Consultant Report 3
Monitoring and Evaluation of Hygiene Promotion
CARE Water and Sanitation Programme
GULU. Uganda

Health Promotion Consultant
Africa AHEAD

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Executive Summary

The training workshop for Health Promotion through Community Health Clubs was conducted by the consultant in November 2004 and 36 staff from HIDO, COME, CARE and Ministry of Health were trained. All activities and a time frame were identified as well as roles and responsibilities for each of the stake holders of the programme (See 2nd Consultants Report). The HIDO trainers were issued with training material and their stations identified at different IDP Camps were they were to take up permanent residence. This was delayed until the Contract Agreement between HIDO and CARE was signed. Radio announcements were made at the end of December and sensitisation of the camp leadership commenced in each camp. Mobilisation of the community was conducted using a drama group performing health plays to draw crowds, and this was successful in promoting registration of members into the health clubs. Most field staff took up their positions in the IDP camps in the last week of January. As such the health promotion sessions have only been going for two weeks. However prior to this a base line survey was conducted with 1,940 respondents and the report presented by HIDO in January. This indicated an extremely low standard of hygiene in the IDP Camps with only 3% using the 2 cup method for taking drinking water, 4% with even a basin of water for hand-washing, 6% with mosquito nets, of all those with traditional pit latrines only 4% had a cement sanplat, only 19% were clean.

HIDO has just presented the first report of activities and this indicates that by the end of January 5,792 members had been enrolled with 115 clubs established. Two weeks later the numbers have risen dramatically, as each trainer has conducted between 1 and 3 sessions. In addition latrine digging and construction of pot racks is evident in all camps visited and there are indications that the method of using Community Health Clubs has been very well received by the IDPs. We are still in the process of collecting the latest reports but already from only 19 out of 25 trainers there are 12,521 members in 115 clubs, and when the outstanding reports are counted it is to be expected that health club members will exceed 15,000, which is **already over the target** for the number of IDPs to be reached **within the first month of the project**. If each member has a family of 10, this means that 120,000 people will benefit **directly** from improved hygiene. The a large proportion of households in 15 IDP camps of 38,804 (estimated 232,824 people) may benefit indirectly from an improved environment, and diffusion of ideas from the dramas and health sessions that are being held.

As regards sanitation the figures are looking optimistic. Project Development Committees in the 25 camps estimate that 7,001 latrines have been constructed in the past few months, however this has not been verified as yet by the consultant. Training and the setting up of casting yards in 16 camps with 33 CBOs have enabled 6,037 sanplats to be produced in the past three months, of which 902 have been purchased and distributed to the IDPs. 2,500 sanplats were brought from World Vision in mid 2004 and distributed. In addition 600 poly sanplats have recently been distributed as rewards for the first 100 in each camp to dig pit latrines. The construction of pot racks and hand washing facilities (Tippy taps) will come on-stream soon, as the health club members are proving very receptive to innovations suggested in the health sessions. 12,000 membership cards have been printed and are in the process of being distributed.

However these activities have all commenced within two months of the official end of project, which was due to be completed in March 2005. The AHEAD methodology[1] requires a minimum of 6 months implementation for a thorough programme of health and hygiene promotion. If the project can be extended until the end of July this will be assured, and all targets will be reached and probably exceeded. In addition it should be taken into account that this is a ground breaking methodology which is being introduced into Uganda, and into IDP camps worldwide for the first time. As such it is being carefully watched by Ministry of Health and other development Agencies as a model that can be taken to scale if successful. A post intervention survey needs to be undertaken to measure the behaviour change that is taking place so as to point a way for a new approach to health promotion in emergency contexts.

[1] For a fuller background to the AHEAD approach and publications please look at www.africaahead.com

Summary of Recommendations:

Recommendation 1:
In order to complete the remaining 19 health sessions in each camp the programme should be extended at least until the end of July.

Recommendation 2:
Dogang has recommended the following which is recorded here for evaluation purposes:

- New 9sanplat) moulds should be provided and painted with burnt oil to prevent warping
- Good quality sand should be provided as poor sand affects the strength of the sanplat
- Old stocks of cement that has set should not be used
- Care should be taken for proper curing of sanplats
- Stone aggregates should be smaller as larger stones reduce strength

Recommendation 3:
To stream line the system and save unnecessary cost, the monitoring and quality control of the sanplat production should be moved from Dogang to HIDO trainers who are based in the IDP camps and are best placed to monitor sanplat production on a daily basis.

Recommendation 4:
One or two producers should be identified in each health club who can made covers in recycled wood or solid tree trunks that can be sold at very little cost directly to health club members with the cement sanplats. They should make the covers in advance and give them to the CBOs who make the sanplats so that they can be used for a mould for the squat hole so that they fit exactly.

Recommendation 5:
The balance of the poly sanplats should be ordered as soon as possible to prevent delays by the manufacturer. They should be given to the first 100 in each camp who finish their pits first. This will account for 1,500 polysanplats.

Recommendation 6:
The balance of 1,500 should be used in the new camps of Opik and Jengari where there are no other technologies, and as they are ready made this will speed up the construction of hygienic latrines, with no need to set up casting yards.

