the overall supervisor of S&H in a district.

The second important stakeholders are the regional structures of Ministry of Water and Environment (i.e. WSDF that is responsible for piped water supply investments) and NWSC and Northern Umbrella of Water and Sanitation, that help to ensure that there is enough water in the town councils at all times. The Umbrella utility has started to provide pit emptying services as well.

Thirdly, there are also development partners such as Save the Children, CEFORD and GIZ, who provide resources to complement government's work in the WASH sector in the towns.

Fourthly, there are Health Centers IIIs who manage the Health and Sanitation Committees of the towns, in addition to treating WASH related diseases and conducting community sensitization drives on S&H in the HHs. Though currently located outside the towns, there are some private companies like the Cesspool emptying company from Gulu that is used by some institutions in the town to empty their line latrines.

Lastly, is the political wing including the Mayors, the RDC, the DPCs, DISOs and Area MPs who should take keen interest in issues of WASH, because inadequate WASH is a security threat to the communities.

Overall, coordination of WASH is not very well streamlined in the five town councils. GIZ S4M programme supported the formation of Sanitation Task Forces (STFs) in each of the towns but these STFs are inactive. STFs can play a vital role in coordination of S&H in the town councils and hence need to be reactivated. In the case of towns such as Anaka, the coordination mechanisms may need to bring on board the Anaka General Hospital-GH Administrator (Medical Superintendent), Assistant Health Educators (also attached to the GH), the Public Nurse and NWSC. The district officials such as the District Health Officer-DHO, District Water Officer-DWO, Assistant District Health Officer-Environmental Health can provide on-going support and mentoring. In the event that all the above-named stakeholders are members of the Sanitation Task Forces in each town, it will be very important that they meet regularly, at least once a quarter, to discuss and deliberate on WASH issues in each town.

Recommendations:

- The Northern Umbrella Utility and WSDF-North should support the Town Councils to in Anaka cluster of towns to re-activate the Sanitation Task Forces (STFs) as coordination mechanism for S&H and oversee implementation of Town Sanitation Plans (TSPs).
- GIZ S4M programme should support an exchange visit to Apac cluster for the Anaka Cluster of towns to appreciate how their counter parts managed to improve on S&H in their town councils.
- GIZ S4M & partners should disseminate relevant sanitation policies, strategies and guidelines (including the PHC Guideline) to town councils.

4 CONCLUSIONS AND RECOMMENDATION

4.1 CONCLUSIONS

Although located in the same area, the five towns in the Anaka cluster are of varying sizes and are at different levels of development and expansion with Olwiyo being the smallest and Anaka being the biggest and fast-growing of them all. Therefore, context differs from one town to the other and so will be the planned sanitation and hygiene interventions in terms of the "what" and the scale.

4.1.1 Assessment On WASH in households

Regarding water supply, generally Anaka cluster of towns has inadequate and intermittent water supply which affects adoption of improved household sanitation facilities that befit the status of towns such as waterborne or pour flush toilets. Water is also required in the institutions and public places such as markets to keep facilities and the environment clean but also for residents to practice handwashing with water and soap. However, there are also some beliefs around use of piped/treated water that need to be addressed.

For sanitation, a one-shoe-fits-all approach may not work given the unique characteristics and peculiarities of each town; the different education and income levels; the current sanitation service levels; the types of toilets options in use, etc. Therefore, a mix of approaches will be required across the towns, with the aim of ending the high rates of OD specifically in Amuru town council. Attention will need to be paid to addressing the cultural beliefs and practice's related to use of toilets, that tend to perpetuate the bad practice of OD. There will be need to involve the local leaders (both political and cultural) to support the change processes. Radio was recommended as a tool for engagement and bringing about positive hygiene behaviour change in communities.

4.1.2 Assessment On WASH in Institutions

As for institutions (schools and healthcare facilities), one biggest challenge is inadequacy of sanitary facilities; poor use and maintenance of existing toilets; and poor disposal of used menstrual pads, which leads to institutions practicing unhygienic manual pit emptying. Therefore, there will be need for development of a comprehensive programme approach for schools and HCFs, with a clear end-in-mind. Most important will be the need for innovation to be able to change behaviour in institutions.

