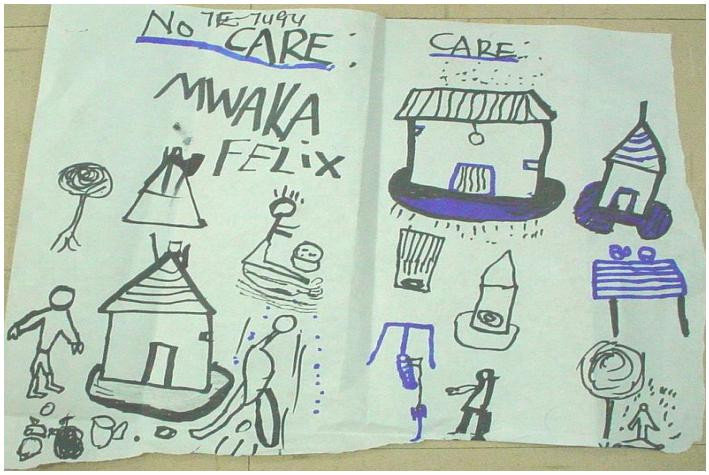
MID-TERM EVALUATION REPORT OF HEALTH PROMOTIONAL ACTIVITIES SUPPORTED BY CARE/HIDO WATSAN PROJECT IN IDP CAMPS, GULU DISTRICT



SUBMITTED TO
THE PROJECT MANAGER
WATSAN PROJECT, GULU

JULY 2005

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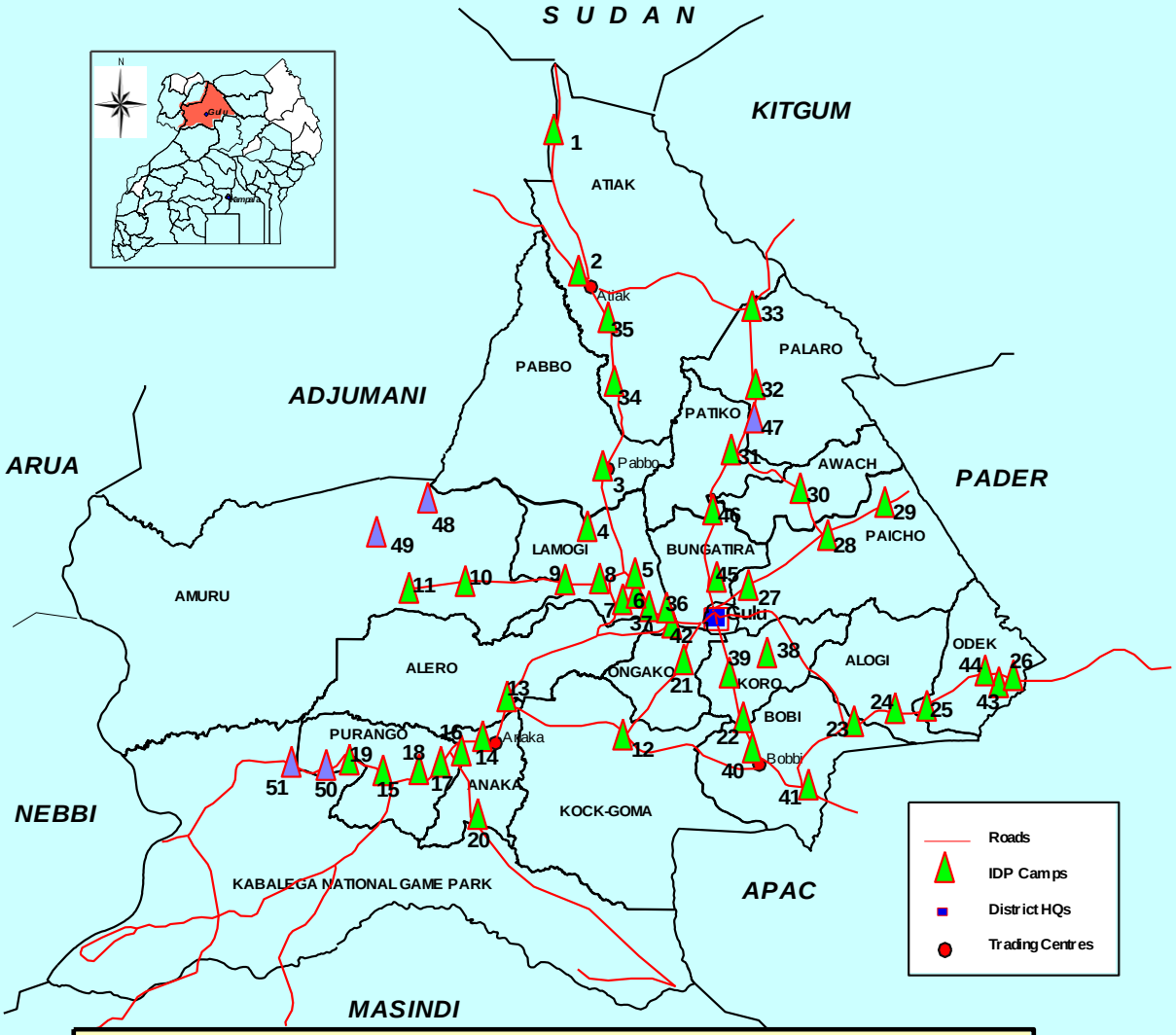
OCHA - UGANDA

Gulu - IDP Camps distribution

Camps with IDPs receiving Relief Assistance

Map elaborated by IMU-OCHA in collaboration with EU Acholi Program and WFP - data source as of April 2005
Map and distances not in scale



TOTAL IDP CAMPS POPULATION : 507,491

REF- Camp Name	Population	REF- Camp Name	Population	REF- Camp Name	Population
01- Bibia	6,046	19- Wianaka	1,878	37- Keyo	7,033
02- Atiak	24,523	20- Agung	1,799	38- Te-tugo	12,980
03- Pabbo	54,468	21- Ongako	8,225	39- Koro-Abili	11,751
04- Guru Guru	5,059	22- Palenga	10,591	40- Bobi	15,000
05- Parabongo	9,453	23- Opit	22,859	41- Awor	no info
06- Awer	18,543	24- Lalogi	20,610	42- Alokolum	9,060
07- Pagak	11,043	25- Acet	21,723	43- Dino	no info
08- Kaladima	1,704	26- Awere	21,383	44- Odek	no info
09- Olwal	112,287	27- Unyama	11,848	45- Coope	11,732
10- Labongogali	7,126	28- Paicho	12,648	46- Lukodi	no info
11- Amuru	33,379	29- Teyapadhola	7,890	47- Lugore	3,655
12- Koch Goma	10,273	30- Awach	16,682	48- Omee Upper	
13- Alero	15,712	31- Patika-Ajulu	14,480	49- Omee Lower	
14- Anaka	27,716	32- Palaro	10,972	50- Te-got-Latoro	
15- Wianono	2,391	33- Oroko	1,799	51- Lolim	
16- Aparanga	2,317	34- Pawel	no info		
17- Olwiyo	1,875	35- Palukere	650		
18- Purongo	9,151	36- Lacor	413		

IMU - OCHA Uganda - If you need a copy of this map, please refer to this code: IDPGULU200504
Organizations are most welcome to provide new information on the camps locations and population numbers - please send your comment to ocha-uganda@un.org

ACRONYMS

ADA	Access Development Associates
AHEAD	Applied Health Education And Development
CHCs	Community Health Clubs
CBO	Community-Based Organisation
DDHS	District Director of Health Services
DDMC	Director of District Health Services
DHI	District Health Inspector
DWO	District Water Officer
FGDs	Focus Group Discussions
HIDO	Health integrated Development Organisation
HIV/AIDS	Human Immune Virus/Acquired Immune Deficiency Syndrome
IDPs	Internally Displaced Peoples
NGOs	Non Governmental Organisations
ORA	Oral Rehydration Salt
PRA	Participatory Rural Appraisal
PWDs	People With Disabilities
UN OCHA	United Nations Office for Coordination of Humanitarian Aid
VISO	Voluntary Initiative Support Organisation
WATSAN	Water and Sanitation

EXECUTIVE SUMMARY

CARE Uganda developed and has been managing an emergency water and sanitation project in fifteen camps in Gulu district. The project was funded by Melinda and Bill Gates Foundation. CARE partnered with Health Integrated Development Organization (HIDO) a local professional CBO to implement the project. The project pioneered a participatory community health club strategy adopted from Africa AHEAD.