Recommendation 7:
ITNs should **not** be packaged with poly sanplat as a one-off incentive. Instead only the poly sanplat should be the reward for digging the pit. If the poly sanplat is installed and the latrine completed the ITN should be given at this stage, thus maximising the effect of the incentives.

Recommendation 8:
To prevent misunderstanding between different aspects of this programme, there needs to be more co-ordination between Field Co-ordinator and Trainer Officer. This should to ensure more equitable distribution in IDP camps where nets are requested by HIDO/CHCs rather than ad hoc distribution from CARE.

Recommendation 9:
The records of those who have dug pits should be kept by the Secretary of the Health Club and verified by the Sanitation Committee and the HIDO Trainer. This list should then be passed to CARE training officer, who passes it to the Field Co-ordinator to verify and requisition the required number of sanplats and ITNs. When distribution takes place in the IDP camp this should be signed off by the chairperson of the CHC as well as the sanitation committee Secretary. This will ensure accountability and transparency.

Recommendation 10:
By the end of February the Malaria topic should have been covered in the health sessions and people should be more aware of the value of ITNs. To ensure more linkage between VISO and HIDO, the VISO staff should be requested to join the HIDO trainers when the Malaria topic is being done in each camp, and distribution of nets should then follow.

Recommendation 11:
It should be the responsibility of the CHC committee to make regular checks on the households who receive ITNs to ensure that they are being used primarily for children, and that they have not been sold. Those who have sold nets should be fined, and this money put into an account for the CHC to be used for communal purposes such a borehole repair.

Recommendation 12:
The design of the spiral entrance (for latrines) should be abandoned (as IDPs want to lock their latrines to prevent vandalism)

Recommendation 13:
CHC members should be encouraged to improvise and find their own jerry cans to make the Tippy Tap to encourage self reliance and sustainability.

Recommendation 14:
HIDO Staff should be remunerated 100% for their accommodation in the camp. In addition, a standard design should be approved by CARE for field staff, which should include an iron roof sheeting and secure doors for any HIDO staff.

Recommendation 15:
Trainers should be remunerated in full for their bus fares depending on their distance rather than a standard travel allowance for all. Bicycles should be provided if necessary. In the next phase of funding, each trainer should be provided with a motor bike.

Recommendation 16:
More responsibility should be given to HIDO staff for requisition and material costs should be included in their budget. Requests for material should originate in the Community Health Clubs, through the committee, be verified by the Sanitation Committee and PMC, and then passed to HIDO, who should contact the Training Officer who together with the Field Coordinator should process the request.

Recommendation 17:
CARE should place an order for the full amount needed well in advance to allow the manufacturer to plan and scale up manufacture.

Recommendation18:
A system (of monthly monitoring) has been suggested by the consultant, and the forms (See Annex 1,2,3, 4 & 5) to be included in the monthly report should consist of:

- Trainers Monitoring Forms (summarised)
- List of CHC membership,
- Ranking of Trainers in terms of number of members, clubs, sessions;
- Distribution of poly sanplats, ITNs and any other incentives;
- Production and distribution of cement sanplats.

Recommendation 19:
A monthly meeting should be held by the HIDO Director at HIDO HQ, attended by all field staff, and CARE Programme Manager , the Field Coordinator and Training Officer, and a monthly report compiled and submitted to CARE by the 15th of the next month.

Recommendation 20:
A motor bike should be hired for the Director to ensure than he has adequate mobility to move to each camp to monitor field staff.

Recommendation 21:
HIDO Director should do monthly spot checks at each Camp to verify Trainers Monitoring Form as against the membership cards.

Recommendation 21:
The Project Manager of CARE should produce a monthly report detailing outputs from all partners.

Recommendation 22:
Copies of monthly reports and systematic files should be kept by all partners and CARE, to be available for final evaluation.

Recommendation 23:
HIDO Trainers should become responsible for all distribution of incentives such as ITNs, and poly sanplats, as well as monitoring of production of cement sanplats and quality control.

Recommendation 24:
VISO is used as mobilisation and sensitisation team for communities in new IDP Camps where the programme is due spread, so that HIDO trainers can move quickly to other communities and start health sessions without the delay of one month formation of CHCs. In order to train for this VISO should be posted alongside HIDO trainers to learn, on the job, how Community Health Clubs work. They can assist HIDO with ITN distribution and follow up on the usage of nets.

Recommendation 25:
VISO should undergo the same TOT training as HIDO Staff in PHAST and AHEAD approach.

Recommendation 26:
All PMC members (as well as Sanitation Committee and Water Committee members) be required to attend all Health Club sessions and gain a certificate of full attendance to ensure they are as well trained as community members. Any PMC member who does not gain a certificate should resign.

Recommendation 27:
HIDO should be provided with at least one desk top computer and printer for their Gulu HQ to enable records and surveys to be done to a minimum standard required by donors. A statistical computer package (preferably SPSS) should be installed and used for all data so that analysis of this groundbreaking programme can be kept on a regular basis. Two HIDO staff and one CARE staff should be trained in SPSS Data input and analysis at a basic level.

