

MAXIMIZING THE BENEFITS FROM WATER AND ENVIRONMENTAL SANITATION

**Rapid Sanitation Uptake in the  
Internally Displaced People Camps of Northern Uganda  
through Community Health Clubs**

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*One of the worst humanitarian disasters in the world is currently taking place in Northern Uganda where 89% of the population in Gulu District now live in 33 Internally Displaced People's (IDP) Camps, with low levels of home hygiene and only 5% sanitation coverage. A local NGO, Health Integrated Development Organization (HIDO), has started 116 Community Health Clubs in 15 IDPs camps, with 15,522 regular members who meet weekly for hygiene sessions. Within 4 months, health club members have constructed 8,504 latrines, 6,020 bath shelters, 3,372 drying racks, and 1,552 hand washing facilities, with an estimated 100,000 direct beneficiaries. The strategy has been based on the A.H.E.A.D Community Health Club Approach using participatory PHAST training tools, and may provide a cost-effective model for future IDP emergency sanitation programs.*

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**Background**

For the last 18 years, Northern Uganda has suffered from a violent rebel insurgency forcing 1.6 million people to leave their homes and seek protection in Internally Displaced Peoples Camps (IDP) organized by the Government in vicinity of the main towns where they are guarded by the army. In Gulu District, this displacement accounts for 89% of the population in 33 IDP camps all of which have between 15,000 people, and the largest at Pabbo having 68,000. These temporary settlements are badly congested, and with scarcity of basic sanitary facilities, shortage of water, poor drainage and poor hygiene have led to a exceptionally poor health conditions in the IDP camps, with high levels of malaria and diarrhoea. This was demonstrated last year when there was an outbreak of cholera in Pabbo, where it was found that all the boreholes and samples of drinking water from homes were contaminated.

Health Integrated Development Organization (HIDO) is an indigenous organization recently started in Gulu District, formed by a group of dedicated graduate Clinicians and Health Assistants. With support from CARE International in Uganda, (funded by the Bill and Melinda Gates Foundation), HIDO is

carrying out health promotion with focus on hygiene in 15 of the 33 IDP camps in Gulu District .The targets set by CARE International in these 15 IDP

camps were high, aiming to provide 120,000 people with health promotion and build 10,000 latrines within a six month Emergency Programme. By any standards this is a challenge, but particularly in this area where the communities are traumatized, fragmented and have developed a strong dependency on donor assistance. To address these social constraints within a short time frame the AHEAD methodology using Community Health Clubs (CHCs) was used. as it had proved its effectiveness in other countries in terms of building community cohesion and demand led sanitation (Waterkeyn 2001, 2003, & Cairncross 2005).

By using Community Health Clubs of between 70-150 people, it is possible to effect a rapid transfer of information and improve home hygiene practices, using peer pressure and the development of a 'Culture of Health' (Waterkeyn, 1999). The design also incorporated local approaches to health promotion, adapting the standard Participatory Hygiene and Sanitation Transformation (PHAST) methodology, which had been used in Uganda during the 1990's. This is the first time in Uganda, that the PHAST participatory training methodology has been combined within the structure of a health club, providing regular reinforcement and targets.

**Implementation**

In the past four months HIDO has formed 116 CHCs having a total enrolment of 15,522 members, which accounts for 42% of the 36,138 households within

the programme area, and approximately 100,000 direct beneficiaries. The broad objective of the NGO is to improve the health status of people living in the selected 15 IDP camps in Gulu District by reducing the prevalence of communicable diseases. The specific objectives are to conduct health sessions to members in CHCs on a weekly basis and to monitor households for impact of health education, as indicated by changes of hygiene behaviour and improved facilities such as drying racks, bathing shelters, and wash hand facilities.

### **Training**

In October 2004, a set of illustrated cards on basic topics (safe water chain, safe food chain, sanitation ladder, malaria, bilharzia, worms and skin diseases) was developed from a combination and adaptation of existing materials (GoU-Ministry of Health, WaterAid, and Zimbabwe AHEAD Organisation) to provide the participatory tools needed for the trainers, who were trained in the AHEAD and PHAST Methodology in the following month.