The objectives of the project were: i) To increase access to safe water for 225,000 IDPs through rehabilitation of boreholes, improve water sources management and increase local capacity for maintenance of boreholes; ii) To improve and sustain the health and well being of 125,000 IDPs through improved excreta disposal, medical waste management, vector control and health education and iii) To reduce the incidence of malaria on 24,000 pregnant women and 20,000 newborn infants by provision of treated bed nets.

The objective of this mid term evaluation was: To evaluate the progress and impact of objective ii) above of CARE WATSAN project for health promotional activities in the 15-targeted IDP camps in Gulu district.

HIDO conducted a baseline study and identified 20 areas in which to improve sanitation and hygiene behavior. With staff based in the camps, HIDO trained the communities in twenty areas of: safe water chain, safe food chain, sanitation ladder, sanitation planning, diarrhea, hand washing, cholera/typhoid, skin/eye diseases, worms, nutrition, good kitchen, drama and songs, environment, malaria, coughs and colds, bilharzia, TB, HIV/AIDS, home based care, and family planning.
Evaluation findings revealed that the strategy transformed the IDPs in the camps. The learning's have translated into practical behavior change like improved pit latrines that are well maintained, hand washing before eating and after latrine use, improved disposal fecal disposal, ventilated huts, use of drying racks, tippy taps to mention but a few. In short there is improvement in hygiene and sanitation overall in the project camps.

The IDPs find the CHC strategy appropriate compared to others because it brings in a feeling of ownership and unites the community for a common cause.
The delivery of the training used visual aid, demonstrations, drama and group discussions that were convenient for illiterate learners. The learning areas answered a real felt need in the community thus the enthusiasm. The participatory approach of CHC has inbuilt sustainability mechanisms.

CARE/HIDO has been linking with groups formed in the camps like sanitation committees by other organizations involved in health and sanitation promotion especially in mobilization and training. As a result most of the sanitation committees have become members of the CHCs. CARE CHC strategy builds on to the foundation laid by other organizations.

CARE/HIDO needs to build on the current success of the CHC strategy to transform the lives of the IDPs in Gulu District.

1.0 INTRODUCTION

1.1 Background

CARE International, a development organisation has been providing development services to the people of Northern Uganda for a long time. Since 2002, CARE got involved in giving humanitarian assistance to internally displaced people (IDPs) in Gulu. In 2003, with funding from Bill and Melinda Gates Foundation worth 2 million dollars, CARE developed an emergency water, sanitation and malaria control project for 15 months. The project was to benefit women, men and children.

The main objectives were:

i) To increase access to safe water for 225,000 IDPs through rehabilitation of boreholes, improved water sources management and increased local capacity for maintenance of boreholes.

ii) To improve and sustain the health and well being of 125,000 IDPs through improved excreta disposal, medical waste management, vector control and health education;

iii) To reduce the incidence of malaria on 24,000 pregnant women and 20,000 newborn infants by provision of treated bed nets.

The assignment was to evaluate the progress and impact of objective ii) above of CARE WATSAN project for health promotional activities in the 15-targeted IDP camps in Gulu district.

This report high lights the methods used, examined the CARE CHC methodology and other methods of health promotion, the key findings, challenges, sustainability issues and general recommendations.

1.2 Terms of Reference

Objective of the Midterm assessment

The purpose of this mid term evaluation was to assess the current health promotion strategy of Community Health Clubs (CHCs) that CARE has adopted from Africa AHEAD and compare it with other health promotion methodologies that have been introduced in the IDP camps in Gulu. In addition, to make comparison between the camps where CARE/HIDO has employed this strategy with camps where the CHC strategy has not been implemented with a view of establishing behavioral changes, successes, constraints/challenges and opportunities.

Outputs

i) Detailed evaluation report about the level of IDP health knowledge and uptakes on practices of the 20 key health areas covered during the health club sessions;

ii) Appropriateness and recommendations on the curriculum and materials designed and currently in use in the promotion of hygiene and sanitation in IDP camps;

iii) The level of community acceptance, appropriateness (or otherwise), sustainability and recommendation of using health clubs as a strategy for promotion of hygiene and sanitation in IDP camps. (Linkages to what others are doing must be mentioned);

iv) IDP assessment and recommendation of HIDO staff capacity in implementing the project.

1.3 Challenges

The security regulations would not allow the researchers to leave for the camps before 10.00 am or stay beyond 4.00 pm. This constrained longer interactions with the community. This however, did not affect the outcome of the report.

2.0 METHODOLOGIES

2.1 Document Review

Key project documents were reviewed and analysed. Specific were the baseline survey conducted by HIDO, Africa AHEAD Consultant's report on health promotion, project implementation reports, HIDO's monthly progress reports, training materials for health promotion, photographs of health promotional activities and the project proposal among others.

Based on the review and consultations with CARE/HIDO, the following criteria were used for choosing the camp sites for field work:

- ✧ Camps in which CARE/HIDO are operating and have operational CHCs;
- ✧ IDP camps that are accessible in terms of security and distance;
- ✧ IDP camps where there is no CHC health promotional activities;
- ✧ Planned versus unplanned camps;
- ✧ Urban versus rural camps;
- ✧ Population of the camps.

The control camps chosen were Alokolum and Awoo. Camps where HIDO implemented the CHC strategy were: Lacor, Keyo, Coope, Tetugo and Koro Abili. Bobi camp was visited briefly.

2.2 Interviews

Interviews were held with the camp leaders, men and women to find out the different strategies being employed by different organisations to promote health in the camps. Respondents were asked about the successes/benefits, challenges and uptake of recommended practices of the CARE CHC strategy.

2.3 Focus Group Discussions (FGDs)

At least two FGDs were held per camp in both control and project camps with women, men CHC members/non-CHC members and children groups. The groups discussed the status of health promotion in the project camps compared with the situation of health promotion in non-project (control) camps.

2.4 Key Informant Interviews

Interviews were held with the CARE staff responsible for the WATSAN project, the HIDO health promoters, camp leaders, and other NGOs that are implementing water and sanitation activities in the camps to find out the approaches used in health promotion and their impact to the IDPs, lessons learnt and possible recommendations for improvement. The key informants interviewed are listed in Appendix I.

2.5 Questionnaire Sample

There were two different kinds of questionnaires used: one was designed by the consultant to assess the impact of HIDO/CARE CHC strategy and the other was the HIDO designed questionnaire used for the baseline for control camps. In all 175 questionnaires were administered in seven camps. The sample size was 25 questionnaires per camp. Of the 25, 10 women and 10 men CHC members and 5 non-members were targeted while in control camps, 5 youth were targeted in addition to the 20 men and women.

2.6 Observations

Observations of health facilities in the camps were made to get evidence of uptake on recommended practices. This helped the researchers to assess impact of the CHC strategy on behaviour, knowledge and practices of IDPs in the project camps. In control camps health promotion facilities set up by other organisations and current practices of the IDPs were observed.

2.7 Children's Drawings

Children were asked to make drawings of what the sanitary conditions in the camps were like before and after CARE/HIDO intervention. The children's assessment depicted the situation before CARE and the changes that have taken place in the community after the intervention.

2.8 Photographs

Photographs were taken to show the current hygiene and sanitation practices in the camps after CARE/HIDO intervened.