Recommendation 28:
A project proposal seeking support for some of the follow on components should be drawn up within the next few months to ensure continuity of involvement of the community and to help sustain the club until it is fully institutionalised in the daily running of each IDP Camp

Recommendation 29:
If there is no intention of continuing this programme beyond July 2005, there should be a careful exit strategy developed, possibly involving passing on the health clubs to other Agencies to ensure that this well formed community is not abandoned prematurely.

Recommendation 30:
The outcomes from this programme should be carefully documented comparing the base line and post intervention survey and the findings presented internationally, so that this approach becomes replicated in other parts of Uganda and in other CARE programmes in Africa.

Background

This report should be read in Conjunction with the 1st consultants report of October 2004, which was an Assessment of the programme to date, the 2nd Report which records the training of trainers and the training material produced for this programme in November 2004. The 2nd report details activities in Gulu Water and Sanitation Programme since the Training took place from November 2004 to February 2005. Accordingly the progress will be assessed against the activities that were planned in the Workshop facilitated by the consultant in November 2004 in which the trainers from the implementing NGO, as well as CARE staff were trained in the PHAST methodology and the AHEAD approach using community health clubs for hygiene promotion.

In accordance with the ToR for the consultant the following outstanding issues will be assessed:

1. Progress of Activities
2. Effectiveness of project team (CARE, HIDO and COME, Dogang, VISO)
3. Assessment of training of sanitation and water source committees
4. Capacity of Project Management Committees in monitoring and accountability
5. Monitoring and evaluation system
6. Success of Community Health Club strategy
7. Constraints and Lessons Learnt
8. Future opportunities
9. Sustainability and replicability

1. PROGRESS OF ACTIVITIES

According to the recommendations that were adopted from the Consultants report at a meeting by all CARE programme Staff on 16th November, the following activities have been achieved:

1.1. Immediate replacement of manager for Watsan project

Prior to my involvement in the programme in October 2004, there had been a gap of some months without a Manager for the programme and this was impacting on the programme as the Field Coordinator and Training Officer were over stretched, and this had been a major concern to the consultant as activities needed to be streamlined.

Action: William Oloya, a member of CARE permanent staff from another project in Gulu, was appointed as Project Manager and has been in position from 5th Jan, and this has been a great boost to the programme.

1.2. Establishment of 120 Community Health Clubs (120,000 members) in each zone in 16 camps to provide reliable implementing groups for latrine construction.

Action: 25 trainers from HIDO took up their posts in the IDP camps as from 5th Jan, and started to mobilise to form Community Health Clubs. They have been highly effective in their efforts and within 3 weeks by the end of January it was estimated that 5,792 members had signed up. By the time of this report 10th February, trainers reported that mobilisation was exceeding expectations, with all trainers having achieved their target of 5 clubs each, and most clubs had over the target of 100 members per club. The table below lists the current membership:

Table 1. Community Health Club Members

Ranking 12.2.05	IDP Camp	Trainer	# CHCs	# members	# sessions
1	Paicho	Jackson Odimba	10	1,207	11
2	Ongako	Victor Kwame	5	900	10
3	Keyo	Richard Nyeko	5	865	15
4	Palenga	Cathy Laker	10	820	15
5	Lalogi	Bernard Odong	5	784	5
6	Lapainat	Justine Onek	5	700	10
7	Opit	Geoffrey Oyat	4	684	5
8	Lacor	Agnes Akello	5	682	8

9	Coo-pe	Benjamin Ocora	5	675	5
10	Awer	Jimmy Okello	4	670	5
11	Coo-pe	Richard Okello	5	617	5
12	Opit	Grace Ayamo	6	588	6
13	Opit	Faith Alinga	5	374+	6
14	Teyapadola	John Okeny	5	557	5
15	Ongako	Jennifer Amony	5	500+	5
16	Bobi	Doreen Abalo	5	499	5
17	Abili	Juliet Akot	5	498	7
18	Pagat	Geoffrey Okello	5	471	8
19	Palenga	Lucy Kipwola	10	430+	15
		TOTAL	**115**	**12,521**	**151**

1.3. Construction of 100 latrines within each health club in new camps (total 10,000) in the next five months with inter-club competitions as performance incentive.

Action: Sanitation has been the first topic undertaken by trainers at their first meeting and this has stimulated a high demand for sanitation. HIDO trainers report that latrine construction has started in all camps. I visited three camps and can confirm that in Lacor and Abili, where sanplats have been delivered, latrines are popping up like mushrooms and the level of response is impressive. The incentive has been effective. The first 100 members in each camp to dig their latrines were given a prize of a poly sanplat as well as a mosquito net. Sanplats and mosquito nets have been distributed to five IDP Camps and the rest will be receiving them shortly.

1.4. 20 health promotion sessions within 120 health clubs for the next five months reaching 12,000 members with 120,000 beneficiaries of improved hygiene.

Action: All the 25 trainers reported that they have conducted between 1 and 5 health sessions to date, and most chose either the topic of sanitation or water chain. As this is the first month of real implementation this is on target, and the 20 sessions will be completed within the next 4 months at this rate. The programme which is currently due to end in March which does not enable the full health promotion to take place. To cut this short would be a waste of all resources invested to-date and would disappoint the community who are very enthusiastic about this programme. It would also jeopardise CARE credibility with the community for future programmes..

Recommendation 1:
In order to complete the remaining 19 health sessions in each camp the programme should be extended at least until the end of July.