### **Mobilisation**

In January, 2005, HIDO field staff moved to their posts within the 15 camps and have integrated well with the people becoming valued members of the IDP leadership. Despite fears that CHCs would create a parallel structure that would overload women, and undermine existing camp leadership, this has not been an issue. One strong indicator of the success of their mobilization is that they have managed to maintain the number of CHC members despite the fact it is the rainy season, when it is normally difficult to attract people, as they are busy in the fields. During the dry season meetings take place under the shade of large trees, but in the rains there is seldom a large roofed area sufficient for a meeting place. However despite the fact that the torrential rains make attending meetings uncomfortable, the membership has not fallen away. The trainers started up at least 5 community health clubs each, with a minimum of 100 members per club (500 members per trainer). Working in tandem with the sanitation committee in each camp and existing leadership, the people were successfully mobilized using drama presentations produced by a local group, to attract the crowds and encourage future members to join. Membership cards were also popular with the new recruits, as this was taken as an indication of the seriousness of the programme as they could see the topics to be covered and plan to attend. They also enjoyed it as an identity card.

### **Health Promotion Sessions**

By May 2005, all the clubs had completed 16 out of the 20 topics to be covered (as listed in the cards) and the community was rapidly implementing the many recommended activities. The PHAST training method has been enthusiastically received by the community and activities such as Blocking the Route and Three Pile Sorting have captured their attention and enabled them to participate easily in problem-solving activities so helping them, as a group, to identify their own resources, and make plans to upgrade their own facilities.

The only incentive was the donation of a cement sanplat, for those who had dug their latrine pits. In addition the fast adapters were rewarded with (ITN) mosquito nets and poly sanplats, and this provided added stimulation. The only other incentive to join the club is the attainment of a certificate if all 20 sessions are completed.

### **Home Hygiene**

To-date most of the health clubs have completed 16 out of their mandatory 20 hygiene sessions. From January to May there were a total of 1,560 health sessions held with an average of 15 topics covered by each trainer at each of the five clubs for which he/she is responsible.

The number of drying racks for the safe storage of kitchen utensils has also increased significantly but again, there is still a wide disparity between areas. In Paicho and Coope there is an over-coverage of 159% and 146%, again indicating a spill over to non club members, who are emulating the latest fashion in kitchen practice. With the lack of space, the problem of thieves stealing crockery, and roaming livestock destroying drying racks, it has been difficult in the IDP camps, but the CHC members have still adopted this recommendation with 2791 of the 4480 new drying racks being built inside the kitchen hut.

Bathing shelters have also proved popular with 6,062 being constructed in 4 months, of which Opit has 1,544, and Ongako with 1,133 have 68% and 77% coverage respectively. Eight camps already have over 55% coverage of health club members whose homes now have a bathing shelter with proper drainage and soak pits, which will improve the poor drainage system for grey water in IDP camps.

## Behaviour Change

It is evident that the method of using group cohesion and peer pressure to adjust hygiene behaviour to minimize risk practices is effective. Changes are taking place in methods of water and food storage and usage, as well as hand-washing with soap, and basic personal and home hygiene improvements. Although the project has only been going for four months, preliminary findings appear to be outstanding, and this will be researched more rigorously when a post intervention survey is undertaken later in the year which will be compared to the base line done in December 2004.

Although the target was to start 120 health clubs (100 members per club), the number of members has been exceeded and there are an average of 134 members per club, with a total of 15,522. In some cases trainers have had to split their larger clubs and cannot meet the full demand for health sessions. The target was to involve 50% of the total number of households in each of these camps and although only 42% are currently involved, this should increase in the next few months.

## Latrine Construction

In an effort to reach the high target of 10,000 latrines it was planned that sanplat production centres would be set up in each camp to produce a total of at least 6,000 cement sanplats within six months. The programme has also piloted the use of ready-made polysanplats for the balance of 4,000 remaining latrines which are given as an incentive to the fast adapters in order to speed up the programme. After only 4 months, 8,583 latrines have been constructed and of these 1,387 have poly sanplats. There are also 1,735 pits ready which means the target of building 10,000 latrines will be surpassed within six months.

Fifteen Sanitation CBOs have been trained to manufacture cement sanplats which are then brought by CARE and distributed back to the members, so providing an income locally. Sanitation coverage varies between camps, due less to the enthusiasm of the health club members or the ability of the trainer, but to logistical problems, such as keeping some of the more remote camps supplied with cement. In Opit, (which is being newly resettled with the overflow of people from Pabbo) 2,280 health club members have built 2,723 latrines in the

last three months. This is encouraging as it shows there is a spill over involving non club members in sanitation improvements. As latrines are built in blocks over a trench, with between two to six stances, many non-club members will be brought into the programme as neighbours to share resources, regardless if they are in the health clubs as regular members. Similarly in Palenga and Bobi Camps, sanitation has covered all registered club members and 8 camps are already well over the targeted 50% coverage of health club members.