3.0 CARE COMMUNITY HEALTH PROMOTION STRATEGY

3.1 The Theory CHC Approach

The Applied Health Education And Development (AHEAD) approach is a development model that uses Community Health Clubs (CHCs) as a 'vehicle for development' leading to sustainable livelihoods through improved family health and hygiene. This approach was adopted from Africa AHEAD. The CHC strategy uses participatory techniques (PRA/PHAST) that looks at development as a long-term process which meets communities' social-psychological needs. The strategy is divided into four phases:

***Phase 1*: Knowledge**: At this phase communities are mobilized and health clubs formed. The clubs elect their leaders and decide when and where to meet and how often they need to meet. This continuous meeting creates common unity among the community members. In every meeting a health message is passed and each club member chooses what hygiene and sanitation behaviour can be improved in their homes and the community.

***Phase 2*: Practicals:** The club members and the community apply what was learnt and chosen to practice in the club sessions. The main areas could be in water facility improvement, safe sanitation, productive water points, safe water and sanitation and other health messages depending on the problem in the community.

***Phase 3*: Economic Support**: As health improves, development challenges begin to emerge. For the community to sustaining the gains, economic initiatives will be necessary. There would be need for skills training, Income generation, Financial management training and Adult literacy.

***Phase 4*: Social support:** Once members have attained skills, unity within the community is consolidated and improved incomes, the need for helping the disadvantaged in the community emerges. Together within the health clubs, social support initiatives can start depending on the problem the communities would be experiencing at the time. The creation of HIV/AIDS awareness, Home based care for the terminally ill, Support for orphans and widows to mention but a few will be the final phase.

3.2 The CHC in Practice

CARE partnered with Health Integrated Development Organisation (HIDO), a Gulu based NGO to implement the CHC strategy in 15 IDP camps.

HIDO staffs were trained by Africa AHEAD and deployed to the 15 project sites. The staff mobilized the community and explained the need to form Community Health Clubs. Community members who picked interest formed the clubs. Each club has 100 members. Each staff covers an average of five clubs totaling to 500 persons being reached with the health messages.

CARE/HIDO designed special membership cards, which contain the 20 health promotional areas. Club members choose topics from the card and record the practice areas for change. The preferred practice area for change written on the backside of the card enhances monitoring. Each club elects its leadership comprising of a Chairperson, Vice Chairperson, Secretary and Treasurer to manage the affairs of the club. So far CARE/HIDO have implemented phase I and II described above.

The CHC strategy uses drama, songs, demonstrations, visual aid for training and most important of all, the CHC members make the decisions of what to do in terms of learning and practices. The zonal leaders, camp leaders and sanitation communities in project camps

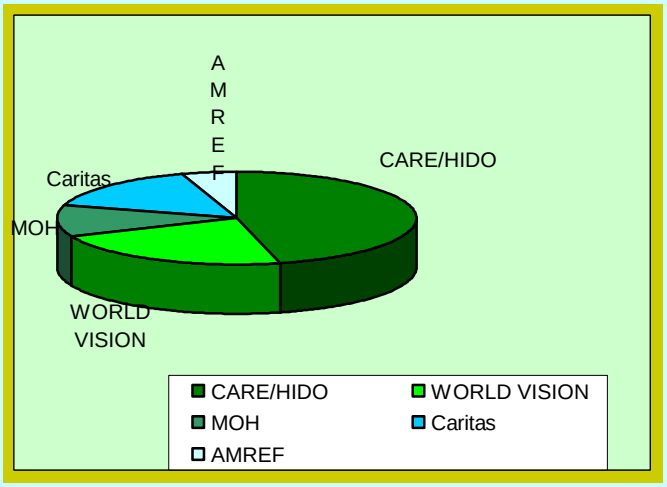
have become members of the CHCs. There is good working relationship between HIDO/CARE staff and health promoters working with other organisations within the camps.

3.3 Other Methods of Health Promotion in IDP camps

The organizations involved in the health promotion in control camps use slightly a different strategy. Either communities elect volunteers to become health promoters or the camp leadership or zonal leaders are chosen to be trained as health promoters. The selected people are trained and go back to the camps. The rationale behind is that the people live within the community therefore are able to pass the message.

However, the challenge with this method is the issue of commitment and ownership to the process and the outcome. The knowledge and skills are limited to a few not the entire community. Self-interests overrides community good while in CHC the community members own the process and the outcome.

Chart 1: % of Respondents who received training in health promotion from different organisations



Note: Camps with CHCs were targeted. Preference was given to organisations that offer training in health promotion. The percentages represent only the views of respondents who were involved in the assessment

4.0 FINDINGS

4.1.0 Introduction

CARE commissioned a baseline before the HIDO intervention in the 15 camps. The results of the baseline revealed bad sanitation and hygiene practices in the camps that included: communal eating and hand washing, use of dirty containers for fetching water, unclean water sources, uncovered water for drinking, no proper fecal disposal, use of communal latrines that were poorly maintained, rampant skin diseases and eye infections and children with worms.

The CARE/HIDO intervention was aimed at addressing some of these identified problems. The set targets and the achievements as at the mid-term review are indicated on the Table 1 below.

Table 1: Main Achievement of Targets

Item	Base line	Target	Achieved by June 2005	Remarks
Formation of CHCs	0	120 groups	116	One of the trainers left the organisation. Replacement within the six months took time. Each group to have 100 members
CHCs members	0	12,000	15,522	Some Trainers have taken more than six groups instead of five. The average number of households for 15,522 people reached is 2,575 (average of 6 persons per household)
Drinking water with 2 cups	39			
Trainers	0	25	25 trained	But one dropped out owing to the remoteness of the camp
Latrines stances Concrete slabs Wooden cover Poly sanplats Pedestals for PWDs	962 67 62 0 0	10,000	11,256 2,120 2120 800 50	These are traditional latrine stances Traditional latrines improved with concrete slabs and wooden covers Traditional latrines improved with poly sanplats
Drying racks	0	No target was set	11,709	Adaptation by both CHC members and non-members of the community. Racks constructed inside and out side the house
Hand washing facilities for all CHC households	45	No target was set	2,127 (596 Tippy Taps 1,531 Basin and cup)	Tippy taps are expensive and they either get stolen or get used by children as toys hence less adaptation rate. CHC have improvised water in basins with a cup for hand washing.

4.1.2 The Level of IDP Health Knowledge and Uptakes on Practices

There is an observable change in general IDP behaviour seen in practices in the camps where HIDO is implementing the CARE health promotional activities using the CHC strategy. Most of the members of the CHCs have embraced the training contents and put the learnings into practice. Below is a table showing the percentage distribution of those who have taken up the recommended practices in the twenty areas against the percentage coverage at baseline

TABLE 2: Uptake of health issues by respondents

Health Issues	Recommended Practices	% of respondents who have adopted practices	% of respondents who haven't adopted practices
1. Safe water chain	Cover water, use 2 cups	70.4	29.6
2. Safe food chain	Pot rack, hanging basket	70.4	29.6
3. Sanitation ladder	Clean latrine, cat sanitation	69.7	30.3
4. Sanitation planning	Dig pits	67.8	32.2
5. Diarrhea	Build latrines	67.1	32.9
6. Hand washing	Tippy tap	71.7	28.3
7. Cholera/Typhoid	Water source clean up	60.5	39.5
8. Skin/eye disease	Bedroom clean up	65.1	34.9
9. Worms	Deworming	65.1	34.9
10. Nutrition	Food processing	63.8	36.2
11. Good kitchen	Lorena stove	66.4	33.6
12. Drama and songs	Practice drama	65.1	34.9
13. Environment	Hay basket	69.7	30.3
14. Malaria	Drainage & clearing, mosquito nets	65.8	34.2
15. Coughs and cold	Mats & ventilation	59.9	40.1
16. Bilharzias	Bathing shelter	59.2	40.8
17. TB	Community project	58.6	41.4
18. HIV/AIDS	Community project	58.6	41.4
19. Home based care	Community project	62.5	37.5
20. Family planning	Community project	59.2	40.8

Children's View

The children also evaluated the impact and sketched the changes that have taken place before and after CARE intervention. The children who participated were in primary five to seven and two boys from senior one. The children were very knowledgeable about what was taught to their parents and how it has contributed to improved community sanitation and hygiene. Below is Ocaya's view on the impact of the CARE/HIDO intervention:

Picture 1: Before CARE intervention After CARE intervention

CARE needs to make a deliberate effort to involve children, because they can be very good change agents in the homes and community.