4.1.3 Assessment On WASH in Public Places

WASH in public spaces such as markets and churches is lacking. Almost all markets were "crying" for water. Markets and some of the churches/places of worship do not have sanitary facilities and hence share with neighbouring institutions. HWWS in such public places is almost unheard of. There is no clear management model put in place by the town councils for management of public facilities, yet public spaces such as markets generate money that can take care of toilets. People are paying for not-so-good toilet services, which means they would be more than willing to pay if the services were improved.

4.1.4 Assessment on Menstrual Health & Hygiene Management

Generally, women and girls lack the right information on MHHM, because majority of past interventions have focused on making reusable pads. There is a gap in knowledge on menstruation; the right materials for women and girls to use when menstruating; knowledge of how to dispose used menstrual pads; and there is limited access to hygiene sanitary facilities such as washrooms and incinerators. There are also myths, taboos and cultural belief surrounding menstruation.

4.1.5 Assessment on Faecal Sludge Management

FSM services are currently not well developed in Anaka cluster of towns. Pit emptying is not happening at household level; it if does, HHs tend to use either family members friendly to empty their toilets which is unhygienic and a health risk. At institutional level, schools and healthcare facilities are grappling with expensive services, obtained from outside Anaka cluster as far as Gulu city because of lack service providers within the cluster. Anaka cluster also lacks a lagoon for treatment of FS.

4.1.6 Assessment on Financing For WASH

Uptake of loans for WASH was found to be still low, simply because of lack of information about potential service providers, the available loan products, and the requirements for one to access loans.

4.1.7 Assessment on the Enabling Policy Environment

The five town councils exist to provide S&H services, but their operations are limited by limited budgets, but also vacant positions that are not filled. Coupled with this, is the limitation in terms of knowledge and awareness about some of the most recent policies and guidelines for S&H in households and institutions such as HCFs. The political wing is not so much engaged and involved. Coordination of WASH stakeholders within the town councils is lacking.

4.2 RECOMMENDATIONS

ASSESSMENT AREA	RECOMMENDATIONS
Households WASH	• The two Utilities, NWSC & Northern Umbrella, should provide reliable water services to motivate residents to connect and pay for services; market the services to HHs and demystify the myths related to use of piped water. This could be achieved through use of radio programmes for sensitization, among others. • MWE/WSDF-N needs to fast-track construction of Amuru town water supply system and an additional system for Koch Goma town council to argument the existing smaller system in the town council. Umbrella can then take over management of the scheme to ensure extensions are made to benefit more customers particularly schools. • Conduct targeted marketing of sanitation (e.g., to landlords) to facilitate HHs to move up the sanitation ladder and make improvements in their current sanitation status. For example, those practicing OD to end OD practice especially in Amuru town council; those HHs with unimproved to construct and/or upgrade to improved

	basic, and HHs with shared/limited facilities to move to individual basic toilets. • Consider working with VHTs as Sales Agents to conduct door-to-door sales, since they are trusted by the community. VHTs should be trained on WASH and their role of a sales agents, so they are clear on the change that GIZ & partners want to see at HH and community level. • Supplement the work of VHT Sales agents with radio programmes (e.g., talk-shows, DJ mentions, radio ads, etc.), targeting the well listened-to radios such as Mega FM and Rupiny. Some programmes could be pre-recorded and relayed over the weekend e.g., on Sunday afternoons when most people are at home. • Select and train masons to provide better quality latrine construction services; and equip them with information such as BoQs and a customised catalogue, with more affordable latrine options, to further guide HHs to construct improved toilets and to help masons market their services. It will be important that H/As and HIs are part of the training for masons and also play a role in providing guidance to HHs, based on the standards. • Make it easy for HHs to change behaviours, for example, by availing viable latrine/toilet options through catalogues; taking toilet products closer to the people (e.g., through engaging hardware stores to stock SATOs, and to supply other toilet construction products such as cement in smaller quantities e.g., kilos); and connect with banks, SACCOs and VSLAs and other financing innovations to improve HH's access to financing. Consider provision of well-targeted subsidies for the vulnerable households. • Conduct advocacy and triggering for local leaders such as politicians, RDCs, MPs, Mayors, Councillors, Cultural Leaders (Rwot Kweris), and religious leaders to live by example but also to mobilise their congregants or constituents to change behaviour positively. • Develop a clear BCC approach and delivery model for sanitation in HHs, that will comprehensively address the different barriers and challenges why HHs do not have access to improved toilets (to address demand and the supply chain). Consistently promote five-six critical behaviours identified during the assessment: o *Build new/upgrade an improved, individual household toilet facility (HHs)* o *End the practice of open defecation (HHs* o *Consistent and proper use of toilets/latrines* o *Children faeces management* o *End the practice of "use of flying toilets"* o *Practice handwashing with water and soap* • Develop or adopt existing IEC materials (e.g., "Living Freshi" by MoH) to counter the negative myths and beliefs; and conduct training for GIZ team and partners on SBC. Consider selection and training local folk groups to perform in communities as part of the BCC strategy.
Institutional WASH	**Schools** • Develop and implement a comprehensive School WASH strategy or approach with a clear end-in-mind, which focuses on software measures and changing the bad S&H practices identified by the

