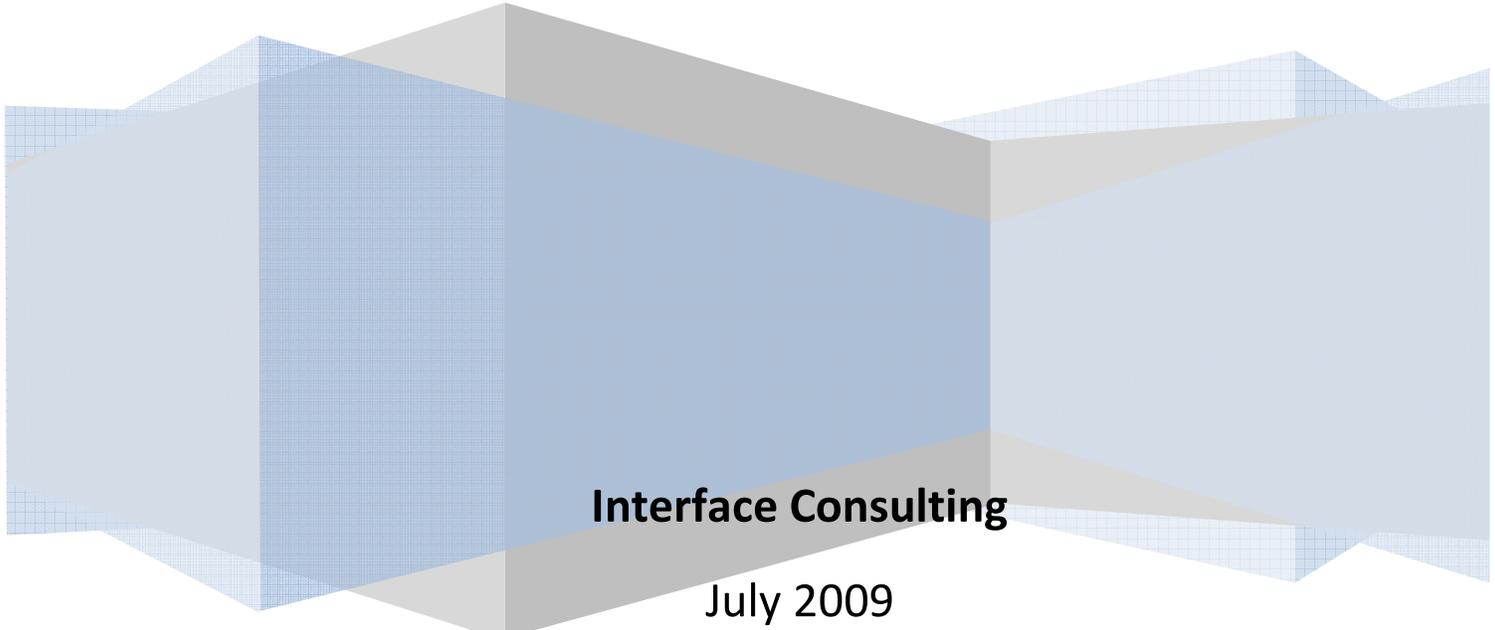




External Evaluation

**Project: Water, Sanitation and Public Health in
Transition- facilitating return and self reliance in
Kitgum District- North Uganda**

FINAL REPORT



Interface Consulting

July 2009

GLOSSARY OF ACRONYMS

CHF: Community Health Facilitator

DEO: District Education Officer

DHI: District Health Inspector

DWO: District Water Officer

GoU: Government of Uganda

HEP E/ HEV: Hepatitis E Virus

IASC: Inter Agency Steering Committee

IEC: Information, Education and Communication

LC: Local Council

LRA: Lord's Resistance Army

NCS: National Change Strategy

OCHA: UN Office for the Coordination of Humanitarian Affairs

OGB: Oxfam GB

PHE: Public Health Engineering

PHF: Public Health Facilitator

PHP: Public Health Promotion

PRDP: Peace, Recovery and Development Plan

UNICEF: United Nations Children's Education Fund

VHT: Village Health Team

WASH: Water Sanitation and Hygiene

WHO: World Health Organization



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SUMMARY

BACKGROUND

This document sets out the findings from the evaluation of Oxfam GB's **Water, Sanitation and Public Health in Transition** project in Kitgum District, North Uganda. The purpose is to provide a measure of the overall success or failure of the project with a view to providing accountability to Oxfam's partners and to improving Oxfam's future programmes.

METHOD

The evaluation structure consists of descriptions of programme outputs, activities and resources as well as an assessment of programme appropriateness, effectiveness and efficiency. Methodology for the evaluation included a review of project documents, interviews with Oxfam staff, WHO, UNICEF and local government officials, focus group discussions with community members and sub-county technical staff and the physical assessment of project sites and facilities.

FINDINGS

The following findings have been made, and are summarized below in a SWOT analysis

STRENGTHS

Overall, the programme's flexibility has been effective in producing improvements in water supply coverage and in the containment of the Hepatitis E outbreak in return sites and villages of origin over the past one year. Focus on gender issues has facilitated settlement of returning populations. Coordination and information sharing at both district and sub-county level have been largely effective and national guidelines and policies have been applied. Oxfam GB's capacity in terms of staff, physical resources as well as financial and procurement systems have contributed to programme efficiency. Oxfam's adaptation to the rapidly changing environment is considered as an organizational strength.

WEAKNESSES

Arguably, the large geographical area strained the programme resources and undermined impact. The relationship with the district and sub-county technical officers has been inconsistent. Procurement and contract management especially at the community level was not always well organized. Some aspects of the Community Based Maintenance System (CBMS) were not incorporated into the project and the cascade public health promotion structure is no longer appropriate. Feedback from the field has not been consistently built into programme planning.

OPPORTUNITIES

Although still characterized as unstable, the security situation has improved significantly. In addition, communities hold Oxfam in high regard. Local government and agencies are supportive and appreciative of Oxfam's past work and there is a positive perception of Oxfam's capacity in terms of human and financial resources.

THREATS

The resourcing environment is in a state of flux. Emergency policy and guidelines are still being applied in many areas and many communities still have a high dependency mindset.



RECOMMENDATIONS

The following recommendations have been made:

- a) Define a more manageable programme geographical area of operation. Ensure that stakeholders are aware of justification.
- b) Formalize relationship with the district local governments
- c) In order to enhance sustainability of installed facilities and practices, additional community level training and monitoring will be required
- d) Expand the analysis of water quality monitoring results to assist and/or predict disease outbreaks and promote behavior change.
- e) Engage with the efforts to find a solution to the emptying of latrines in institutions
- f) Assess the impact of hygiene and sanitation promotion with a view to refining training methods and promotion messages in order to close the gap between knowledge and practice at the community level.
- g) Devise appropriate strategy for the phase out of public health cascade structure
- h) Refine procedures for more effective management of small community based contracts



1 INTRODUCTION

1.1 BACKGROUND AND PURPOSE

This document sets out the findings of the evaluation of Oxfam GB's **Water, Sanitation and Public Health in Transition** project in Kitgum District, North Uganda. The purpose of the evaluation was to: determine the progress of the project based on the activities undertaken as specified in the project design; provide a measure of the overall success or failure based on an assessment of the use and maintenance of the facilities provided, the active participation of the affected population in project activities as well as stakeholder perceptions; and to assist in the planning future projects based on the findings, especially if there were any unexpected problems occurring.