1.5. Production of cement sanplat in 22 old camps to make use of CBOs who have already been trained and provide them with an income.

Action: COME had completed the training of 30 people in each of the 6 camps (for cement sanplat production by December 2004. Since then eight new casting yards have been constructed and sanplats have been made in all. (See Annex 2.)

Although the teams are able to produce 10-20 per day, this depends on regular supply of material which has been a constraint in some areas. Dogang General Enterprises, were hired specifically to ascertain the quality of slabs produced by 32 CBOs in 16 camps to ensure that CARE does not purchase inferior quality. Their findings indicate that there were various problems in the casting of sanplats, ranging from a poor ratio of cement in the mix and poor quality of sand delivered, to moulds which had warped and needed replacing. Only one casting yard (Lalogi) was actually producing when the spot check took place, and others were held up due to lack of materials. In total there were 902 sanplats brought and a total of 9,020 ,000/- was paid out to the CBOs at the rate of 10,000/- per sanplat in Jan/February 2005. This amount is meant to be reinvested in materials necessary for the 2nd phase of sanplat production which is due to start in February. Only Bobi and Abili have moved to the self-reliance stage where they sauce their own material. Bobi was found to be

stretching one cement bag to make nine sanplats instead of the recommended six. However this was picked up by Dogang and corrected, so emphasizing the need for constant quality control.

Recommendation 2:
Dogang has recommended the following which I record for evaluation purposes:

- New moulds should be provided and painted with burnt oil to prevent warping
- Good quality sand should be provided as poor sand affects the strength of the slab
- Old stocks of cement that has set should not be used
- Care should be taken for proper curing of slabs
- Stone aggregates should be smaller as larger stones reduce strength

Recommendation 3:
To stream line the system and save unnecessary cost, the monitoring and quality control of the sanplat production should be moved from Dogang to HIDO trainers who are based in the IDP camps and are best placed to monitor sanplat production on a daily basis. They can also trouble shoot and assist in the smooth running of the production to ensure sanplats are being made continuously. They can alert CARE if there are shortage of materials and ensure that the quality is up to standard. They are qualified to supervise this activity having been training as clinicians or Health Assistants to know about this process. They should also be remunerated for this supervision over and above the health club sessions that they take. This will be more cost effective as Dogang will no longer be involved. It will also streamline the production and integrate it more with the health clubs.

Analysis of Cost Effectiveness
The investment in this activity has been substantial with over 38 million shillings being needed to set up the process, and it is hoped that the enterprise proves successful as an income generating activity. In total the project has a target of 12,000 sanplats tobe produced. If 10,000 of these sanplats are produced in the casting yards and brought for 100,000,000 million Uganda shillings, the true cost of each sanplat including 38,373,000/- start-up costs will be 13,837/-. As one thousand sanplats have been produced already the balance of 9,000 will entail each casting yard producing 562 sanplats in the next four months.. They should therefore work to a target of at least 150 cement slabs per month. This should be easily achieved given that they can produce 20 slabs a day if materials are in place.

Cost of sanplats	**Inputs**	**Purchased**
Training Workshops	12,811,000	
Building Materials	21,418,000	
Casting yards	3,744,000	
Quality Control	400,000	
Sub Total	**38,373,000**	
Purchased 902 sanplats	9,020,000	9,020,000
Total	**47,393,000**	**9,020,000**

1.6. Covering existing latrines with either locally-made well-fitting (foot operated) wooden covers for cement sanplats to prevent hand-to-hand contamination from touching handles.

Action: COME has produced prototypes of a wooden foot cover and has trained CBOs to make them but as yet this not been scaled up into production. At the moment the cement sanplats are given out without a cover which is a health risk that has not been addressed as yet.

Recommendation 4: One or two producers should be identified in each health club who can made covers in recycled wood or solid tree trunks that can be sold at very little cost directly to health club members with the cement sanplats. They should make the covers in advance and give them to the CBOs who make the sanplats so that they can be used for a mould for the squat hole so that they fit exactly.

1.7. Introduction of hygienic polyfibre sanplats with well-fitting (foot operated) covers for *existing* latrines in 38 camps to prevent diarrhoea and control fly breeding sites.

Action: 600 poly sanplats were purchased and distributed to 5 IDP Camps (Ongako, Abili, Lacor, Jengari, Opit). (See Annex 3) Those who did not get poly sanplats will be given the cement sanplats which have been purchased. Two demonstration sites have been constructed at Koro and Abili, and each camp has made a demonstration model to provide the community with a visible example. The new poly sanplat design has been well received by the community who also accept the new idea of used a foot to remove cover. The plastic material used ensures a higher level of cleanability and consequently it achieves the target of improving levels of hygiene particularly as the well fitting cover ensures that there is limited fly breeding and consequent faecal oral contamination. However the superior quality and durability comes at a price and the sanplat is twice the price of the cement sanplat at (US$14.28). Whilst it is ideal for an emergency response as it can be rapidly installed without training of local producers and procurement of materials, it does not contribute to the local economy. As such it is ideal for incentives but sustainable beyond the life of the project.

Recommendation 5:
The balance of the poly sanplats should be ordered as soon as possible to prevent delays by the manufacturer. They should be given to the first 100 in each camp who finish their pits first. This will account for 1,500 polysanplats.