4.1.3 Analysis of the key health issues

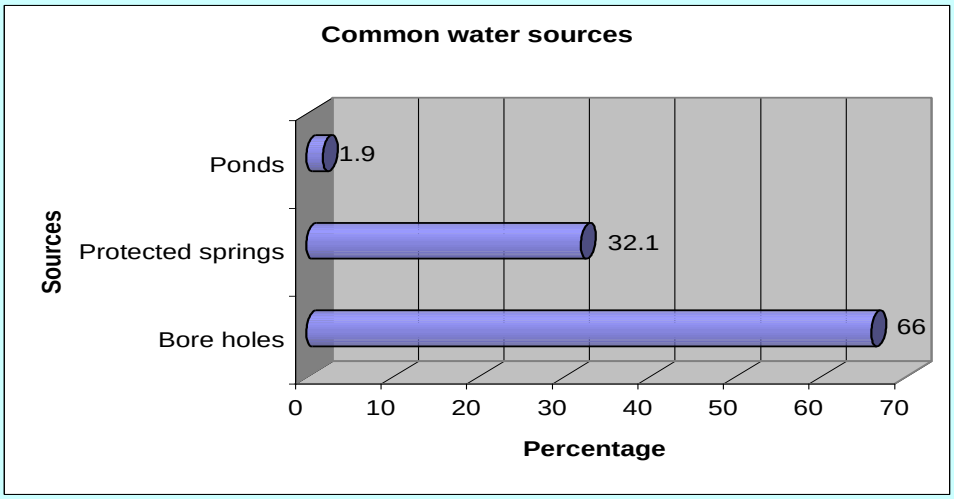
i) Safe Water Chain

The chain involved training in avoiding contamination of water from the source, the containers used for fetching, the storage and drinking. While 66% of the water sources in project and control camps are safe water from boreholes as indicated below, the evaluation showed that IDPs in the control camps still used dirty containers with no covers/lids for collecting water; and use of one cup for drinking. The CHC intervention recommended covering of water and 2 or 3 cup method for drinking.

70.4% of the households have adopted the method of using two or three cups for drinking water: one for getting the water from the pot, and the other for pouring the water for drinking. The pots for keeping drinking water are covered; the jerry cans for fetching water and the surrounding of the water sources are kept clean in most of the camps with CHC intervention.

The challenge is that boreholes are few. During dry seasons the lines are long forcing people to look for alternative water sources. CARE could consider sinking of more boreholes in the 15 IDP camps with CHC projects.

Chart 2: Common water sources in IDP camps



ii) Safe Food Chain

The safe food chain highlights the stages of food handling, covering, storage and serving. The baseline survey results showed that in most of the households, food was served communally in one bowl to be shared by all members of a family and hands were also communally washed in one basin regardless of how dirty ones hands would be. This is also a common practice in control camps at the time of evaluation.

This situation has changed in project camps where food is served on individual plates and the pour method for hand washing used. 70.4% of the people in project camps practice safe food chain method compared to 30% in control camps as shown in Chart 3a and 3b. In addition, communities in project camps have learnt to use hanging racks for keeping raw foods. This is unlike in the control camps where a greater percentage of the IDPs still eat and wash hands communally. They stand a high risk of getting hand to mouth infections. *CARE needs to expand the CHC strategy so that other camps can benefit. Support in Alokolum and Awoo as control camps would be ideal.*

Chart 3a: Comparison of eating practices in control camps and CARE/HIDO support camps by percentages

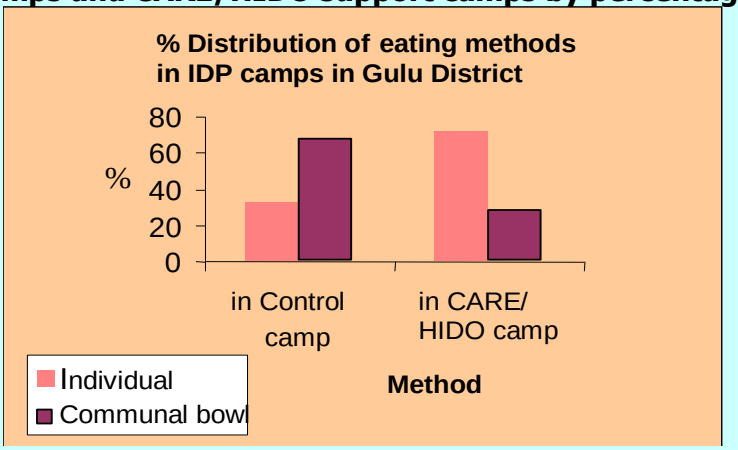
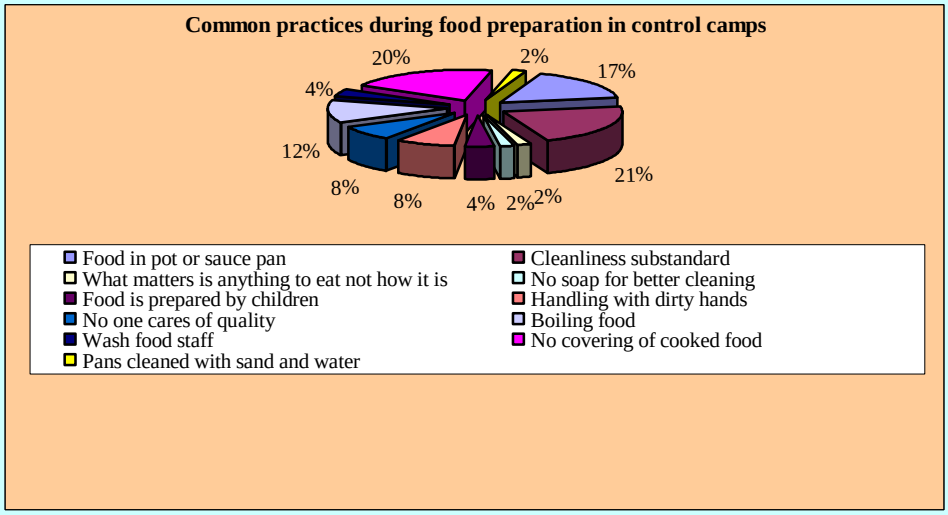


Chart 3b: Food handling practices in control camp



iii) Sanitation Ladder

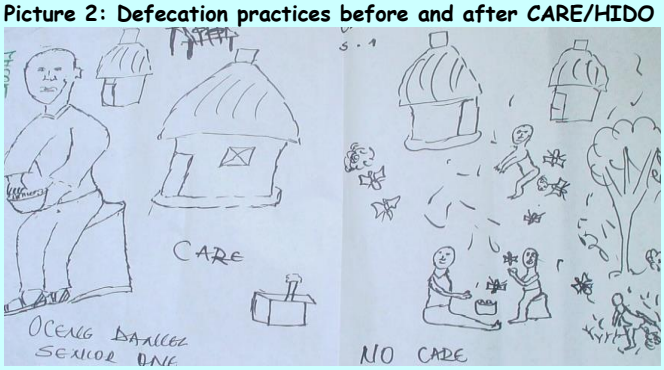
The sanitation ladder provides the different levels of sanitation from feaces in the bush to VIP latrines up to hand washing facilities of tippy taps. The project promoted cat sanitation and clean pit latrines. CARE/HIDO provided 2,120 concrete slabs with wooden covers, promoted construction of 11,256 traditional latrine stances and supplied 800 poly sanplats and 50 pedestals with cover for people with disability.