The outcome of the evaluation will be a clearer understanding of the overall effectiveness and impact of the project, the coverage achieved by Oxfam, as well as constraints faced. The main output is a comprehensive narrative report that records the evaluation process and results, (this document).

1.2 BACKGROUND TO THE PROJECT

Following the signing of Cessation of Hostilities agreement between the Lord's Resistance Army (LRA) and the Government of Uganda (GoU) in July 2006, the security context in northern Uganda and in Kitgum improved significantly. As a result, a considerable proportion of the internally displaced population has now gradually moved out of the main camps into transit camps or back to their villages of origin. While movement was expected, it was larger in scale than had been envisaged, and has gradually gathered pace.

Oxfam GB has implemented public health programmes in Kitgum since 2003, characterized by largely reactive humanitarian operations. However since January 2007, the programme increasingly shifted away from a focus on interventions in the main camps to a mix of work in main camps, satellite camps and villages of return as the population moved.

Oxfam GB received funding from Irish Aid through Oxfam Ireland. The support was aimed at facilitating the return and the enhancement of living standards for up to 128,400 people in eight sub-counties of Kitgum District. This was to be achieved through the provision of affordable clean drinking water and safe sanitation facilities; improving hygiene practices and establishing community management systems. Funding from Irish Aid augmented the support from other donors as indicated in the table below.

TABLE 1 SUPPORT THAT FUNDS FROM OXFAM IRELAND/IRISH AID AUGMENTED

Agency/Funding source	Funding secured (EUR)	Period
Oxfam GB Unwrapped	36,660	May 2008—Apr 2009
Oxfam Ireland/Irish Aid	326,720	May 2008—Apr 2009
ECHO	1,180,000	Jan 2008—Feb 2009
Total	1,543,380	

National policies, including the Peace Recovery and Development Plan (PRDP), are driving much of the transition in northern Uganda in terms of programming and resourcing. In recognition of the need to adapt to the changing context, Oxfam developed and adopted a National Change Strategy and is currently in the process of reviewing and realigning its Public Health and Livelihoods work in northern Uganda. Therefore, this external evaluation, while being part of broader administrative project cycle management, also dovetails into Oxfam GB's own work. As the current changes in programme approach take root within the district, Oxfam continues to draw lessons from its



performance on recent and on-going projects in order to improve in its problem analysis, project design and implementation approaches.

1.3 SCOPE AND METHOD

1.3.1 BACKGROUND DATA COLLECTION AND PRELIMINARY ACTIVITIES

Meetings with Oxfam team: First, the evaluation team met with the Kitgum Public Health Programme management team and the regional Public Health Advisor. The purpose was to discuss in detail the expected outcomes and outputs of the assignment and based on this, devise appropriate methodology to effectively carry out the work over an eleven day period. At this stage, the Consultant also obtained background documentation about the project. The Consultant then met with the available Oxfam public health team members implementing its water, sanitation and public health humanitarian response. Objectives of the evaluation were clarified, and an appropriate work plan to conclude meetings with stakeholders and conduct project site visits within the stipulated timeframe was outlined. Key issues emerging from preliminary document review were also discussed in this meeting. Later on during the evaluation, the Consultant met with staff from the finance department. Field staffs including Public Health Facilitators and Child-to-Child hygiene facilitators were also met.

Review of Background information: The Consultant reviewed various documents relevant to the evaluation exercise that were provided by Oxfam GB. These included interim reports (to ECHO and Oxfam Ireland), internal review documentation (Malile M Maithya, 2008) and internal Oxfam financial reports. Current water and sanitation statistics and practices for Kitgum were obtained from OCHA, WHO, the District (Health Inspector, Water Officer and Bio Statistician) and UNICEF, and were also carefully assessed.

1.3.2 CONSULTATION

Interviews: of duration of 1–2 hours were carried out with district and sub-county technical and political leaders, school head teachers, WHO, UNICEF as well as Oxfam public health and support staff. The purpose was to establish their involvement in the project as well as their view about the strengths and weaknesses of the programme and the opportunities available for future programmes.

Focus Group Discussions: seven in total were conducted with the community. In some instances, women and men were consulted separately, and in others, the group was mixed. A focus group discussion was also conducted with health inspectors and health assistants responsible for seven sub-counties in which Oxfam is currently active.

TABLE 2 STAKEHOLDER CONSULTATION DURING THE EVALUATION

Level	Individual interviewed	Purpose
District	DWO, DHI, District Bio Statistician and DEO	Technical offices responsible for sectors in which OGB programme activities are carried out
Agencies	WHO and UNICEF	Assess approaches, involvement and perceptions about Oxfam's work
Sub-county	LC III Council Chairman, Sub-county Chief, CDO, PDC, Health Assistants	Political and technical leadership and facilities management at the s/county level
Community	Water user committee, hand pump mechanics, users, school head teachers PHF and child-to-child facilitator	Assess involvement and capacity constraints in O&M
Programme staff	PH Team Leader, PH Manager, Regional Advisor, PHP and PHE teams	Overview of programme, challenges, issues etc



1.3.3 PROJECT SITE VISITS

Project sites: in four sub-counties selected in consultation with the Oxfam Team were visited to collect information relevant to the evaluation. Sites visited included the motorized piped water schemes, boreholes, and schools where Oxfam had worked. In addition to physical observation, assessment of facilities also considered the following aspects.

- Quality: Technical appropriateness; social and cultural acceptability; potential health hazard; and sustainability
- Quantity: Number of facilities/ activities; capacity; and distances to facilities
- Usage: Accessibility; and operation and maintenance.
- Gender: Impact of facilities on gender relations and stereotypes within the community

TABLE 3 FIELDWORK CONDUCTED FOR THE EVALUATION

Sub-county	Key project facilities, features	Evaluation activities
Palabek Kal	Motorized schemes, household latrines, child to child public health promotion, boreholes, hand pump mechanics	Physical inspection of scheme, interviews with sub-county leaders, community focus group discussions
Palabek Gem	Institutional latrines, household latrines, boreholes, motorized system	Interviews with sub-county leaders, community focus group discussions
Mucwini	Institutional latrines, HEP E latrines, Health Centre	Interviews with school leadership, sub-county leaders, community focus group discussions
Padibe East	Motorized system, health centre, institutional latrines, household latrines	Interviews with sub-county leaders, community focus group discussions

1.3.4 FEEDBACK TO OXFAM

At the end of the fieldwork, a feedback and discussion session was held with the Oxfam management and public health team members. Staff from support services was also invited. This meeting clarified a number of issues (outlined below) that had emerged from the fieldwork and consultation.

Consultant's estimate of beneficiary population: The Consultant estimated direct beneficiaries of the OGB public health project based on recommended optimal number of users for water supply facilities (boreholes, rainwater tanks, and motorized schemes tap stands¹) provided by Oxfam. It can be argued that Oxfam reached more people indirectly through the radio shows and other mass hygiene and sanitation campaigns conducted at peak of the Hepatitis E outbreak. However, this data was not available.