Recommendation 6:
The balance of 1,500 should be used in the new camps of Opik and Jengari where there are no other technologies, and as they are ready made this will speed up the construction of hygienic latrines, with no need to set up casting yards.

1.8. Distribution of ITNs as an added incentive for pit latrine construction.

Action:
The incentive strategy agreed at the workshop with HIDO Staff was that the *first* 100 IDPs to dig their latrine pits in each camp would receive a poly sanplat. However this handout was later coupled with a mosquito net as an added incentive, and 5,000 ITNs were provided to the community through the health clubs, over and above the distribution of 11,800 to pregnant mothers and mothers with under 5's to the community at large. Although this was a generous thought it has in fact created equity problems, as well as misuse and lack of use of mosquito nets, as it was not coupled with adequate sensitisation. HIDO trainers in the field were put under pressure as there were not enough mosquito nets and in some camps the trainers was intimidated by members who did not receive an ITN with a sanplat.

The NGO VISO has been engaged in the distribution of ITNs, but they have neither been trained or informed of the Community Health Clubs, nor have interacted with HIDO Staff in the field. This is an unfortunate oversight as it has undermined the strategy which it is strength of the programme: that all the community are encouraged to join CHCs and only receive incentives as a result of participating in hygiene sessions. By providing handouts external to the health clubs and without the involvement of HIDO Trainers, the health promotion is being eroded, and the two aspects of the project (health promotion and reduction of Malaria) are out of sink. This indicates the CARE staff have not fully understood the AHEAD approach and may need more training in the basic concepts.

Recommendation 7:
ITNs should **not** be packaged with polyslabs as a one-off incentive. Instead only the polyslab should be the reward for digging the pit. If the polyslab is installed and the latrine completed the ITN should be given at this stage, thus maximising the effect of the incentives.

Recommendation 8:
To prevent misunderstanding between different aspects of this programme, there needs to be more co-ordination between Field Co-ordinator and Trainer Officer. This should to ensure more equitable distribution in IDP camps where nets are requested by HIDO/CHCs rather than ad hoc distribution from CARE.

Recommendation 9:
The records of those who have dug pits should be kept by the Secretary of the Health Club and verified by the Sanitation Committee and the HIDO Trainer. This list should then be passed to CARE training officer, who passes it to the Field Co-ordinator to verify and requisition the required number of sanplats and ITNs. When distribution takes place in the IDP camp this should be signed off by the chairperson of the CHC as well as the sanitation committee Secretary. This will ensure accountability and transparency.

Recommendation 10:
By the end of February the Malaria topic should have been covered in the health sessions and people should be more aware of the value of ITNs. To ensure more linkage between VISO and HIDO, the VISO staff should be requested to join the HIDO trainers when the Malaria topic is being done in each camp, and distribution of nets should then follow.

Recommendation 11:
It should be the responsibility of the CHC committee to make regular checks on the households who receive ITNs to ensure that they are being used primarily for children, and that they have not been sold. Those who have sold nets should be fined, and this money put into an account for the CHC to be used for communal purposes such a borehole repair.

1.9. Introduction of spiral entrances for new latrines to prevent hand-to-hand contamination from touching doors where community agree.

Action: There has been no uptake of the spiral design for latrines as it takes too much space. The camps are extremely congested with huts squeezed side by side, and latrines are terraced in lines to save space. Materials for doors are improvised out of recycled jerry cans and flattened oil tins. (See photo below). The spiral design is not appropriate as the doors need to be locked to prevent vandalism. Each latrine is owned by one or two households and as such SPHERE standards of less than 20 per latrine are being met.

Recommendation 12:
The design of the spiral entrance should be abandoned.

1.10. Promotion of Tippy Taps for handwashing with soap, potracks, rubbish pits, covered water and 2 cup system.

Action: COME has trained Sanplat CBOs on making Tippy Tap, and plastic jerry cans will be supplied to enable members to construct Tippy Taps as it appears even the cost of 2,000/- is prohibitive. However there were no tippy taps in evidence in the camps visited, although it is expected that the community will address this shortly.

Recommendation 13:
CHC members should be encouraged to improvise and find their own jerry cans to make the Tippy Tap to encourage self reliance and sustainability.

2. Assessment of CARE project team: support to Partners

CARE has been working with the following partners:

HIDO:	To provide health promotion in 15 IDP Camps
COME:	To train 33 CBOS in 6 camps in sanplat production
Dogang:	To monitor and provide quality control of sanplat production
VISO:	To distribute ITNs in all camps and relocate IDPs to 2 camps

2.1. HIDO (Health Integrated Development Organisation)

As the HIDO trainers have only been at their posting in the IDP camps since the beginning of February there are still a lot of issues to iron out, and this report should be seen in the light of trouble shooting to fine tune the process rather than as direct criticism. At a meeting with the Director of HIDO and 15 trainers, feedback from the field indicates there are still many challenges. The trainers were asked to fill in an evaluation form to provide the consultant with concrete information as well as qualitative responses to assess how their first 3 months in the programme has been going. (Annex.4) The responses for the assessment of their level of job satisfaction indicates that although they enjoy working with the community and the strategy of using community health clubs has been a great success with rapid uptake, the trainers are not being adequately remunerated for their minimal costs of living in the IDP camps, and this accounts for some lack of job satisfaction.

