

SOUTHWEST INTEGRATED HEALTH & WATER PROGRAMME

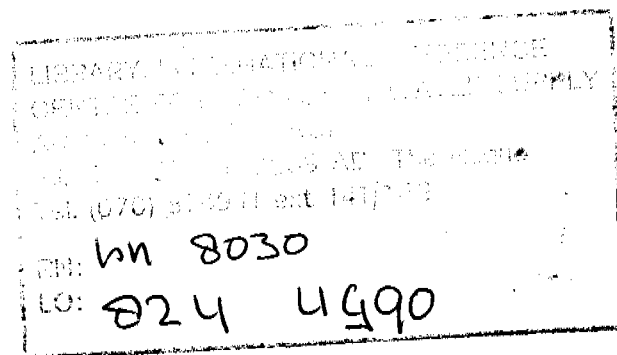
SWIP

MID TERM EVALUATION REPORT

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November 1990

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ABBREVIATIONS AND ACRONYMS

CBHC	-	Community-based health care
CBMS	-	Community-based maintenance system
CDO	-	Community Development Officer
CHW	-	Community health worker
CIDA	-	Canadian International Development Agency
DANIDA	-	Danish International Development Agency
DMS	-	Director of Medical Services
DPO	-	District based Project Officer
IMSC	-	Inter-Ministerial Steering Committee
MLG	-	Ministry of Local Government
HOF	-	Ministry of Finance
MOH	-	Ministry of Health
MPED	-	Ministry of Planning and Economic Development
MWID	-	Ministry of Women in Development
MAMD	-	Ministry of Water and Mineral Development
NGO	-	Non-governmental organization
PHC	-	Primary health care
PS	-	Permanent Secretary
RC	-	Resistance Committee/Resistance Council
RUMASA	-	Rural Water and Sanitation East Uganda Project
SIDA	-	Swedish International Development Authority
SWIP	-	Southwest Integrated Health and Water Programme
TBA	-	Traditional birth attendant
UCBHCA	-	Uganda Community Based Health Care Association
UNDP	-	United Nations Development Programme
UNICEF	-	United Nations Children's Fund
UNV	-	United Nations Volunteer
VIP	-	Ventilated improved pit (latrine)
VHC	-	Village health committee
WDD	-	Water Development Department
WHO	-	World Health Organization
WID	-	Women in development
WSC	-	Water source committee

ACKNOWLEDGEMENTS

The Evaluation Team would like to express its appreciation and gratitude to all who provided help and advice during the mid-term evaluation of the Southwest Integrated Health and Water Programme (SWIP). Without this assistance, completion of the assignment within the short time available would have been impossible.

Many people deserve thanks and recognition for their efforts. It is not possible to mention each and every one, and the Team hopes it can be forgiven for not doing so.

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At national and district levels, the Team would like to thank the officials of the Ministries of Local Government, Health, and Water and Mineral Development, the District Administration officials at Kabele, Rukungiri, Bushenyi, Kasese and Mbarara Districts, and the project officers at UNICEF for their cooperation, comments and opinions.

Lastly, the Team would like to give its very special thanks to the SWIP Team -- Dr. John Ndiku, Programme Manager, Dr. Jan van der Horst, Programme Coordinator, the rest of the SWIP management team and the support staff of the SWIP Mbarara office, especially the drivers and secretaries on whom the Team depended so much. The help, information and assistance they provided during the Team's stay in Mbarara, combined with the positive spirit of cooperation in exchanging information and viewpoints, was appreciated by all Evaluation Team members.