Geographical coverage and coordination at the district level: Oxfam operations during the project did not extend to all parishes within the 8 sub-counties Oxfam had decided to focus on. During the evaluation, there were instances where community members from unserved parishes claimed that the district had decided not to construct a water supply in their parish because of the mistaken expectation that Oxfam would do this. Agencies implementing public health programmes in Kitgum also raised the issue of inadequate clarity about Oxfam's coverage in operational areas at parish and village level.

¹Sector guidelines stipulate 300 users per deep borehole equipped with hand pump; 150 users for piped water supply tap and 6 users for each rainwater tank.



Although Oxfam had informed stakeholders about the decision to scale down activities within its project area, this information required reinforcement and better coordination by Oxfam especially in the linking of communities from unserved parishes to potential service providers including the district. Another approach to this issue in future could be the concentration of Oxfam's programme into fewer sub-counties, but with services delivered to all parishes within those sub-counties. This would have less risk of spillover from poor practices or epidemic outbreak from unserved neighbouring parishes and would arguably result in better impact in terms of reducing mortality and morbidity within the project area.

Community level contract management: At the peak of the Hepatitis E outbreak, Oxfam provided over 1000 latrines to survivors of the epidemic and other vulnerable persons within the community. Construction was contracted out to about 300 community based petty contractors, in phases (pit digging, superstructure construction etc). Payments by Oxfam were triggered by claims or invoices made by these contractors, and approved by community leaders on the basis of their opinion about the completeness of the works. In one instance during this evaluation, a petty contractor had been paid for pit digging but follow up payment for construction of the superstructure had not been made. This eventually resulted in conflict at the community level, because the contractor locked up the latrine. Nine months after construction had been completed; the latrine was not yet in use.

Although the contracting model was innovative, because local contractors from the affected communities earned some income from participation on the project, a more effective communication system was required to ensure that third parties (community leaders in this case approving works) making decisions on behalf of Oxfam were always compliant with Oxfam's policies.

By the end of the evaluation mission, the OGB public health team had considered this issue and payment to the contractor had been made. Wider feedback to the community to discuss the situation may also be necessary

Effectiveness of Hygiene and Sanitation Promotion: Throughout the project, Oxfam, the district and other agencies have carried out sustained hygiene promotion and sanitation campaigns to improve community practices and reduce mortality and morbidity from water and sanitation related diseases. However, despite the high levels of knowledge at community level on the related public health risks, the resultant behavior change is not proportionate to the level of input. What is required are more innovative ways by public health practitioners to ensure that the approaches to hygiene and sanitation promotion result in comparable increases in adoption of good hygiene practices within target communities.

Future role of Public Health Facilitators: PHFs were used by Oxfam in the humanitarian operations as one of the strategies in the promotion of community hygiene and health issues. In the IDP camp setting, they proved to be quite useful. In the transition from emergency to recovery and development, Oxfam has continued to employ some of these health promoters based at the sub-county level. Given the complete government staffing establishment at this level, the continued existence of these staff can be questioned.

Oxfam staff informed the evaluation team that the main strategy was to incorporate the PHFs into the Village Health Team, which is operational at the lower parish and village levels and that in some sub-counties this had in fact already happened.



2 FINDINGS

2.1 PROJECT OUTPUTS

2.1.1 OUTPUTS

As depicted in Table 4 below, outputs on the project have all been met, and exceeded in some cases.

TABLE 4 PLANNED AND ACHIEVED TARGETS SUPPORTED DIRECTLY BY IRISH AID

No	Item	Planned	Achieved
1.	Maintenance or replacement of camp latrines	33	428
2.	Institutional latrines with rainwater tank	2	5
3.	Maintenance of piped water schemes	4	4
4.	Drilling and construction of boreholes	5	5
5.	Training of local leaders and community cascade structures	1	1
6.	Incentives to child to child facilitators	8	8
7.	IEC materials, radio talk shows, posters etc	1	1
8.	Partnership mapping	1	1
9.	Non Food items		
	a. Soap	12,250	362,187
	b. Jerry cans	1,000	28,279

2.1.2 COVERAGE AND GEOGRAPHICAL FOCUS

The entire programme to which Oxfam Ireland /Irish Aid support contributed, directly reached an estimated population of 79,230² or 62% of the population envisaged at proposal stage.

Initially, Oxfam worked effectively with centrally encamped populations from 8 sub-counties carrying out mainly humanitarian operations. In this setting the population reached by the programme was quite high. However, it became impractical to reach a high number of people when movement to transit sites and eventually villages started. Distances between the sub-county headquarters and transit sites, between sub-counties and villages, and between households in the same village are considerably lengthier. In response to this reality Oxfam scaled down its operations to focus on 24 out of the 45 parishes in 8 sub-counties. The new operational parishes were identified as the most in need of public health services from a needs assessment conducted by Oxfam. Although there are still reports of strain, in terms of operational requirements, this was a more manageable project area to cover by Oxfam considering the human, physical and financial resources that were available to the programme. As a result of the scale down, population reached by the programme reduced considerably. Geographically, the project area is not continuous and in some instances parishes where Oxfam is not operational neighbor those in which it is active.

The first concern about this arrangement is that agencies that would complement Oxfam's efforts are under the impression that Oxfam covers all parishes in the 8 sub-counties. Unserved parishes in sub-counties where Oxfam is active therefore miss out on potential opportunities for service provision from other agencies. Secondly, the parishes where Oxfam is not working also have poor indicators for access to safe water and sanitation services and therefore pose public health risks even though relative to those in Oxfam's project area they appeared better off. Therefore in the case of

² 5 Institutional tanks *6 persons(effective supply) ; 5 motorized schemes with 64 tap stands (15 in Padibe; 17 in Lokung; 12 in Kal; 8 in Gem and 12 in Amida) each with 6 taps * 150persons; 15 new boreholes*300persons and 57 rehabilitated boreholes *300 persons



disease outbreak the likelihood of spillover into parishes where Oxfam has worked is quite high. In this way, Oxfam risks reversals to improvements made in public health.

According to the recently developed 3-5 year public health strategy, from 2010, Oxfam will focus more on building partnerships with locally based organizations in the sub-counties and within the district with clear geographical focus in order to cost effectively fill in the service provision gaps at parish and sub-county level and to scale up in a more sustainable way.

2.1.3 RELEVANCE

In the context of ongoing population return, the support from Oxfam GB was required and appropriate. Water provision in areas of Kitgum affected by the insurgency has been highly centralized and focused on the IDP Camps. During the project period, population return intensified to the extent that over 75% of the population is believed to have returned to either their home areas or decentralized sites in their parishes of origin in a fairly short period of time. Overall levels of access to safe water (defined as access to water point within a 1.5 km radius³) were as a consequence believed to be lower than 40% and in some sub-counties in which Oxfam intervened such as Padibe West, less than 30%. The case for ongoing focused work to increase provision of water and sanitation facilities is clear particularly in the light of the ongoing vulnerability and risk posed by diseases of epidemic potential including Hepatitis E and cholera.