2.1.1. Accommodation:

Small issues can become an irritation in an isolated posting. The trainers have been asked to live in the camps, just like other IDP's and have rented rooms, or had traditional mud huts with thatch roofs built for their accommodation. Many indicate that they are afraid of living under thatch as their roof maybe burnt if any jealousies arise. They also have to store material (ITNs) and this is an added security risk as their can become a target of attack. They are not adequately remunerated for this modest lifestyle: for example although to rent a simple hut in the camp costs is only 10,000/- per month (US$7.50), the project only contributes 3,000/- for living expenses and this is apparently because the initial budget was pared to provide the bare minimum. This is a false economy as the amount is negligible in terms of overall costs, but the effect on field staff moral is considerable. There is no reason why they should subsidize the programme from their own meagre income, particularly in a hardship posting.

Recommendation 14:

HIDO Staff should be remunerated 100% for their accommodation in the camp. In addition, a standard design should be approved by CARE for field staff, which should include an iron roof and secure doors for any HIDO staff.

2.2.2. Travel:

Travel expenses are another issue. A standard amount is provided to each member regardless of distance from Gulu and therefore the trainers in the furthest and most dangerous camps are penalised. Again it seems that HIDO has not enough in the budget to cover these expenses. Trainers use public transport or walk. This is not cost effective and is a security risk. They should be able to exit the camps if there is insecurity without relying on public transport. In addition they would be able to cover more ground if they could use a motor bike to travel around the camp, and run CHCs in more than one camp.

Recommendation 15:

Trainers should be remunerated in full for their bus fares depending on their distance rather than a standard travel allowance for all. Bicycles should be provided if necessary. In the next phase of funding, each trainer should be provided with a motor bike.

2.2.3. Requisition and Distribution

CARE has retained control of all requisition and this has entailed distribution of poly sanplats, building material for the production of cement sanplats, ITNs, and membership cards, all of which are sourced and paid for directly by CARE. The lack of material costs within the HIDO budget of course reduces the overall percentage that HIDO can charge for administrative costs, which were also reduced from 15% to 10%. The control of material distribution also places HIDO in an invidious position with the community if there are delays or insufficient incentives/materials delivered, as the community can become actively hostile and blame HIDO for this lack of support.

Recommendation 16:

More responsibility should be given to HIDO staff for requisition and material costs should be included in their budget. Requests for material should originate in the Community Health Clubs, through the committee, be verified by the Sanitation Committee and PMC, and then passed to HIDO, who should contact the Training Officer who together with the Field Coordinator should process the request.

Recommendation 17:
CARE should place an order for the full amount needed well in advance to allow the manufacturer to plan and scale up manufacture. However this was not done initially because the poly sanplats were a new technology and there was a need to ascertain whether they would be acceptable for the community. Now that it has been established that there is a high if not infinite demand, CARE should not delay in ordering the full amount, especially in view of the fact that the programme is due to end in March, unless a no cost extension can be agreed.

2.2.4. Monitoring

A good report was produced by HIDO for January and this was informative and clear. However the Director has no transport and consequently little direct monitoring has taken place. Initially in the project proposal from HIDO, there was a request at the very least, to supply a motorbike to the Director who should be visiting the trainers to ensure their programme is running smoothly and conduct spot checks to verify outputs, but this was denied. In the next few months more exact monitoring is required and a number of forms need to be completed monthly.

Recommendation18:
A system has been suggested by the consultant, and the forms (See Annex 1,2,3, 4 & 5) to be included in the monthly report include:

- Trainers Monitoring Forms (summarised)
- List of CHC membership,
- Ranking of Trainers in terms of number of members, clubs, sessions;
- Distribution of poly sanplats, ITNs and any other incentives;
- Production and distribution of cement sanplats.

Recommendation 19:
A monthly meeting should be held by the Director at HIDO HQ, attended by all field staff, and Programme Manager , the Field Coordinator and Training Officer, and a monthly report compiled and submitted to CARE by the 15th of the next month.

Recommendation 20:
A motor bike should be hired for the Direction to ensure than he has adequate mobility to move to each camp to monitor field staff.

Recommendation 21:
HIDO Director should do spot checks at each Camp to verify Trainers Monitoring Form as against the membership cards

Recommendation 21:
The Project Manager of CARE should produce a monthly report detailing outputs from all partners.

Recommendation 22:
Copies of monthly reports and systematic files should be kept by all partners and CARE, to be available for final evaluation.

2.2. COME, Dogang and VISO:

The consultant requested to meet the Director of **COME** but he was unavailable and the pressure of the impending visit of the Donor made this meeting difficult to arrange within the 4 days of field time remaining. The Director and Assistant Director of **VISO** were interviewed and it seems that they

have a role to play in the programme but this has not been adequately dovetailed into the role that HIDO plays. Their Contract and Terms of Reference have not yet been signed, although they have already undertaken considerble distribution of ITNs and are responsible for distribution of bamboos for roofing in the new camps of Jengari and Opik.