	study. Consider promotion of three priority behaviours & messages in schools: o *Consistent and proper use of toilets* o *Practice of hand washing with water and soap at critical junctures* o *Proper menstrual hygiene management* • Develop a Step-by-Step Guide for WASH in Schools to operationalise the strategy, covering purpose & objectives; a menu of activities to be implemented by GIZ S4M & partners; and the key BCC messages to trigger change in behaviours at schools. • Develop and/or print BCC campaign materials, with messages aligned to the behaviours under bullet #1 above, to help support learners to change behaviours. Examples of BCC materials for schools could include Snakes & Ladders games, jingles, behaviour calendars, posters, champion badges, etc; and train teacher on BCC. • Paint nudges (as part of BCC) in strategic places/locations (such as toilet walls) in schools with key hygiene messages to promote behaviours but also to reinforce or keep learners reminded of hygiene messages. • Support schools to construct and/or rehabilitee toilets in schools with inadequate facilities, especially those without drainable toilets; and address the issue of disposal of used menstrual pads through construction of incinerators. • Support installation of adequate HWFs in strategic locations in each school e.g., near the toilets, and next to the dining and/or eating areas; and sensitize learners, so they all know how to wash hands and the critical times when to WASH hands. • Conduct training for school-level individuals and structures (such as teachers, Senior Women Teachers, SMC, PTAs, SHC, parents), so they know and play their roles well on WASH in schools. Support each of the schools to develop an O&M plan and budget for inclusion into the overall school plans and budgets. **Health Care Facilities-HCFs** • Adopt innovative approaches such as “TMG” for schools to organise competitions in the HCFs. This will involve use of a participatory approach to implementation of the competition, with an implementation structure (e.g., Organizing or Steering Committee-SC) set-up comprising of selected technical staff and politicians from each of the towns. The HCF Contest Steering Committee will meet periodically (e.g., on a monthly basis) to prepare for the launch of the contest. Technical support and guidance will be provided by the GIZ S4M team. Time will be required to adapt the materials from schools to HCFs, create buy-in and market the contest to HCFs. There will also be need to train the SC on “TMG” and its benefits, then the SC will be charged with the responsibility to come up with a clear name or message for the Contest, a Roadmap and communicate the purpose of the Contest as well as the entire process (e.g., how to submit entries, how assessment will be conducted, setting up an assessment team, when to conduct assessments; the jury; etc.) to key stakeholders, including the requirements for participation and timelines and prepare and launch the Contest. Ideally, the purpose of