2.1.4 EFFECTIVENESS AND IMPACT

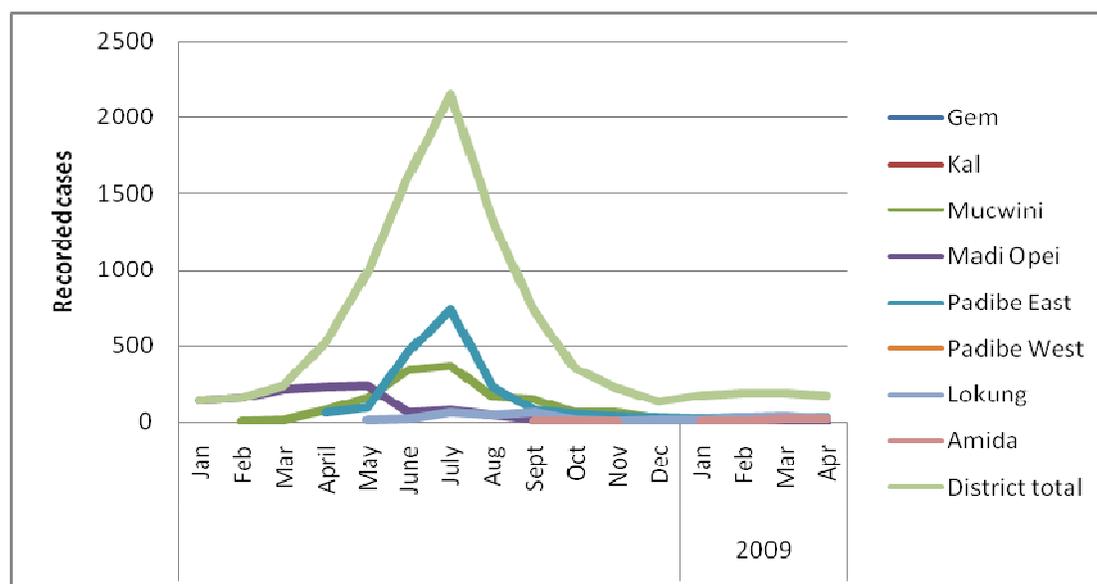
Support from Oxfam Ireland/Irish Aid supplemented funding from other donors who supported Oxfam's Public Health in Transition Project. Under the whole programme, Oxfam provided 15 new boreholes, rehabilitated 57 boreholes and procured various materials for hygiene and sanitation promotion. In addition 5 piped water schemes are being maintained, water treatment supplies are being provided to households and community training is being carried out to enhance ownership. Overall the additional functional boreholes and piped water schemes have provided access to improved water supplies to an estimated 79,230 persons that returned to their villages of origin.

The intervention was focused on the provision of support to areas experiencing an outbreak of Hepatitis E and those considered at risk. In northern Uganda, Kitgum bore the brunt of the epidemic with 9274 cases by April 2009 with 151 deaths representing a case fatality rate of 1.5%. The worst affected sub-counties were Mucwini, Madi Opei and Padibe East recording 48% of the cases. It was in these sub-counties that Oxfam intervened. There was a sustained district wide multi-agency response that contained the Hepatitis outbreak and helped reduce morbidity and mortality in Kitgum. Oxfam's contribution to this response has been acknowledged by the district and sub-county authorities as well as other implementing agencies and the UN. In this way, the specific objective of Oxfam's response has been largely achieved for its intervention areas, especially in Madi Opei and Lokung, as depicted in Figure 1 below.

³ National Level standard set by Ministry of Water and Environment



Figure 1 Hepatitis E cases recorded in OGB's operational area, compared to the district total



Source: District Bio-statistician Kitgum

“Oxfam has been with us since this camp was established in 1997. There were periods when the security situation was at its worst, when gunfire could be heard from midday onwards. This forced many people into the camps where they could not be productive and therefore relied on outside support. Throughout that time, Oxfam supported us and still repairs all the 31 boreholes in this area and funds the operation and maintenance of the piped water scheme. During the Hepatitis E outbreak, Oxfam moved quickly to provide us with support. We are grateful because we know that at the peak of a previous Cholera epidemic up to 10 people would die daily “

James Otto, LC III Chairman, Palabek Kal

Gender: At the project design stage, Oxfam identified strategies to ensure that women and children would be reached by project activities. During implementation Oxfam placed extra effort into the identification and provision of supplies to vulnerable groups including Hepatitis E survivors, the elderly, women and children. Women comprise 50% of all the Water User Committees members in line with national guidelines. Also 55% of the Hand Pump Mechanics trained by the project were women.

Observations from the field visits as well as findings from the focus group discussions and local IASC reports indicate that the provision of water and sanitation infrastructure and services has generally lagged the pace of population return. As a result, many families have remained or continue to return periodically to the camps in order to maintain their accessibility to the existing education and health facilities. Therefore, the support to schools in return areas by Oxfam through the construction of latrines and the provision of hand washing facilities and sanitary kits to girls has arguably helped populations returning to their villages of origin to settle down.



2.1.5 SUSTAINABILITY

Motorized boreholes and piped schemes: Many of the piped water systems in camps have now aged, ranging from 3—5 years old. Breakdowns are more frequent, and some of the tap stand committees are no longer functional. In addition Kitgum Local Government passed a council ordinance stipulating that beneficiary communities would not be required to contribute funds towards operation and maintenance⁴. As a result, communities have now grown overly dependent on external assistance. Currently, Oxfam provides oil and diesel to run the pumps, supplies materials for equipment servicing, responds to breakages and pays the pump operator. This is not sustainable. Many of the camps are evolving into urban centres and will therefore require water supply. Oxfam will need to consider how best these schemes can be effectively managed in the long term.

Oxfam plans to hand over the 5 schemes to the district by December 2009, after careful technical and institutional assessment on the most appropriate management options. Preliminary studies on the schemes assessment have already begun.

Boreholes: Oxfam has provided toolkits for the periodic maintenance of boreholes. In conjunction with the district and sub-county staff, Oxfam carried out training for water user committees and hand pump mechanics after construction of the boreholes. Currently, monthly monitoring meetings are held at the sub-county level with the political and technical leadership, and health workers at this level to discuss operation and maintenance of the water supplies. In the short term these actions may ensure sustainability of the benefits from the boreholes. However, Oxfam still carries out most of the maintenance works and has not completely disengaged from these communities. This is not sustainable in the long term. In order for beneficiary communities to effectively lead in the management of facilities in line with national sector policy on rural water supplies, further training and monitoring will be required.

Oxfam plans to gradually reduce agency driven maintenance by December 2009, and will then focus on support to partner organizations and the local government at the sub-county level to promote the adoption of the Community Based Management System.

Response to disease outbreaks: Oxfam's response to the Hepatitis E, together with efforts by other agencies, the UN and the district, was largely effective in containing the outbreak. However the sustainability of this approach can be questioned considering the resource input required in terms of funds, staff, vehicles logistics etc. It can be argued that water and sanitation related diseases even those of epidemic potential such as Hepatitis E, cholera and dysentery can be effectively contained using conventional longer term development approaches that focus on hygiene behaviour change and sanitation promotion within communities. These approaches generally result in lower costs per beneficiary and are more likely to result in changes in hygiene practices that can be replicated by communities without agency support.