A lot more thought needs to be done by CARE to analyse the cost-effectiveness of **multiple** partners. VISO, like HIDO is a new group, comprising of 14 newly qualified young men and women but of less useful background than HIDO whose 25 trainers are all Clinicians or Health Assistants. In VISO there is only one Health Assistant, whilst there are four teachers and a development worker. The remaining nine have diplomas in business administration which is not highly appropriate for this type of programme. However like HIDO they are young and energetic and need employment. Whilst it is commendable of CARE to build capacity within the community, this should not be at the expense of the targets of the programme which are to increase water, sanitation, health promotion and decrease malaria.

Dogang is a commercial company of engineers and technicians and can be useful in many fields related to water and sanitation. However Health Assistants and clinicians are also trained in basis technologies such as building latrines, sanplat production and water point rehabilitation. There was clearly a need for quality control of sanplat production before HIDO trainers were installed in IDP camps but now that they are on site it is to be expected that this becomes their task. Similarly the distribution of ITNs would be more efficiently handled by HIDO rather than VISO. COME has been useful in starting up new sanplat production centres but this is now underway and their continued involvement may be an extravagance that can be avoided.

Recommendation 23:
HIDO Trainers become responsible for all distribution of incentives such as ITNs, and sanplats, as well as monitoring of production of sanplats and quality control.

Recommendation 24:
VISO is used as mobilisation and sensitisation team for communities in new IDP Camps where the programme is due spread, so that HIDO trainers can move to other communities and start health sessions without the delay of one month formation of CHCs. In order to train for this they are posted alongside HIDO trainers to learn on the job how Community Health Clubs work. They can assist HIDO with ITN distribution and follow up on the usage of nets.

2. Assessment of Training of Sanitation and Water Source Committees

Training of trainers workshop was done in 2 days and covered all standard content needed for sanitation committees and water point committees. However no reference was made to the Community Health Club strategy and how this fits in with sanitation and water committees, or the Project management committees. There are two strategies that have not been integrated as per discussions in the November TOT workshop done by the consultant. See Annex 6. Organisation of IDP Camps. There was also no attempt to use the PHAST tolls developed for use in the field. Thus the VISO staff are unaware of these tools and will not introduce them to the sanitation committees. This is a serious oversight. It means that those leaders in the camp will know less than the health club members, and this will undermine their understanding and effectiveness.

Recommendation 25:
VISO should undergo the same TOT training as HIDO Staff in PHAST and AHEAD approach. Failing that they should be posted along side HIDO staff to learn on the job.

3. Assess the capacity of Project Management Committees in monitoring and accountability

This has not been done due to shortage of allotted time in the Consultancy. However given that VISO have been inadequately trained and know nothing of the CHC approach or

PHAST Training Tools, it is expected that the PMC who they are supposed to train will also be somewhat in the dark.

Recommendation 26:
All PMC members be required to attend all Health club sessions and gain a certificate of full attendance to ensure they are as well trained as community members. Any PMC member who does not gain a certificate should resign.

4. Refine Monitoring and Evaluation system

The Monitoring and Evaluation System was explained at length by the consultant in the TOT workshop. (See 2nd Consultants Report). This hinges on the correct usage of the membership cards together with a monthly Monitoring From detailing trainers activities which is signed by the Health Club chairperson at each session. Further spot checks should be done at each camp every month by HIDO Director, accompanied as much as possible by the Training Officer. The consultant has reiterated this process on this visit and provided monitoring forms and indicators to be completed monthly and analysed.

The base line survey was well executed by HIDO and should provide a good basis on which to measure changes of hygiene behaviour using observable proxy indicators. However it was disappointing to see that this was done by hand, rather than computerised as it will be difficult to make comparisons with the post intervention survey unless both are computerised.

Recommendation 27:
HIDO should be provided with at least one desk top computer and printer for HQ to enable records and surveys to be done to a minimum standard required by donors. A statistical computer package (preferably SPSS) should be installed and used for all data so that analysis of this groundbreaking programme can be kept on a regular basis. Two HIDO staff and one CARE staff should be trained in Data input and analysis at a basic level.

5. Assess success of Community Health Club strategy

The Community Health Clubs have been started in the last month and it is beyond all expectations that the uptake has been so rapid and that the concept of health clubs has been so popular in IDP Camps. The target of 12,000 members and 20 health clubs has been met and exceeded within a few short weeks of a three month programme. The response can be readily witnessed by visiting any IDP Camp where vast crowds gather at every session. In the three sessions attended by the consultant the trainers were dealing with clubs of over 200 members, and the largest gathering at Abili when the donor visited was attended by all 5 clubs with an attendance of well over 1000 members. Enthusiasm for the sessions was palpable and leaders repeated thanks the consultant (CARE) on behalf of the community for this programme. In one camp it was reported that the leaders have said this is the only programme that has adequately reached the people with health promotion. Previous attempts has involved training a few members of the community and expecting them to go from house to house, which has not benefited the other members of the community. It was said that if there is a choice of NGO activities the members will stay in the health sessions, however the scramble of donors within IDP camps has engendered fierce competition for the attention of the community. Usually those that provide food handouts win! The health clubs are however appealing to the deep need of IDPs to improve themselves and regain control over their lives and their own health. They are said by all trainers to enjoy the participatory approach and in particular are fascinated by the visual aids, and the variety of topics. They also enjoy having a membership cards and cause trouble if there is a delay or shortage in distribution. They have been extremely quick to implement recommended practises and pot rack and pit latrines are being erected everywhere. Trainers have reported a reduction in faecal deposits at night and apparently members clear the open defecation along the roads before the health promoter passes in the morning in an effort to improve hygiene standards. This is unprecedented in the IDP Camps notorious for open defecation. The donor was present when a farmer adjoining Abili IDP Camp thanked CARE for the health club as for the first time his field are free from fresh