	the Contest will be geared towards sustainable change of behaviours within the HCFs. • Treat Anaka GH as a special case, and set aside a small team of technocrats (including NWSC) and politicians to support the hospital to address the issues with WASH in the hospital; the hospital will also need support to rehabilitate the current lagoon which is a health risk to neighbouring communities. • Support construction of hardware (sex-segregated toilets with incinerators) in HCFs, as well as installation of adequate HWFs in strategic locations in each HCF e.g., near the toilets, for easy access and use by patients and caregivers.
WASH in Public Places (e.g., Markets & churches)	**Markets:** • Umbrella Authority should support the town councils to review agreements with Tenderers and to breakdown the roles and responsibilities of the Market stakeholders i.e., Town Council and Market Operators/Masters/Tenderers. • NWSC and Umbrella should extend water services/connections inside the markets (e.g., in Anaka and Purongo towns) to improve access to services but also hygiene. • Support construction of additional sex-segregated toilet facilities and/or rehabilitate existing toilets in each town in identified public spaces, and ensure provision of facilities/stances for the disabled, washrooms for women, bathrooms and incinerators. • Support the town councils to adopt a private sector-led model to manage public toilets on behalf of the town councils so that toilets become a source of revenue for the town councils; conduct training for the private operators on the basics of managing public toilets and how to plan and budget for recurrent costs such as consumables and toilet emptying. • Conduct Training of Trainers (ToT) for the Market leadership and town councils on proper O&M of sanitary facilities; and develop and share with them the BCC materials on the “dos” and “don’ts” of public toilets (in local language). **Churches and mosques** • GIZ S4M programme considers construction of toilet facilities and WASHaLots at each mainstream place of worship in each town, equip the religious leaders with skills to manage the sanitary facilities. • Conduct training on S&H and messaging for the religious leaders and trigger them to lead by example and to influence their congregants to improve sanitation and change negative behaviours. Christian leaders should be encouraged to quote Deuteronomy 23: 12-13 – “Designate a place outside the camp where you can go and relieve yourself” in their respective churches.
MHHM	• Develop and implement a comprehensive MHHM program in communities, schools, HCFs and markets that covers: o awareness creation and provision of information on MHHM, targeting both boys and girls; and men and women. o demystifying the various taboos, myths and beliefs

	○ male (boys & men) involvement- to fight stigma, for them to know that menstruation is normal and to be supportive of the girls and women during menstruation. ○ training on the different options/alternative materials for catching menstrual blood (including re-usable pads) • Develop or adopt BCC materials with messages such as “Don’t throw pads into pits”; “Menstruation is normal”; for promotion targeting both boys & girls; and men and women. • Engage Latino Adunu Social Enterprise to implement MHHM programmes, both in communities and schools. • Support construction of toilets in schools and public places with provisions for washrooms and incinerators for disposal of used menstrual pads.
FSM	• Support Northern Umbrella Utility to implement the FSM model developed with support from GIZ S4M programme which centres on scheduled emptying and leasing. Accompany it with a well thought-through marketing strategy for promoting safe pit emptying. • Support the construction of a lagoon for treatment of FS in Anaka Cluster, while working closely with the Water and Sanitation Development Facility-North (WSDF-N). • Support Anaka GH to rehabilitate the lagoon for treatment of faecal waste from the hospital. • Focus project interventions to increase the target market size through promotion of emptiable HH toilets e.g., improved basic latrines (lined). • Promote other pit emptying options/enterprises such as the Gulper (Long-term) which is more suitable for emptying the type of existing household toilets/latrines in the Anaka Cluster of towns; interest the manual pit emptiers to adopt the Gulper technology to improve their pit emptying services.
Financing for WASH	• Identify local money lending institutions to partner with such as PostBank and VSLAs or SACCOs; support the money lending organization to create awareness and market their loan products. • Subsidize the costs e.g., capitation, so that this can contribution to reduction of the final costs of the loan for the HHs. There will also be need to know the impact of the loans through a proper monitoring system. • Provide well targeted subsidies to households for toilet construction, especially targeting the most vulnerable HHs such as women-headed households
Enabling Policy Environment	• The Northern Umbrella Utility and WSDF-North should support the Town Councils in Anaka cluster of towns to re-activate the Sanitation Task Forces (STFs) as coordination mechanism for S&H. • GIZ S4M should support an exchange visit to Apac cluster for the Anaka Cluster of towns to appreciate how their counter parts managed to improve on S&H in their town councils. • GIZ S4M & partners should support to disseminate relevant S&H policies, strategies and guidelines including the PHC guidelines to town councils.