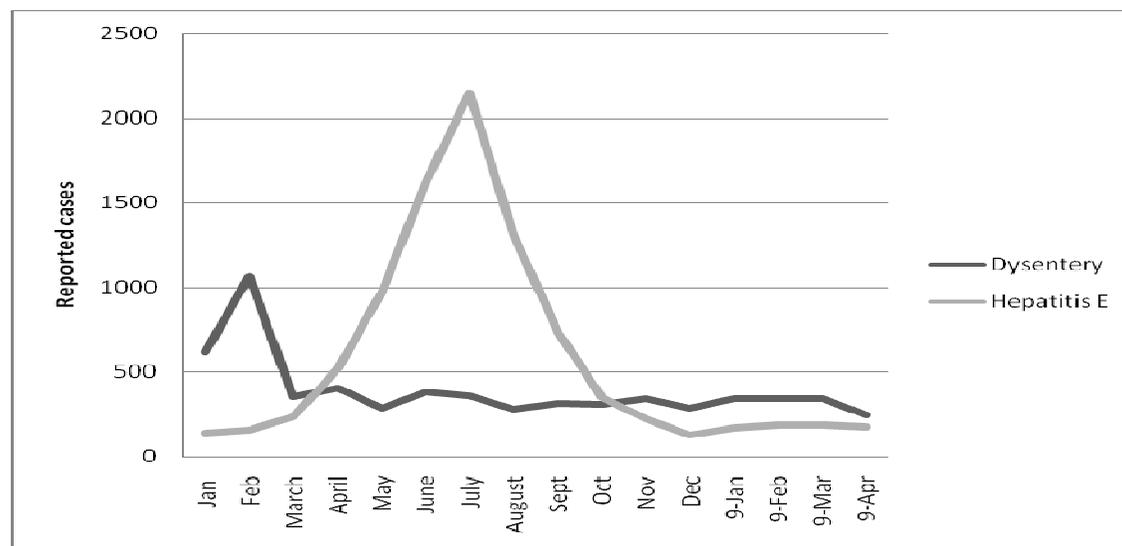
For instance, Figure 2 below shows the recorded cases of dysentery and Hepatitis E in Kitgum District since January 2008. Both diseases are caused by contact with faeces, lack of hand washing after defecation and before food preparation, and by flies. Because Hepatitis E has a longer incubation period, its onset lags that of dysentery by about six weeks. Public health workers can therefore use the onset of dysentery as an indicator for the need to consider possible outbreak of Hepatitis E and

⁴ Interviews with sub-county officials as well as the FGD with health assistants and health inspectors revealed the belief that because of the inability or refusal to contribute funds towards O &M many people reverted to unprotected water supplies, and that this exacerbated the Hepatitis E and Cholera epidemics



to prepare communities and other stakeholders appropriately. The onset of dysentery can be predicted from the results of water quality monitoring.

FIGURE 2 REPORTED CASES OF DYSENTERY AND HEPATITIS E IN KITGUM DISTRICT FROM JAN 2008 TO DATE



Source: District Bio-statistician Kitgum

Link water quality results to disease outbreak: Oxfam is supporting the District Water Office to carry out water quality surveillance on protected water supplies in its operational area. Results from the monitoring are submitted and discussed in the WASH Cluster. Depending on the results, Oxfam carries out remedial measures such as well chlorination and distribution of aqua tabs for chlorination of drinking water at the household level. This has been effective in the short term, but there are reservations by agencies and the district about the sustained use of chlorine at household level.

The current level of analysis of water quality monitoring results by Oxfam can be expanded to establish trends and explore links to the likelihood of disease outbreak within Oxfam's project area. Results of this analysis can then be used as an entry point or as an opportunity to emphasize hygiene and sanitation behaviour change in affected communities. Further, sharing this information with other agencies and the district can assist in the prediction and prevention or mitigation of disease outbreaks in Kitgum and thereby increase the impact of Oxfam's work.

Communal latrines: constructed in the main camps may not be sustainable in the long term as most of the users have moved to transit camps and villages of origin. There are a number of instances where the communal latrines that are no longer in use have been vandalized (removing doors, roofs etc). In such cases (in Palabek Gem for example), Oxfam staff has had to board off the communal latrines.

Institution latrines: constructed in schools and health centres are generally sustainable for the long term. However, appropriate operation and maintenance systems will be required. Many of the institutional latrines constructed under the programme have been completely lined in accordance with guidelines issued by the Ministry of Education through the District Education Officers. The technology was widely adopted in Kitgum partly as a result of the sandy soils over much of the district. There was also an urgent need to mitigate environmental risks of groundwater contamination resulting from the construction of many unlined pits concentrated in a relatively small area as was the case in the main IDP camps. Issues that need to be considered for sustainability include the collection of funds to pay for emptying, method for emptying, user sensitization to



ensure the use of appropriate anal cleansing materials, and the safe disposal of the pit contents when the latrines are emptied. At the moment, there is only one cesspool emptier in the district and skills and experience in latrine emptying are inadequate.

BOX 1 SOME ISSUES TO CONSIDER FOR LATRINE PIT LINING AND EMPTYING IN KITGUM

Pit size: The first issue is the need to appropriately size pits (within limits of space), so that emptying is not frequent. Pit emptying is most difficult where pits fill rapidly, where hard or plastic anal cleansing materials are used, and where vehicular access is difficult.

Emptying: The easiest and most hygienic method for emptying latrines is to use a vacuum tanker (cesspool emptier). Vacuum tankers are more effective for removing liquid. Dry pits or pits containing large quantities of solid materials such as stones, sticks, plastic bags etc cannot be emptied. Alternatively, a collection tank can be mounted on a flat bed truck and a portable pump used to pump the waste from the pit to the tank. The pump must be carefully selected especially where hard anal cleaning materials are used. Specialist sewerage pumps are recommended. Some pumps are hand operated, but these require experience in their use, are slower than mechanical pumps and are only effective for wet pits.

As a last resort, pits can be emptied manually. This generally involves workers climbing into the pit and using spades and buckets to take out the waste. This can then be placed in a wheel barrow or truck and taken to a safe off-site disposal site. This should only be attempted once a pit has been closed and the contents left to decompose preferably for more than two years.

Sludge reduction: There are sludge reducing agents on the market. These bio-additives are used to speed up the sludge digestion process by boosting nutrient, enzyme or bacteria production. If successful, when added to pit latrine contents, sludge volumes and fly infestation are reduced. In emergencies they may not be appropriate due to the fast rate of sludge accumulation.