faeces deposited nightly. These anecdotal reports are to give a flavour of a revolution of hygiene that is happening in the camps. It is imperative that a post intervention survey is done a month after the end of the health sessions to provide quantifiable evidence of behaviour change.

The following table is a summary of a survey conducted with 15 out of 25 HIDO trainers to solicit their views on how the strategy is working from their point of view. They were asked to score out of ten how appropriate they though the health club approach was for IDP camps and 60% scored the highest response, whilst all were above 50%. Most though the concept of the health club was easy to explain to the community (100% over 6) and that they could attract members with ease (86% over 7). 93% found PHAST an easy method and 93% confidently claimed that they were highly popular with the community (over 8).All except one felt that the approach was a good use of their time and they wanted to continue in the IDP camp. The only spread was over job satisfaction with only 1 marking 10 whilst the others marked between 5 and 9 in an attempt to draw attention to their concerns over incentives such as housing and travel allowance. An average shows that 10 out of 10 was scored for 49% of responses. This indicates a strong acceptance and enthusiasm on the part of the trainers who must in the final analysis be the best judges of this approach.

Community Health Clubs :	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**N**
Appropriate for IDP camps	9	1	2	2	1						15
Easy to explain concept	6	2	3	2	2						15
Easy to attract members	7	1	1	4		2					15
Easy to facilitate sessions	6	4	3		1	1					15
PHAST is an easy method	8	4	2						1		15
I am very popular	6	5	3						1		15
Job satisfaction is high	1	5	1	3	4	1					15
Good use of time	7	1	4	2					1		15
I want to continue	11	1	2							1	15
Total	**61**	**25**	**21**	**13**	**8**	**4**			**3**	**1**	**135**
Percentage	**48**	**19**	**15**	**8**	**5**	**2**			**2**	**1**	**100%**

6. Identify follow on initiatives to maintain continuity and future opportunities

Health clubs should be seen as a vehicle for community development and not just as a means to implement a hygiene and health programme. Whilst this project has been an emergency response and focused on immediate improvement of sanitation in the camps as a means to improve health, many other aspects have been neglected.

As identified in the Powerpoint presentation (See Annex.7) presented to the representative of Bill and Melinda Gates Foundation the following on going activities would be appropriate in the next phase:

- HIV Aids Coping Strategies, Prevention and Home based Care
- Nutrition and Use of medicinal herbs
- Self motivation and weaning from dependency
- Tackling alcohol and drug abuse
- Dealing with returning rebels and abductees
- Gender based violence and child abuse
- Functional literacy and numeracy
- Skills training for self reliance
- Livelihoods

Recommendation 28:

A project proposal seeking support for some of the above components should be drawn up within the next few months to ensure continuity of involvement of the community and to help sustain the club until it is fully institutionalised in the daily running of each IDP Camp

Recommendation 29:
If there is no intention of continuing this programme beyond July 2005, there should be a careful exit strategy, possibly involving passing on the health clubs to other Agencies to ensure that this well formed community is not abandoned.

Recommendation 30:
The findings from this programme should be carefully documented comparing the base line and post intervention survey and the findings presented internationally, so that this approach becomes replicated in other parts of Uganda and in other CARE programmes in Africa.

7. Sustainability and Replicability

The Community Health Clubs will have the capacity to become important structures within the Camps organising their members to manage their own health in the following fields:

- Maintenance of hygiene standards
- Upgrading personal and home hygiene
- Monitoring of latrine cleanliness and repair
- Organising cleanup and a faecal free environment
- Organising the disposal of solid waste
- Monitoring Cholera outbreaks
- Monitoring the use of ITNs
- Identifying needy cases to authorities
- Support for disadvantaged families
- Child growth monitoring and nutrition
- Monitoring of immunisation
- Providing counselling and practical home based care training for afflicted families
- Assistance to orphans, widows and abductees

This will be sustained if the club leadership continues to be transparent and conduct annual elections of office bearers to ensure that long term opportunists are forestalled.
The approach can easily be replicated in other camps depending on the number of trainers supported. Local counterparts should be trained up from the camp to ensure that when CARE withdraws there will be local expertise available to guide the health clubs. If the IDPs return to their own villages within the next few years it is to be expected that the membership will reform in their own areas. This will depend on how deeply the habit of meeting weekly becomes and to what extent the regular club meetings provide and forum for social and intellectual pursuits and how strongly their meet the needs of those members. A health club will only continue for as long as it is of use. If it dies at that point it may have served its purpose which was to improve the hygiene of the club members and decrease the prevalence of communicable diseases in their families. If it continues it can become a major CBO partner of any external agency wanted to work with a well tried and reliable community based organisation.