Although there was a challenge of few supplies for sanitation compared to the number of community members willing to improve their sanitation, the disappointment in a positive way set competition among CHC members. This is being strongly backed by the setting of communal cleaning and inspection days. People who did not get slabs regularly smear their latrine floors and walls to match up the standards in the latrines with slabs. The improvement the project has made can be seen in the photograph below:

Plate 1: Latrine in Keyo camp

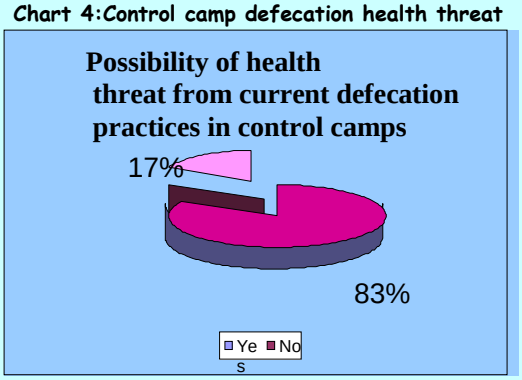
The distribution of the san plats and sensitisation encouraged construction of many latrines. This has solved the problem of open defecation, which had been a health hazard. Below is a child's view of what the CARE/HIDO intervention has done in camp. However in the control camps defecation practices are still poor and pose health threats as indicated by the 83 % distribution of respondents who say there are health threats from the current defecation practices in Chart 4.

Picture 2: Defecation practices before and after CARE/HIDO



After CARE/HIDO Before CARE/HIDO

Chart 4:Control camp defecation health threat



The main challenge with sanitation is lack of enough land for digging pit latrines in project camps. But in control camps the lack of sensitisation aggravated the problem. Even in camps where CARE supplied some slabs, they are not being used in some control camps. CARE/HIDO will need to support the communities to negotiate with landowners so that IDPs get more land for construction of pit latrines. CARE needs to expand the project to new camps so that IDP health can improve over all.

iv) Sanitation Planning

The IDPs are expected to plan for their sanitation including rubbish disposal and setting latrines. While pits from brick making have been used for rubbish disposal, the management has become a problem due to the fact that the pits are very large and burning rubbish during rain season is difficult. Mango, sugarcane and maize seasons were sighted as hazardous periods in the camps.

Although respondents reported 68% adoption rate, in Bobi camp open disposing of refuse as can be seen in the photograph below still needs attention. Despite the existence of the project there is still lack of sanitation planning in some of the camps. In addition, the

leadership in some camps is quite weak. *There is need for HIDO staff in Bobi, Koro Abili and Coope to put more effort to improve the situation. CARE needs to invest in building capacity of camp leaders through the project so that the leaders can play their role.*

Plate 2: Photograph of rubbish in Koro Abili

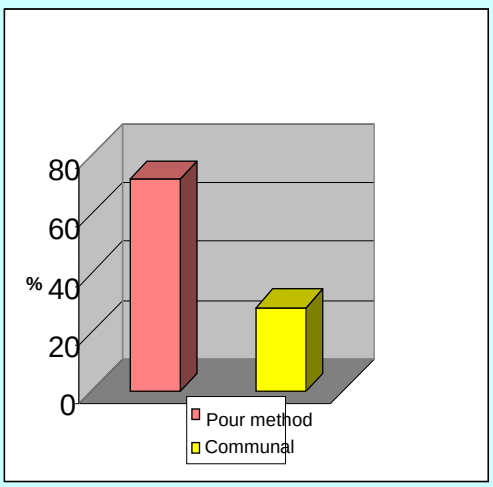
v) Diarrhea

During the sessions, the communities were taught how to make ORS, which they have quickly taken up by 67.1%. To prevent diarrhea, women encourage their children to wash hands before and after eating and latrine use. The families have improvised basins and cups for hand washing. Zone leaders have taken responsibility to supervise clearing of rubbish and burning to fight diarrhea. In Koro Abili camp women constructed a latrine without the help of men. *There is need for continuous sensitisation by CHC members to support these achievements.*

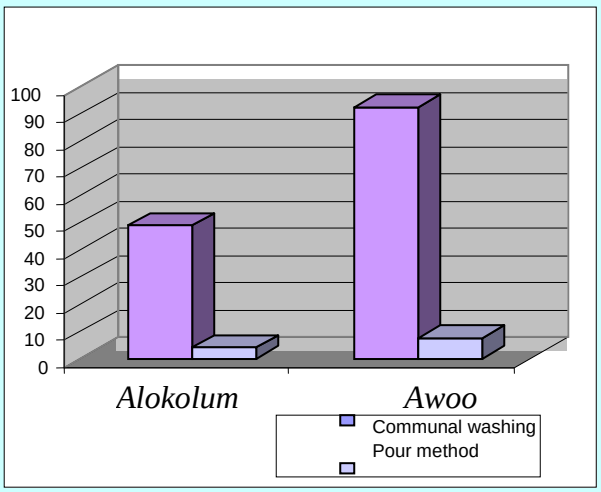
vi) Hand washing

The IDPs in the project camps have taken up washing their hands whenever they are from the latrine and during meal times. Water is poured for individuals in the hands before and after eating. However, in the control camps there is still a high level of communal hand washing during meal times. They see nothing wrong with that. Below is a graph showing the statistics of respondents in control camps who use communal method of hand washing against those who use pour method.

Chart 5: Common methods of hand washing in IDP camps



Project camp



Control camps

All the project camps have various hand washing practices adopted, the most common one being the basin and cup for use after visiting a latrine. Tippy taps have also been a good innovation but the problem the community has faced with maintaining them is that other community members sometimes steal them. Where they are not stolen, children empty them and turn them into toys.

Plate 3: Tippy tap (hand washing facility)

vii) Cholera/Typhoid

The common recommended practices taken up are drinking clean/boiled water and fetching water from a clean source. The main source of clean water is the borehole. But the boreholes are very few compared with the number of IDPs in the camps. During the dry season the water yield is low. Thus the women and children experience long lines of waiting. About 60% of respondents have adopted the good practices to avoid cholera/typhoid. *There is need to sink more bore boreholes for the IDPs.*

viii) Skin/eye infection

Skin/eye infections are a big problem to both children and adults in the control camps. This is mainly because of poor personal hygiene. In both Alokolum and Awoo, which were the control camps communities are not trained on these health issues. While in the project camps respondents clean up their homes, bodies and beddings to address the problem of skin diseases. The adoption rate of the good practices is up to 65.1% in CHC project camps. However, some of the respondents complained about the effectiveness of the skin ointments recommended from the clinics for treating skin diseases especially for ringworms. *This claim needs to be investigated by the health people. HIDO/CARE need to link up the CHCs with the relevant department. The education on personal hygiene and use of clean beddings needs to be strengthened.*

ix) Worms

To treat worms IDPs have taken up recommended practices like avoiding raw food, covering feaces, boiling water and de-worming. Although 65% of the community has tried to take up the practices mentioned; some of the children appeared to have worms. Most respondents believe that children can outgrow the age of having worms once they learn to take up personal hygiene seriously. So having worms does not bother them much.
More effort needs to be put to change the community attitude towards de-worming of children. HIDO/CARE need to link the communities up with health departments or organisations that can provide de-worming services to the children in the camps.

x) Nutrition

There has been minimal impact on the feeding habits of the beneficiaries of this project. But the knowledge for future implementation lives with them. The low level of income and lack of incentives has made this quite impossible. The IDPs have limited resources to buy the food supplements required and limited land to grow the supplements. IDPs depend mainly on relief food which is augmented by the carpenter fish and common vegetables. Nutrition situation is worse in control camps. *CARE/HIDO need to extend the project so that the third and fourth phases of economic empowerment and social support can be implemented. This would address the nutritional problems. IDPs need to be trained to adopt food preparation and handling methods that best retain the nutrients like washing foods before chopping and eating boiled/steamed foods other than frying. In addition avoid polished foods that are less nutritious.*

xi) Good Kitchen

The 66.4% of women who adopted use of Lorena stoves in CARE/HIDO supported camps pointed the benefits so far. It has eased cooking, proved economical (uses less firewood) and affordable. Other practices include: smearing of the kitchen floors and/or walls weekly; using racks for utensils and pots; and storing food rations above the ground by use of bricks and stones instead of putting directly on the ground. This keeps food safe from being spoiled.