Sludge disposal: Sludge that has been left undisturbed for over two years is not a hazard to the environment. It can be safely spread anywhere convenient such as a garden. Its fertilizer value is not good, but it will add humus and fibre to the soil which will promote plant growth. Open disposal of fresh sludge into water or onto land is undesirable as it is an environmental and health hazard. A more appropriate solution is to bury the sludge in pits where it cannot come into contact with humans or animals, and will not contaminate ground water. Alternatives are to mix it with influent at a nearby sewage works or compost it with domestic refuse

Adapted from Harvey, Baghri and Reed (2002)

2.2 PROJECT EFFICIENCY

2.2.1 STAFF

Recruitment: Based on Oxfam's traditional structure for public health programming in emergencies, 53⁵ management, technical and casual staff were stipulated in the proposal for deployment on the programme. At the field level, Oxfam employed 16 Public Health Facilitators at sub-county level whose role was to supervise about 166 Community Health Facilitators and support 8 child-to-child facilitators and a number of Village Health Team members in the promotion of hygiene and sanitation. This structure was central in the intensification of hygiene education and promotion of effective sanitation to large populations concentrated within the main and transit IDP camps. Public health staff numbers increased to 78 by the end of the project. This was a 47% increase of mainly support staff to assist in the scaled up operations of the Hepatitis E response. During implementation, justification for staffing changes was provided to ECHO.

⁵ Source: Proposal documents including Oxfam Ireland/Irish Aid and ECHO



Oxfam has set guidelines for recruitment and conflict resolution and these were employed appropriately throughout the project.

Training: Because of the short project duration, project staff training had not been envisaged in the project proposal. However, Oxfam conducted relevant capacity building for staff in the form of training in project cycle management and partnership building skills development. Selected programme staff also attended various forums within the district (such as the monitoring and evaluation training provided by Institute of Public Health). Staff also visited other Oxfam programmes in the region. Staff trained consider that the training received was relevant to their work.

At the field level, Oxfam conducted extensive training for the PHFs, CHFs and the Village Health Team members in community health promotion, Child-to-child health promotion and in monitoring and evaluation. This training has been useful in terms of increasing knowledge at both trainer and community level. However, to a large extent this knowledge has not translated into changes in hygiene behavior and practices within communities.

Staff effectiveness: Oxfam public health staff in Kitgum is a mix of international and national staff that includes skilled individuals from the affected region. During project implementation, the team was assisted periodically by a team of professionals including the Engineering and Promotion advisers based in Oxford and in the region. Humanitarian Support Professionals (HSP) with specific technical expertise in the management of responses to specific outbreaks and epidemics periodically stayed in Kitgum to support the team during the Hepatitis E response. Remuneration was pegged to performance and in some cases there were incentives for working under difficult conditions. Although there were regular appraisals carried out for staff, there has been limited follow up of results in terms of related staff development.

Phase out of field staff: Oxfam plans to incorporate the Community Health Facilitators and Child to Child Facilitators into the Village Health Teams which are a part of the government structure as the population moves into villages. In some areas this has already happened and is appropriate. As communities return to their villages, greater effort is required on the ground to work with these communities because of their vulnerability to public health risks resulting from the limited water and sanitation infrastructure and services in return areas.

The challenge for Oxfam is to devise an appropriate strategy to phase out the Public Health Facilitators (PHFs) who are based at the sub-county and not in the community. The sub-county establishment is currently fully staffed with health assistants and health inspectors. Therefore it is not clear what role the PHFs will play. Additionally, the PHFs, CHFs and some VHTs have become accustomed to an incentive regime provided by Oxfam which is not sustainable in the longer term non-humanitarian context. Oxfam will need to carefully consider how best it can avoid duplication at the sub-county level, whilst achieving the necessary presence within in the community to effect desired behaviour change using longer term development approaches.

Staff efficiency: Oxfam's staff implementing the humanitarian response was deployed along the routes (main roads) to the project areas, by necessity to manage security procedures better. In terms of geographical coverage, the areas along these routes actually overlap. Consequently, the staff on some of the routes would have been fewer in an improved security situation. Arguably, for the entire project period the security context in the project area had improved and the number of staff necessary to manage operations in these areas could have been reduced. However from April—August 2008, the Hepatitis E outbreak was at its peak, and the extra staff proved to be necessary to take up the extra workload from the scaled up operations.



In recognition of the changing needs, Oxfam GB is currently reviewing and reorganizing its programme. The staffing structure itself has evolved in the past six months, further integrating Public Health Engineering and Public Health Promotion functions. Restructuring that will result in better clarified roles especially for the public health technical officers and the public health assistant is ongoing. Overall the team tasks now reflect more development orientated programming and overall team size is being reduced.

2.2.2 RESOURCES

Logistical procedures: Oxfam has well developed and clear logistical procedures which include appropriate communication and consultation between the field office and the main office in Kampala. These were employed throughout the project. All the resources identified in the project memorandum were procured. These included non food items such as hand washing facilities, sanitary kits, sanitation platforms, pumps and other water supply equipment. From financial records, project resources have been sufficient. According to some stakeholders interviewed, Oxfam's supplies were available even at the peak of the Hepatitis E response when many agencies' provisions had run out.

However, Oxfam's information flow, priority setting and execution time between programme, finance and logistics departments will need to be improved. There a number of instances when delays at the Oxfam office have resulted in avoidable poor experiences at the field level.⁶

Use of local resources: Under this project, latrine pits were dug by local persons from the affected community, paid by Oxfam. Latrine covers were made by school health clubs, locally under the Child-to-child sanitation promotion initiatives in schools. This has proved to be important in achieving behaviour change within the schools and in the communities were the children come from and in the creation of local income earning opportunities. On the other hand, the manufacture and transportation of sanitation platforms (san plats) from outside the community (Kitgum town) by Oxfam can be questioned. Not only is the local population deprived of an income generating opportunity, the unit costs are also increased on account of the transportation cost and breakages during delivery of the slabs.

Environmental risk: Within the main camps, there were various environmental risks associated with overcrowding. These included the depletion of trees around the camps and the contamination of groundwater supplies by latrines and other poorly disposed waste. Oxfam implemented mitigation measures developed in collaboration with other agencies and the district in the WASH Cluster. In the return areas, the risk of groundwater contamination is minimal. However, the risk of deforestation remains because of the high demand for building materials by the returning population. Oxfam is addressing this risk by creating awareness and promoting mitigation measures through its livelihoods programme.

2.2.3 FINANCES

Oxfam has established robust financial systems and procedures to support the effective and efficient implementation of programmes. Personnel from the finance office have been meeting every month with the public health programme management staff to review budget performance and to plan expected expenditure and cash flows in the short term. Before each expenditure, the finance office

⁶ Including such instances as the unpaid latrine builder mentioned earlier as well as delays in borehole construction after communities have been informed of the plan



carefully considers available funds on the relevant budget line, and provides feed back to the programme management staff. The finance office participates in the procurement of goods and services for the project.

Budget performance: Records from Oxfam’s finance department in Kitgum indicate the spend outlined below

TABLE 5 BUDGET SPEND ON THE OXFAM PUBLIC HEALTH PROGRAMME

Agency/Funding source	Funding secured (EUR)	Period	% Spend
Oxfam GB Unwrapped	36,660	May 2008—Apr 2009	58
Oxfam Ireland	326,720	May 2008—Apr 2009 ⁷	100
ECHO	1,180,000	Jan 2008—Feb 2009	100
Total	1,543,380		

Unit costs: Comparing Oxfam’s unit costs for borehole construction to those of UNICEF and the District Water Office reveals a disparity.