## New Technology for Emergency Sanitation

For an emergency sanitation programme the new design of poly sanplat, (tried out for the first time in this programme) is proving ideal in terms of instantly sealing latrines: it is made of strong, light-weight polyfibre, and can be delivered in bulk, obviating the time-consuming task of training communities to make cement sanplats, as well as the difficulty of transporting, storing and accounting for cement. In addition it has a cleanable, plastic finish which enables proper hygiene, unlike home-made sanplats, with a rough cement finish which are frequently urine-stained, faecal-contaminated, foul smelling and attract flies. Cement designs are also seldom found with lids, and if they are, these tend to be ill-fitting or have handles that are faecal-contaminated. By contrast, the polyfibre sanplat has a well fitting manufactured lid operated by foot, so that there is little cross contamination from dirty hands. This foot-operated cover is being tried out for the first time in this project, and has been accepted by the community. In this project it has been supplied alongside the cement sanplat, which is a cheaper but less effective hygiene option.

## Appeal to Scale Up

The situation in the IDP Camps has been largely neglected for the past 18 years, and their plight was recently cited (UNHCR) as currently the worse humanitarian disaster in the world today. We hope that our concern over the appalling sanitation situation in the IDP camps may help bring this situation to light and that this case study will indeed catch the imagination of agencies and government who are welcome to visit and verify these claims. There has been enough debate over **how** to tackle this issue, and now that it is clear that **sanitation conditions can be rapidly improved** we hope that this cost-effective pilot project may be **taken to scale** by Government of Uganda and other genuinely

concerned Agencies, to ease the suffering of the people of Northern Uganda.

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**Table 1. Number of Households, Health Clubs and Members and % achievement of recommended practices already undertaken by health club members in 15 IDP Camps achieved in 4 months (2005)**

IDP CAMP	H/hlds	CHCs	CHC Members	Health sessions	Latrines complete	D/racks built	B/shelter	HWF
Bobi	3,460	10	786 (22%)	145 (75%)	817 (103%)	530 (67%)	525 (66%)	34 (4%)
Palenga	2,450	10	781 (32%)	160 (80%)	790 (101%)	431 (55%)	428 (55%)	356 (47%)
Abili	1,816	5	743 (40%)	80 (80%)	203 (27%)	371 (50%)	124 (16%)	435 (58%)
Lapainat	1,852	5	659 (35%)	80 (80%)	438 (66%)	580 (88%)	512 (77%)	184 (28%)
Ongako	2,166	10	1,522 (70%)	160 (80%)	1060 (70%)	1003 (66%)	1133 (74%)	122 (8%)
Lacor	1,403	5	821 (58%)	80 (80%)	265 (32%)	286 (35%)	126 (15%)	187 (23%)
Keyo	1,216	5	804 (66%)	80 (80%)	312 (38%)	16 (1%)	?	?
Awer	2,763	6	1090 (39%)	70 (70%)	?	?	?	?
Pagak	2,051	5	498 (24%)	80 (80%)	390 (78%)	162 (33%)	328 (66%)	73 (15%)
Pabbo	10,893*	10	1328 (12%)	155 (75%)	587 (44%)	391 (29%)	?	?
Coope	4,089	10	980 (23%)	160 (80%)	646 (66%)	1435 (146%)	218 (22%)	94 (9%)
Paicho	2,864	5	878 (30%)	165 (85%)	693 (79%)	140 (159%)	549 (63%)	39 (4%)
Teyapadola	1,427	5	781 (54%)	75 (60%)	9 (1%)	?	?	?
Opit	7,601	15	2280 (29%)	240 (80%)	2,723 (119%)	820 (36%)	1544 (68%)	10 (1%)
Lalogi	3,743	5	871 (23%)	75 (75%)	558 (26%)	251 (29%)	533 (61%)	18 (2%)
<b>TOTAL/ Average</b>	<b>36,138</b>	<b>116</b>	<b>15,522 (42%)</b>	<b>1650 (80%)</b>	<b>8,583 (65%)</b>	<b>3372 (61%)</b>	<b>6020 (47%)</b>	<b>1,552</b>

NB. Percentages indicate level of coverage of club members; e.g. # latrines completed/ # number of health club members



A session in one of the 116 Health Clubs in which over 15,000 members each week learn about hygiene  
(photo J.Waterkeyn)