Plate 4: Photograph of kitchen with Lorena stove

These practices need to be improved in some project camps while control camps need serious intervention.

xii) Drama and songs

Through the formation of the health clubs the communities have formed drama and music groups for sensitisation and entertainment. The practice of the drama ranges from weekly to monthly. But when there is a special occasion, the clubs meet more regularly in a week. Sensitisation using drama and songs is not only done for health promotion but also for sensitisation on other areas.

HIDO and CARE should promote this method in future programmes. Men should be encouraged to participate but not leave it to the youths and women alone as was observed in Keyo camp.

xiii) Environment

The camp leadership ensure that there is general cleaning once every week on set dates. In Koro Abili inspection is done every Sunday. This promotes generally cleaning in the camps. However, no hay baskets were observed and the CHC members did not talk about them. All

the camps that receive CARE/HIDO support were clean with exception of Coope during the evaluation time. *HIDO needs to get a specific person to be a health promoter in Coope camp since the current staff doubles as the HIDO Accountant.*

xiv) Malaria

In both the control and project camps more women sleep under nets than men for the reason that CARE/VISO gave nets to expectant mothers and those with children under five years. The nets were also supplied to camps where CARE is not doing health promotion so the control camps also benefited. Other practices to prevent malaria include filling potholes, digging trenches to drain surface run off, clearing nearby bushes during community work, using mosquito coils and herbs that repel them and when there are symptoms of malaria, visit to the health centre is encouraged. While project camps were clean with proper drainage, the control camps were dirty with poor drainage. *This means supply of nets without health education is not very useful. This is a lesson CARE and other organisations can learn from. Communities need to understand the reason for supplying the nets.*

xv) Coughs/Cold

The new huts built have been decongested and ventilators made wider to allow proper aeration. This has reduced incidences of coughs/colds infections. 59.2% of the respondents have also taken up practices like covering the mouth when coughing, drinking a lot of fluids and seeking for help from a medical practitioner when symptoms persist. The CARE health Centre at Coope comes handy for treatment. Common cough and colds were observed among children in control camps. *There is real need to scale up this project by CARE.*

xvi) Bilharzia

There have not been many reported cases of bilharzia in communities sampled but where the cases have been reported medical advice was sought. However, precautions including fetching water from a clean source, drinking boiled water, building bath shelters and proper drainage trenches and avoiding body contact with dirty water are being taken in camps with CHC project. *Control camps need support.*

xvii) TB

The respondents confessed not much has been done about TB control because no cases had been seen yet. TB was viewed by respondents as a difficult topic that would need more training. Although no community project was planned for the phase of implementation there *is still cause for CARE to continue with this project and change it from an emergency project to a programme so that the phase three and four could be implemented to get the expected impact of the CHC strategy.*

xviii) HIV and AIDS

The community has got knowledge and feels sensitised on the issues involving HIV and AIDS. However, there is a lot more that should be done about it. Life in the camp comes with a lot of challenges one of which is losing family identity because of the crowding. There are also issues of the social life. It is hard to monitor ones family. Children learn to relate with the opposite sex before they are ready for it. There is still stigma in talking about HIV/AIDS. So it was difficult to establish the real impact of the training in relation to HIV/AIDS issues. Most respondents reported the use of condoms and abstinence as practice areas. *CARE needs to link the communities to specialised organisation for HIV/AIDS support. In addition, the project should be developed into a longer term project to realise the sustainability of the project benefits.*

xix) Home based care

Out of the home based care the CHC members have taken up some of the action points such as taking care of the sick, creating clean environment in the houses and showing love to the sick. *There is need to have the community projects as part of what has already been covered to strengthen the recommended practice areas.*

xx) Family Planning

CHC members found family planning a very relevant topic but difficult to understand. The composition of the CHCs in the training sessions were mixed men and women and this could not enhancing asking of sensitive family planning questions. Family planning involves men and women but the gender composition and participation as couples was not considered and this has compromised the adoption rate. *HIDO/CARE need to link the communities to family planning practitioners and also invite both partners and consider gender desegregation during family planning sessions in future.*

4.2 Assessment of the curriculum and materials

4.2.1 Overview

The following training materials were developed for the project: sanitation ladder, sanitation planning, safe water chain, safe food chain, worms infection chain, vector control especially malaria, hand washing and skin diseases.

The training materials were adopted from already existing training materials for Watsan in the market especially from WaterAid, UNICEF, CDRN, CARE, Africa AHEAD.

Overall the materials were relevant, the diagrams/sketches were appropriate to the local situation and the content of the modules covered the critical areas of need.

The following are the comments on the training materials:

- √ The illustrations were clear and made it easy for illiterate members of the community to understand the situation better;
- √ The sketches reflected the real hygiene behaviour in the community so people could easily relate to them.

4.2.2 Training material areas that need improvement

i) Safe water chain

While all the stages of the water chain are clearly illustrated, the sketches showed the traditional role of women. From chart 1 to chart 20 only the mother is shown to undertake the roles of fetching, preserving, feeding the children. This portrays stereo-type in gender roles. Responsibilities like fetching water, fetching firewood for boiling water, helping a child to drink water can be done by men. *It would be ideal to make the illustrations gender sensitive for example the role of fetching water could be assigned to men or boys.*

ii) Sanitation Planning

Due to the limited land allocated for pit latrines, the community undertakes the sanitation planning in emergence/camp situation. The terms used in the training manual need to reflect the 'we' what CHC members can do together since this material is targeting community health club members and it is communal planning for sanitation not individual as reflected n the manual.

iii) Safe food chain

The issue of blocking the children's feaces arises from the fact that children's feaces are always around the house. The children's evaluation sketches also show adults defecating in near by bushes. since flies travel far, the cat sanitation should cover all feaces by adults/children alike.

In all the training covered the main issues as set in the SPHERES standards for water supply, sanitation and hygiene promotion, water supply, excreta disposal, vector control, solid waste management and drainage management thus was appropriate for the project.