TABLE OF CONTENTS

	<u>PAGE</u>
Map of Uganda	1
Abbreviations and Acronyms	2
Acknowledgements	3
Table of Contents	4
Executive Summary	5
<u>PART I -- SWIP PROGRAMME EVALUATION:</u>	
Chapter 1. Introduction	8
1.1 Background	8
1.2 Members of Evaluation Team	8
1.3 Scope of Work	8
1.4 Approach and Methodology	9
1.5 The Evaluation as a Learning Exercise	11
1.6 Report Concept	11
1.7 Boxed Text	12
Chapter 2. The Southwest Integrated Health and Water Programme	13
2.1 Historical Development	13
2.2 What is SWIP Today?	13
2.3 Major Achievements	15
2.4 SWIP 1990-1995 in Brief	15
2.5 Expenditures on SWIP to Date	17
Chapter 3. Findings	19
3.1 Introduction	19
3.2 General Remarks	19
3.3 Findings Relating to Implementation to Date	20
3.4 Findings Relating SWIP and its Operating Environment	21
Chapter 4. Recommendations	25
4.1 Introduction	25
4.2 Recommendations	25
<u>PART II -- PROJECT EVALUATIONS:</u>	
Chapter 5. Water and Sanitation -- Achievements and Output	32
5.1 Project Description	32
5.2 Achievements	33
5.3 Targets and Output	34
5.4 Inputs	38
5.5 Expansion of SWIP to Masaka and Rakai Districts	40
Chapter 6. Water and Sanitation -- Findings, Lessons Learned and Recommendations	41
6.1 Introduction	41
6.2 General Findings and Recommendations	41
6.3 Specific Findings and Recommendations	42
Chapter 7. Community-Based Health Care	47
7.1 Introduction	47
7.2 Objectives and Targets	47
7.3 Training Activities	47
7.4 Findings	48
7.5 Lessons	49
7.6 Conclusions	49
7.7 Recommendations	49
Appendices	
A. Terms of Reference and Itinerary	
B. List of Persons Met	

EXECUTIVE SUMMARY

During three years of implementation, SWIP -- the Southwest Integrated Health and Water Programme -- has developed from a water provision project to a community development programme aimed at improved health through an integrated approach. Among SWIP's major achievements to date are:

- * Provision of water to a rural population of almost 600,000 people in five districts in southwestern Uganda.
- * Introduction of a community-based maintenance system for installed water points and pumps that enables the community to take responsibility for care and repair.
- * Development of a large Government community-based health care project, covering a population of about 150,000 people living in the programme area.
- * Creating a strategy for social mobilization that aims at community self-reliance regarding preventive health and water supply through extensive training.

SOUTHWEST INTEGRATED HEALTH AND WATER PROGRAMME

SWIP started in 1987 in Mbarara district to respond to reconstruction needs after the war. The Programme has an integrated approach to development, using clean water in the community as an entry point to long-term improvements in health. Self-reliance is an important concept of the Programme, with project elements focusing not only on water and sanitation and necessary mobilization and training, but also community-based health care and community-based maintenance of the water source. SWIP implementation is assisted by UNICEF and supported financially by the Swedish International Development Authority (SIDA) and the Canadian International Development Agency (CIDA).

FINDINGS AND CONCLUSIONS

SWIP is a well established and well accepted programme. Contacts with district officials have been established, physical infrastructure is in place, there is an enthusiastic team of Government, project-supported and UNICEF staff, routines exist, activities are being planned and implemented, supplies are being ordered and received, people are being trained, and communities are being assisted.

As with any set of development projects, there are implementational problems and a number of constraints, but nothing insurmountable or life-threatening. Improvements can be made with respect to activities under way, strategies, overall programme management, supervision and monitoring, but the SWIP approach is basically sound and SWIP functions.

General areas where improvement can be suggested are (1) better communication and collaboration at and within all levels, (2) increased emphasis on objectives-orientation rather than activities-orientation, and (3) need to make a full transition over to a long-term development programme that includes sustainability, replicability, capacity-building and gradual donor phase-out objectives.

RECOMMENDATIONS

Recommendations for improvement included in this report are grouped according to "key issues" that were identified early in the evaluation process. These key issues are considered important for planning, project implementation and long-term sustainability. By grouping the recommendations by issue, it was hoped that equal emphasis could be placed on SWIP as a programme, and SWIP within the larger environment in which it operates. It is also hoped that the tendency to "compartmentalize" recommendations strictly by sector or by project could be avoided.

Two areas under which many recommendations are grouped are

- * Integration, Collaboration, Coordination
- * Sustainability, Replicability, Affordability, Integration, Capacity-Building, Community Participation,

which again stresses the importance of communication, partnership and responsibility-sharing in integrated development cooperation programmes.