TABLE 6 COMPARISON OF UNIT COSTS WITHIN KITGUM DISTRICT

ITEM	UNIT COST BY ORGANISATION		
	OXFAM	UNICEF	DISTRICT
Borehole construction	14,900,000	17,000,000	17,671,499

The lower unit costs for Oxfam are not necessarily advantageous considering that the borehole construction was procured in small batches. If not carefully supervised, contractors may compromise the borehole location, well design, total drilled depth and pump materials used in order to fit costs and profits within this low budget. This eventually results in short design life of the installed borehole. In order to mitigate this risk, Oxfam now works more closely with the district water officer to identify suitable and prequalified contractors. However, supervision of construction works by the District Water Officer is still limited.

For future programmes the involvement of the district in borehole construction supervision in an appropriate formalized framework is recommended. This will ensure capture of key system information to assist in future maintenance and will enhance district ownership of the installed boreholes.

2.2.4 TIME

Borehole rehabilitation, and hygiene and sanitation promotion activities were on schedule. Borehole construction was delayed. First, the rapid population movement rendered the sites initially selected for borehole construction redundant. Secondly, staff changes (public health engineer and manager level) occurred within Oxfam and replacements arrived after sometime following the completion of the recruitment process. In addition, at this time there was increased focus by programme staff on the Hepatitis E response which peaked in mid-2008. Eventually, new boreholes were constructed in the period from November 2008—January 2009 after a fresh community needs assessment exercise. Delay affected mobilization and planning at the community level as well as the training of water user committees, which was carried out after construction (and not before as stipulated by sector policy). This may undermine the effective operation and management of the water supplies in the long term.

⁷ Oxfam Ireland/Irish Aid commitment has been (non cost) extended to June 30th



2.2.5 COMMUNITY INVOLVEMENT

The Oxfam Public Health in Transition Project was designed by Oxfam staff, basing on information from Oxfam's own assessments, as well as information from local IASC reports and the WASH Cluster. Community groups participated in the baseline assessments and in the decision to locate facilities. After construction, water user committees, hand pump, mechanics were provided with basic training on the operation and maintenance of the water supplies.

A monthly review meeting is held by Oxfam (PH technical officers, PHFs and CHFs) with key representatives (e.g. VHTs, LCI Chair person) from the target communities to discuss issues related to the installed facilities and the needs of the community. The sub-county political and technical leadership, health inspectors and health assistants attend the review meeting. Although discussions from these monitoring meetings have informed some of the decisions by Oxfam, a major frustration at the field level is the limited systematic follow through of issues from the monthly monitoring meeting into Oxfam's subsequent programme planning.

At the height of the Hepatitis E outbreak, Oxfam emphasized the link between the disease and the poor latrine coverage in areas which were affected. There was deliberate focus by the programme on the construction of communal and institutional latrines and latrines for the vulnerable, which resulted in increased latrine coverage in these parishes and villages, from 19%, to 24% and eventually to 32%. There is evidence that this strategy has helped contain Hepatitis E. Institution latrines and hand washing facilities visited were found to be properly used, and clean. The activities of the school health clubs, radio talk shows, sanitation competitions and child-to-child promotion have been found to be effective in increasing community participation and in effecting behaviour change. In return sites and villages of origin visited, many pit latrines were observed to be in proper use and clean. Although tippy taps have been installed, many were found to be empty especially in villages with low access to improved water supplies. This inevitably increases the risk from fecal-oral diseases stemming from limited hand washing.

2.2.6 COORDINATION AND INFORMATION SHARING

Project level: Oxfam GB has complied with all reporting requirements and procedures on this project. Technical and financial reports recording project progress have been submitted at the intervals stipulated in the project memorandum. At the project level, adequate information about the project exists and is sufficient for future use. Documents include baseline assessments, quarterly situation reports and financial reports. There is effective communication between the technical team and the finance office both in the Kitgum field office and in the Kampala headquarters. Technical system information for the motorized schemes and boreholes needs to be consolidated before handover to the district.

WASH Cluster: Initially Oxfam hosted agencies and district officials at the Kitgum office, and led the WASH Cluster discussions about an appropriate response to the Hepatitis E outbreak. Later UNICEF took up this role. Oxfam provided the bulk of the initial field information about the disease outbreak. The WASH Cluster has been effective in enhancing coordination and information sharing between agencies especially in the prevention of duplication and overlap of project activities at the field level.

District Water Office: Initially Oxfam carried out borehole construction with limited consultation with the District Water Officer. This was a technical oversight and resulted in some duplication at the field level and an unnecessary demand on Oxfam's technical and management resources, stemming from the need to closely follow up weak contractors. This has now changed. Oxfam now shares the list of



sites to be developed and hires drilling contractors from a district prequalified list. In addition Oxfam supports the Water Office to carry out water quality surveillance.

District Health Office/ District Health Inspector: Oxfam supported the District Health Inspector, through the District Health Office to carry out radio talk shows and sanitation campaigns during the Hepatitis E response. At the sub-county level, Oxfam involves health inspectors and health assistants in the training of water user committees and in the child-to-child hygiene and sanitation promotion activities in the schools. Health inspectors and health assistants take part in the monthly monitoring meetings to discuss WASH issues. In some cases Oxfam has supported the execution of weekly work plans implemented by the health assistants to assist carry out specific Oxfam tasks. Oxfam plans to sign a letter of agreement to guide the support to the DHO and DHI both at district and sub-county level in a more specific way.

District Education Officer: The DEO is responsible for sanitation in schools. Generally, Oxfam shared project information about interventions, and the specific schools where activities are being implemented. The DEO provided designs for school latrine construction and on Oxfam's request, participated in some school sensitization campaigns and in the monitoring of latrine construction and use.

Overall, Oxfam's relationship with the local governments is seen as an area Oxfam can improve. Although Oxfam shared information about geographical focus from the district it did not involve district officers in programme planning and project budget data was not shared. During implementation information sharing improved although some information from Oxfam's activities was not adequately shared (water quality monitoring results as an example). Health Inspectors and health assistants, are not always informed in adequate time about the training they are to facilitate and in a number of cases, the monthly monitoring meeting coincides with other sub-county based forums such as the Technical Planning Committee. The basis for weekly allowances paid to health inspectors and health assistants is inconsistent and is not well understood. The effectiveness of the allowance can be questioned because it is too low (UGX 5000 or 2USD per week) and in some cases, health assistants do not have motorcycles for which fuel can be provided.

In recognition of these issues, Oxfam has had discussions with the district and sub-county top management, with a view to clarifying the support Oxfam is ready to offer to the relevant district departments and to deliver it in a more structured and consistent way.

2.3 CONSISTENCY WITH POLICIES AND COMMUNITY NEEDS

The project has been appropriate with respect to the needs of the affected population, Oxfam's mandate and policies, as well as national policies.

2.3.1 NEEDS OF THE AFFECTED POPULATION:

Oxfam's approach was flexible reflecting the fluctuations in population movements in Kitgum. Public health services were delivered in the main IDP camps, transit camps as well as in the villages of origin as the population moved. In addition, Oxfam combined the provision of water supply with hygiene and sanitation promotion services to provide a total package. This has achieved observable impact in the affected communities.