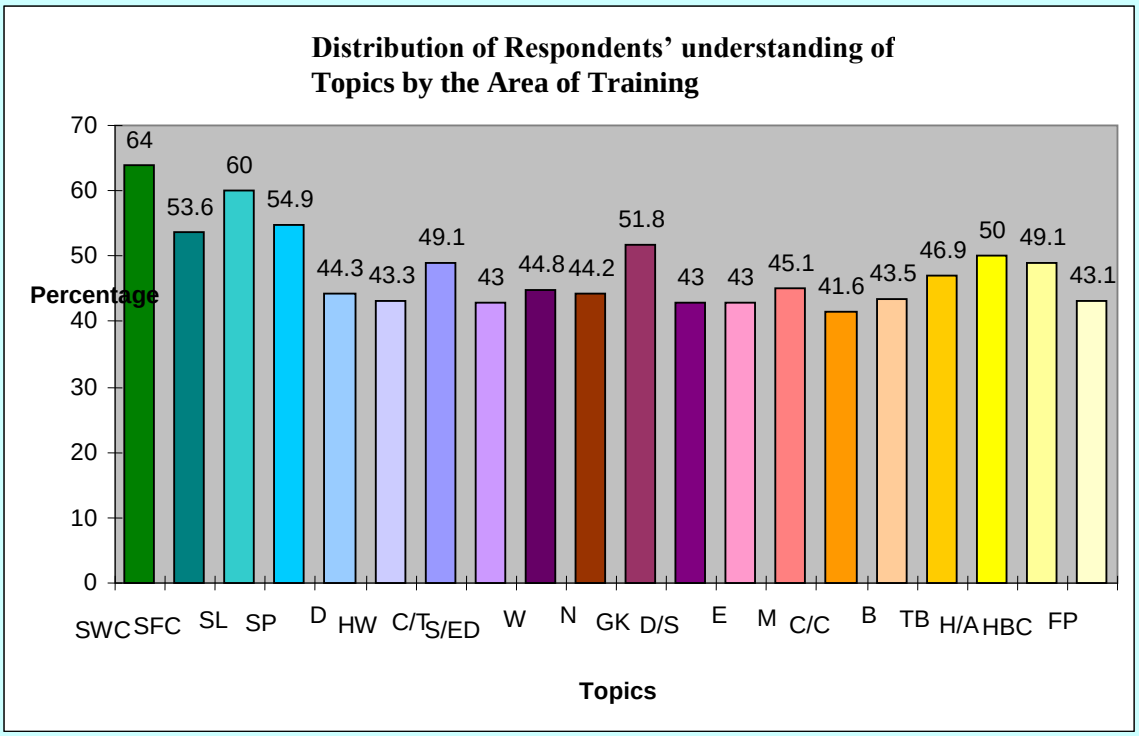
4.3 Level of Community Acceptance, Appropriateness and Sustainability of CHCs

A culture of health has been promoted in the camps. The HIDO health promoters have lived in the camps from the time the project implementation began therefore making them accessible where there is need for consultation. In the process the health promoters monitor and evaluate the impact of the project with the CHCs and Sanitation Committees.

The statistics showed that there is more knowledge, understanding and acceptance in some topics such as sanitation planning, safe food chain, sanitation ladder, hand washing, safe

water chain, safe food chain, good kitchen, worms and diarrhea than the others like family planning, HIV/AIDS, cholera and home care.

Chart 6: Respondents understanding of the health education topics



SFC	***Safe food chain***	***W***	***Worms***	***B***	***Bilharzia***
SL	***Sanitation Ladder***	***N***	***Nutrition***	***TB***	***Tuberculosis***
SP	***Sanitation Planning***	***GK***	***Good Kitchen***	***H/A***	***HIV/AIDS***
D	***Diarrhea***	***D/S***	***Drama & Songs***	***HBC***	***Home based care***
HW	***Hand washing***	***E***	***Environment***	***FP***	***Family Planning***
C/T	***Cholera***	***M***	***Malaria***	***C/C***	***Coughs & Colds***

The reasons why some of the topics were clear while the others were not and therefore would need more training are summarized below:

Reasons for Understanding Topics

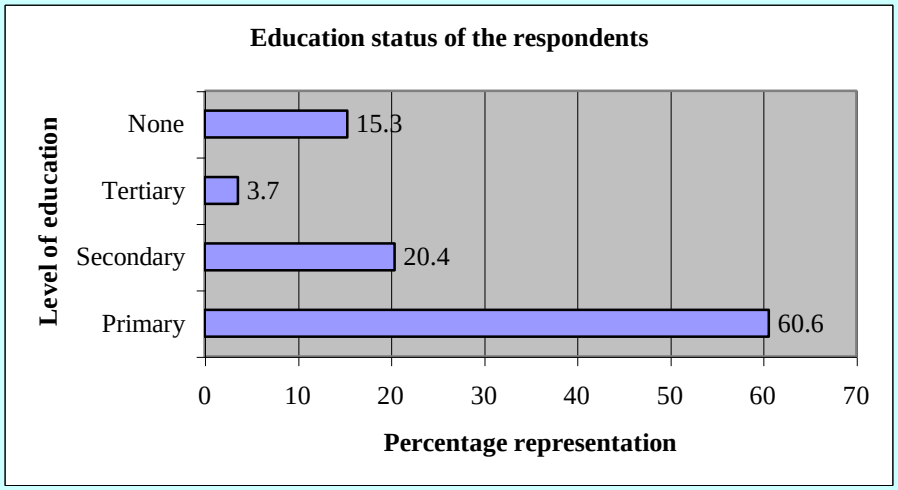
- ✧ The topics for discussion related well with the life story of the CHC members;
- ✧ The strategy was gender responsive in that both men and women were free to participate in all the twenty areas;
- ✧ The methodology used to deliver the training eased and enhanced understanding and practice of the recommendations.
- ✧ Experiences before CARE/HIDO intervention;
- ✧ There was new knowledge being imparted which knowledge was useful for the IDPs in relation to the conditions they are living in;
- ✧ The facilitators had the skills of dealing with the people and could even speak the Acoli;

Reasons for Partial Understanding of Topics

- ✧ The timeframe for the training was too short especially for topics like family planning, HIV/AIDS, TB and Home based care;
- ✧ Some people missed some of the sessions;

- ✧ Cultural barriers related to gender which could not allow men and women to discuss certain issues in a group affected their understanding;
- ✧ While the understanding was average, the practice has been very good. This can be attributed to the low education level of the CHC members. Below is a graph showing the level of education among the respondents.

Chart 7: Education status of Respondents



Over 60.6% stopped in primary over 20% went to secondary school and 15.3% never went to school.
CARE in future might consider linking up with organisations providing functional adult literacy or incorporate it in its programmes.

4.4 Sustainability

While the CHC strategy provides for phases 3 and 4 where sustainability issues are addressed, CARE has not been able to introduce this to the community given the time frame. However, the communities have considered the following options for sustainability of the project benefits:

- ✧ Sharing knowledge with those who did not have the opportunity to be part of a club;
- ✧ Practicing the recommended practices in their homes especially in the areas of hand washing, safe food chain, diarrhea, sanitation planning, sanitation ladder and safe water chain;
- ✧ Continuing with the meetings as CHCs to remind themselves of the training and recommended practices;
- ✧ Teaching their children so that as they grow, the knowledge and practices grow with them;
- ✧ Asking the camp leadership to take up the monitoring role;
- ✧ Being 'your brother's keeper' i.e. monitoring one another;
- ✧ The training materials should be provided to the CHC members so that they can continue with sensitizing others.
- ✧ The camp leaders, zonal or sanitation leaders joined the CHCs and these people offer a good foundation for sustainability since they are resident and knowledgeable about hygiene and sanitation.

4.5 Benefits of the Project

In as much as the project was an emergency project the IDPS appreciated its initiation and greatly thanked HIDO/CARE for the good work done. There may have been some challenges faced in the implementation of this project but overall there has been an immeasurable impact created in the camps. The benefits include the following:

- ✧ Traditionally men constructed latrine pits. But through the project women have learnt to take up this challenge;
- ✧ The new skills learnt have enabled the community to change behavior in health and sanitation practices. For example from open defecating, the community have embraced the importance of using covered pit latrines which are cleaned regularly;
- ✧ A culture of health has been promoted and by-laws set to keep improving the standards of sanitation and hygiene in the project camps.
- ✧ Some of the IDPs in both the control camps and project camps got slabs and nets. The slabs were given to a targetted number of people who had dug pit latrines while the nets were given to expectant mothers and those with children under five years in both control camps and project camps;
- ✧ IDPs have learnt to solve problems participatorily;
- ✧ The programme helped them to organise IDPs into groups by zones. The developed CHCs structures can be used for future development programmes;
- ✧ A common community of purpose has been built in the camps. In some of the camps people were living like strangers but the project helped them to come together, hence promoting unity and a social identity;
- ✧ Communication in areas other than health promotion has been eased with the weekly meetings;
- ✧ The IDPs have learnt to take health issues seriously;
- ✧ High levels of hygiene have been reached with mothers taking up the role of imparting the practices in their young children;
- ✧ Communicable diseases have reduced through good home hygiene