As SWIP takes action on the recommendations it can do something about, so should those who can influence the enabling environment that surrounds SWIP also work for change. In this partnership, the maximum potential of SWIP be reached.

Note: Detailed technical recommendations are included in Chapters 6 and 7 of Part II of this report.

EVALUATION WITH FOCUS ON LEARNING AND THE FUTURE

This report presents the findings, conclusions and recommendations of the mid-term evaluation of SWIP that was carried out during the period 12-30 November 1990. The Evaluation Team was a combined national-international team representing the Government of Uganda, SWIP, CIDA and SIDA. The Evaluation Team consisted of seven men and one woman.

The evaluation was conducted as a review of experiences from three years of field implementation, but also intended very much as a timely opportunity to look at ways in which future programme activities could be strengthened.

Throughout the exercise, the Evaluation Team tried to accommodate the SWIP Management Team's hope that the evaluation could be "a learning experience with focus on the future" for them. Regular interaction between both the Evaluation and SWIP Management Teams, joint participation during field visits, and combined working sessions where issues of importance to implementors could be addressed were thus given high priority in the scheduling and carrying out of work.

Main evaluation objectives, as stated in the terms of reference, were to (1) review SWIP performance, (2) document achievements and shortcomings, and (3) to suggest appropriate programme improvements related to such areas as integration of health, water and sanitation activities; community participation; affordability, sustainability and replicability; inter-sectoral cooperation; collaboration with other projects in the area; and opportunities for integration and cooperation at district-level and below.

In both the evaluation and this report, the Evaluation Team has looked at SWIP in two contexts: SWIP as a programme of activities, and SWIP as a unit operating within and relating to a larger "enabling environment".

Boxed text is included throughout the document to provide a perspective into how development is practised and perceived in the programme area.

ISSUE: INVOLVEMENT OF WOMEN

We got together (two men and one woman) to discuss how more women can become involved in SWIP at all levels. The starting point was that women are the most important target group for the project as they are the providers of food and water and take care of the children in the family. The heavy workload of women was acknowledged in the discussion on income-generating activities as we feared that these could put an extra burden on women.

First we looked at what SWIP can do to foster greater participation by women in the programme. We thought that women's participation in SWIP should be institutionalized at all levels of the programme and that realistic targets should be set. In the planning process the concerns of women should always be considered and plans should be made on how to facilitate the participation of women, for example by having meetings and training courses at times and places that suit women. We felt that SWIP has an advocacy role towards men on women's issues, especially concerning women's health and heavy workload. Maybe it is possible to use men's concerns about their children's health as an entry point for safe motherhood issues.

SWIP can promote the participation of women by strengthening district capacity to analyze the situation of women through gender-awareness training and assistance with the collection and analysis of data. SWIP can also promote technologies that reduces the workload of women. An example that came up during the discussion was to build wheelbarrows that could be used by men for collecting water and firewood. As the education of women is especially important for the health of their children and since women need an income for greater self-reliance, SWIP could support other agencies interested in starting literacy training and income-generating activities in the area.

PART I

SWIP PROGRAMME

EVALUATION

Chapter 1

INTRODUCTION

1.1 BACKGROUND

The UNICEF-Uganda Country Programme 1990-95 provides for a mid-term evaluation of the Southwest Integrated Health and Water Programme (SWIP or the Programme) in late 1990. The evaluation is intended to serve both as a review of experiences from three years of field implementation and an opportunity to improve future Programme activities.

The present status of the Programme is stated in the terms of reference for the evaluation:

"The programme is in transition because most technical "hardware" components, such as borehole drilling and pump replacement, are likely to be over by early 1991 in four out of five Districts. Much more intensified activities will then focus on the "software" components, such as follow-up support and community mobilization/education, so that more communities are organized to be active in the prevention of disease, promotion of health, maintenance of water sources and to ensure sustainability in all programme activities."

The planned evaluation was carried out during the period 12-30 November 1990. This report presents the findings and recommendations from that exercise.