2.3.2 OXFAM'S MANDATE AND POLICIES:

Oxfam has worked in Uganda since 1963. During this time it has been involved in a variety of both development and humanitarian programmes with a focus on the rural poor and most disadvantaged



communities. This has included work in; public health, education, livelihoods (including pastoralist development), land rights, trade, and voice and accountability.

Oxfam began working in Kitgum in 1988 with programmes in relief item distribution (including cash for work), water and sanitation, shelter construction, malaria prevention and food security/livelihoods. When, in June 2002, the security situation deteriorated dramatically Oxfam operated for a period through a remote management structure. This utilized IDP camp residents who worked as facilitators and volunteers and a network of older women who reported back on the progress of implementation. Current programme activities in Kitgum include Public Health and Livelihoods interventions. Since October 2007 when the first case was recorded, Oxfam has played a major role in helping the District respond to the Hepatitis E epidemic.

2.3.3 NATIONAL POLICIES:

The PRDP: In October 2007 the GoU launched a three year Peace Recovery and Development Plan (PRDP) for northern Uganda. The PRDP has four strategic objectives: (1) consolidation of state authority, (2) rebuilding and empowering communities, (3) revitalisation of the northern economy and; (4) peace building and reconciliation. The indicative cost of programmes and activities covered by the PRDP has been put at US\$ 606 million. The Office of the Prime Minister (OPM) is responsible for the coordination of the PRDP.

The development of the PRDP has been widely welcomed both within Uganda and, more broadly, by Development Partners. Government has made it clear that it sees the PRDP as a coordination framework for all programmes and projects in northern Uganda and that off budget interventions such as Oxfam's Public Health in Transition Project can play a part in its programming.

The Parish Approach: From mid 2006 it became apparent that there were increasingly significant movements of people taking place away from the main camps to either smaller "satellite" camps at Parish level or, in a smaller number of cases, to original villages. While a welcome development as it reduced overcrowding in the main camps and enabled increasingly large numbers of people to access their land and recommence productive activity, it also created significant problems in terms of ensuring access to basic services such as health, education, safe water and sanitation. By July 2007 approximately 380 "satellite" locations existed in Acholi at Parish level in addition to the 120 main camps. UN agencies and NGO's came under increasing pressure from government and, to a certain extent, communities to make major inputs in these locations as well as the main camps. In early September 2007 the local Inter-Agency-Standing-Committee (IASC) met with the Office of the Prime Minister and agreed a strategy for an approach to transition in the war affected areas based on the provision of services at the Parish Level, in line with national standards, rather than at site specific locations in line with SPHERE standards. Core priorities under this approach include; access to health services, provision of basic education materials and infrastructure, provision of safe water, enhancement of civil administration, further development of the rule of law through continued deployment of police and judges, stimulation of livelihoods and opening of roads. The approach was endorsed by the Joint Monitoring Committee comprised of central Government, local Government, Donor, UN and NGO representatives.

Broadly, this approach informed the basis for Oxfam's programming in Kitgum. Oxfam scaled down operations from 45 parishes within the eight sub-counties it had been delivering services to 182 villages in 24 parishes.



Rural water and sanitation sector policy: Oxfam has broadly followed some key aspects of the rural water and sanitation sector policy. These include:

- ✓ **An integrated approach**—to management of the use of water resources, liquid and solid waste, safeguarding of health and protection of the environment.
- ✓ **A “package approach”** for rural water supply that not only includes construction and installation, but also all associated software aspects including community mobilization, community based planning and monitoring, hygiene education, gender awareness and capacity building at the user level required for continued use and sustainable operation
- ✓ **Coordination and collaboration**—of the major actors to agree and recognize a common approach, and for adoption of innovation and best practices
- ✓ **Private sector participation**—in the form of consultants and contractors in the design and management of facilities.

For this project aspects of sector policy that were found to be weak include:

- × **The need for a demand responsive approach**—in which users initiate the development of their water supply facility, contribute to the construction costs and manage the operation and maintenance of facilities.
- × **Financial viability**—of public utilities and sound financial practices, appropriate tariffs for capital costs, operation and maintenance

One reason for the above weaknesses is the continual application of the emergency policy and guidelines for certain aspects of implementation by Oxfam, although this is largely influenced by the external environment within which Oxfam operates.

Because of the improved security context, Oxfam and other agencies in the WASH Cluster, as well as the district technical officers believe that the mainstream rural water policy needs to be applied to the development of new water supply and sanitation facilities in return sites and in villages of origin. This will require more community sensitization and training. However, a resolution by the district council that requires agencies to deliver services in accordance with the emergency policy is still applied. It stipulates a more supply driven approach with no contribution by the beneficiary community.

In order to increase compliance to sector policy and guidelines, Oxfam is positioning itself to play a more active role in the water and sanitation sector at the district and nationally.



3 CONCLUSIONS AND RECOMMENDATIONS

3.1 CONCLUSIONS

3.1.1 STRENGTHS

Overall, the programme's flexibility has been effective in producing improvements in water supply coverage and in the containment of the Hepatitis E outbreak in return sites, villages of origin over the past one year. Focus on gender issues has facilitated settlement of returning populations. Coordination and information sharing at both district and sub-county level have been largely effective and national guidelines and policies have been applied. Oxfam GB's capacity in terms of staff, physical resources as well as financial and procurement systems have contributed to programme efficiency. Oxfam's adaptation to the rapidly changing environment is considered as an organizational strength.

3.1.2 WEAKNESSES

Arguably, the large geographical area strained the programme resources and undermined impact. The relationship with the district and sub-county technical officers has been inconsistent. Procurement and contract management especially at the community level was not always well organized. Some aspects of the Community Based Maintenance System (CBMS) were not incorporated into the project and the cascade public health promotion structure is no longer appropriate. Feedback from the field has not been consistently built into programme planning.

3.1.3 OPPORTUNITIES

Although still characterized as unstable, the security situation has improved significantly. In addition, communities hold Oxfam in high regard. Local government and agencies are supportive and appreciative of Oxfam's past work and there is a positive perception of Oxfam's capacity in terms of human and financial resources.

3.1.4 THREATS

The resourcing environment is in a state of flux. Emergency policy and guidelines are still being applied in many areas and communities still have a high dependency mindset.

3.2 RECOMMENDATIONS

The following recommendations have been made:

- a) Define a more manageable programme geographical area of operation. Ensure that stakeholders are aware of justification.
- b) Formalize relationship with the district local governments.
- c) In order to enhance sustainability of installed facilities and practices, additional community level training and monitoring will be required
- d) Expand the analysis of water quality monitoring results to assist predict disease outbreaks and promote behavior change.
- e) Engage with the efforts to find a solution to the emptying of latrines in institutions
- f) Assess the impact of hygiene and sanitation promotion with a view to refining training methods and promotion messages in order to close the gap between knowledge and practice at the community level.
- g) Devise appropriate strategy for the phase out of public health cascade structure
- h) Refine procedures for more effective management of small community based contracts



REFERENCE

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