4.6 Assessment of HIDO Capacity

The communities have greatly accepted and widely embraced the CHC strategy, which is relevant and easy to understand and practice. The community appreciated the use of visual aid, drama, explanations, demonstrations and group discussions to deliver the training package. During the evaluation the CHCs were asked to rate the training in terms of content, methodology, relevance and M & E, which they did as follows:

Table 3: Assessment of training

Area of training	Very good	Good	Fair	Poor	V. Poor
1. Content	81.0	14.3	4.7		
2. Methodology					
Drama	37.8	31.1	20.0	6.7	4.4
Visual Aid	71.9	17.7	6.3	3.1	1.0
Explanations (Lectures/ Brainstorming)	25.8	16.1	19.4	15.1	23.7
Demonstrations	30.9	28.7	32.9	8.5	
Group discussions	27.7	25.1	22.3	14.9	
7. Relevance	64.2	20.8	5.7	7.5	1.9
8. Monitoring and follow up	10.5	19.3	68.4	1.8	
9. Health Promoters' ability to deliver training	72.5	21.6	5.9		

The CHCs ranked the content at 81%, which means it answered a real need in the community and was well understood. The methodology especially visual aid was ranked second best and community members were demanding to have the materials. The capacity of HIDO health promoters were ranked at 72.5% for very good and 64.2% for relevance of the training overall. The problematic area is monitoring and evaluation. The community members see HIDO health promoters and project management structures set by CARE as one of them. The community expects CARE and HIDO office to monitor what is going on but this was ranked only fairly done at 68.4%. *While security could have compromised monitoring CARE needs to make an effort to independently monitor and follow up the field activities.*

HIDO links with other organizations involved in health and sanitation promotion especially in the area of mobilization. Most of the members of the CHCs are from the sanitation committees set up by World Vision. This has helped to create a link between the CHCs and other strategies by other organizations. CARE CHC strategy builds on to what the foundation laid by other organizations.

A separate organisational assessment was done for HIDO and is attached in Appendix III (page 31). While HIDO identity is clearly defined with clear strategies to achieve them, the main concerns are in the areas of building Board capacity in governance, human resource management, the staff skills in policy development, financial management, planning monitoring and evaluation all need enhancement. *CARE may need to support HIDO further to strengthen the organisation.*

4.7 The main Constraints/Challenges of the CHC Strategy

- In the beginning some of the IDPs preferred going to the field to attending the CHCs meetings. This affected some sessions as time had to be spent waiting for the members to come together. This was sometimes discouraging to the health promoters;
- Some people have not changed from their poor sanitation practices as the statistics shows. The people have the information but the negative attitude and some cultural beliefs have affected the adoption rate;
- The criterion of giving out the slabs was not clear to the IDPs. It started as an incentive to those who had already dug latrine pits but later the slabs were given to others. Those who missed were disappointed since the criteria

were not clear. In the control camps some of the slabs were kept to be used after resettlement.

- ✧ CARE had trained IDPs in making slabs, provided the materials for making the slabs and bought some of the slabs from the IDPs. While this is a good initiative during emergency, it creates dependency and undermines the sustainability of the project.
- ✧ Some practices required financial input but with the life in the camp where communities hardly own any income generating projects, it has been hard. The main source of income is the local brew "*enguli"* but not so many people can do this business. Sometimes even a basic like soap is too expensive for one to buy it just for washing hands let alone bathing or laundry.
- ✧ While the project benefits can clearly be seen, the sustainability plan of an emergency project is not clearly in place yet.
- ✧ There was a generally lower response from men compared to the women. This made it difficult for some practice areas to be implemented since they required cooperation of both especially family planning and HIV/AIDS.

5.0 Recommendations and Conclusion

HIDO

- ✧ Needs to continue doing periodic monitoring and guidance to CHCs because HIDO staff are resident in the communities;
- ✧ Avail the CHCs with the training materials for future reference;
- ✧ Prepare the leadership of the CHCs to continue with stewardship of the health clubs and health promotion.

CARE

- ✧ Should either extend the project or change it into a program so that the last two phases of the CHC strategy can be fully implemented. Only then can the real impact of the CHC strategy be assessed;
- ✧ Need to do more monitoring when such programmes are implemented than it has been doing;
- ✧ Review some of the training materials to be gender sensitive;
- ✧ Should popularize the CHC strategy and share the findings with organizations involved in health promotion so that CHC strategy can be adopted by them;
- ✧ Link with other organizations involved with health promotion in the 15 targeted camps to ensure sustainability of the project benefits.

CHCs

- ✧ Should hold on to what they have learnt and strive to make it a part of their lives;
- ✧ Share the knowledge and skills learnt so that the community can share in the benefits of the project;
- ✧ Monitor one another and keep reminding themselves of the learning points of the training.

General Community Members

- ✧ Should be encouraged to cooperate and take interest in similar development programmes that come up;
- ✧ Should follow the by-laws set by their leaders to ensure effective sanitation and hygiene practice;
- ✧ Trained members should replicate knowledge to others;
- ✧ Need to help children grow up with the recommended practices.

Conclusion

The emergency programme for health promotion has had a tremendous impact on the health of the IDPs and has done them proud. It is the skills they never thought of getting. The CHC members have pledged to use the model to set their new homes when they return. CARE needs to expand this project and turn it into a developmental programme that can run for at least three years so that the gains within the six months will be strengthened for a lifetime.

The CHC strategy has proved its worth. Within the few months it has transformed the community and it needs to be replicated. It brings in ownership, which is vital for sustainability of the project benefits. If the recommendations are taken on board the health of the IDPs will surely improve for a longer time.

Glossary Terms

Communal eating	Food serving method in which members of the household are served and eat from the same dish/utensil
Communal hand washing	Washing hands in the same container
Drying rack	A raised flat surfaced structure on which dishes can be put to dry
Individual plate	Recommended food serving method in which an individual eats food on his or her own plate
Lorena stove	Stove which uses fire wood/charcoal (see picture on page 20)
Poly sanplats	Plastic slabs used in a pit latrine. It is easier to clean than a concrete slab
Pour method	Recommended method of washing hands with water being poured into ones hands
Tippy tap	Foot operated tap for hand washing. This is done to avoid hand contact with the tap and passing of germs to other people

APPENDIX I: LIST OF CAMPS VISITED

CAMP NAME	Control/CARE Camp	County
AWOO	Control	Omoro
ALOKOLUM	Control	Omoro
BOBI	CARE Camp	Omoro
KEYO	CARE Camp	Kilak
TETUGO	CARE Camp	Omoro
COOPE	CARE Camp	Aswa
KORO ABILI	CARE Camp	Omoro
LACOR	CARE Camp	Kilak

APPENDIX II LIST OF ORGANISATIONS CONSULTED

Name	Officer	Organisation
1.Janet Adonga	Coordinator	AMREF
2. Matthew Uyugi	Manager, Development Programmes	CARITAS
3. James Apire	Project Officer	COME
4. Boniface L.Opwonya	District Health Inspector	MOH
5. William Oloya	Project Manager-WATSAN	CARE
6. Joyce Atim Pawaki	Training Officer	CARE
7. Philip Okot	Programme Coordinator	HIDO
8. Kinyera R. Okello	Field staff, Coope	HIDO
9. Victor Kwame	Field staff, Ongako	HIDO
10. Jimmy O. Lukone	Field Officer, Awer	HIDO
11. Richard Nyeko	Field staff, Keyo	HIDO
12. Juliet o. Akot	Field staff, Koro Abili	HIDO
13. Andrew J. Timson	Head of Gulu sub office	UNOCHA
14. Dr. Nyeko	In charge - WATSAN	UNICEF

APPENDIX III HIDO ORGANISATIONAL ASSESSMENT