1.2 MEMBERS OF EVALUATION TEAM

The SWIP evaluation was performed by an eight member interdisciplinary team of consultants engaged by SIDA and CIDA (the two major donors to the programme), senior Government officials and a consultant engaged by SWIP. Members of the Evaluation Team are presented in Table 1.1.

1.3 SCOPE OF WORK

The overall objectives of the evaluation were:

- to review SWIP's performance,
- to document SWIP's achievements and shortcomings, and
- to suggest appropriate programme improvements related to such areas as integration of health, water and sanitation activities; community participation; affordability, sustainability and replicability; inter-sectoral cooperation; collaboration with other projects in the area; and opportunities for integration and cooperation at district-level and below.

The full terms of reference and the itinerary for the evaluation are included in Appendix A. A list of persons met is provided in Appendix B.

Table 1.1. SWIP Evaluation Team

Individual	Agency	Position/Organization/Country
Mr. Clifford Wang	SIDA	Consultant (Water and Sanitation), Norconsult, Norway, and Team Leader
Ms. Marianne Erge	SIDA	Freelance Consultant (Information-Education-Communications), Sweden
Dr. Nana Enyiasyew	SWIP	Regional Director of Health Services (Volta Region), Ministry of Health, Ghana
Dr. George W. Imani	MLG	Director of Rural & Urban Health Services, Ministry of Local Government (MLG), Uganda, and Deputy Team Leader
Dr. Joseph Kyabaggu	MON	Deputy Director of Medical Services (Public Health), Ministry of Health (MON), Uganda
Mr. Simon Mugayo	MDD/MMD	Deputy Director of Drilling, Water Development Department (MDD), Ministry of Water and Mineral Development (MMD), Uganda
Mr. Martin Poulin	CIDA	Consultant (Hydrogeology), ADS, Canada
Mr. Philip Wabulya	MPED	Senior Lecturer, Department of Social Work and Social Administration, Makerere University, Uganda

1.4 APPROACH AND METHODOLOGY

1.4.1 General

In selecting a general approach to be followed, the Evaluation Team chose to put greater emphasis on objectives than activities and on the future rather than the past wherever possible.

During initial team-building, the Team concluded that when considering the overall complexity of the Programme (which includes seven projects), the number of activities underway, and the important inter-relationships between various projects and their components, it would help to structure analysis of approaches and activities within a general framework. The Team thus defined a matrix cross-linking "key issues" against the main SWIP projects, shown in Figure 1.A.

Figure 1.A. Matrix of Key Issues and SWIP Projects

KEY ISSUE \ SWIP PROJECT CATEGORY	Community-Based Health Care	Social Mobilization	Water/Sanitation
Human Resources Development
Project Design
Integration
Collaboration & Coordination
Community Participation
Situation of Women
Capacity-Building
Sustainability
Replicability
Affordability
Environment

1.4.2 Basic Groupings of SWIP Projects

For purposes of organizing an evaluation methodology, the Evaluation Team grouped the seven SWIP projects under three basic groupings, each of which is briefly described below.

Community-Based Health Care (CBHC) Project

CBHC is basically a strategy to enable a community to care for its own health and to work together for development. CBHC in SWIP is carried out as a programme of training local trainers to train abahwezi (unpaid community health workers) and traditional birth attendants (TBAs) in the community to spread knowledge of how to prevent diseases and act as agents of change for development.

Social Mobilization Project

In SWIP, a process of social mobilization is supposed to precede water development activities to create awareness as regards health, as well as a sense of "ownership" of the water point by the community, which then should lead to continued maintenance over the long-run. Social mobilization is carried out at meetings at district and different community levels to spread information and involve beneficiaries in planning and implementation of activities. Social mobilization is also carried out in the form of training community leaders, extension staff, Water Source Committee members, pump mechanics and caretakers to spread basic health messages in the communities.

Water and Sanitation Projects

The water development programme provides community water supplies in the form of drilled boreholes, rehabilitated boreholes, protected springs and gravity schemes. Social mobilization carried out beforehand is intended to help the community prepare itself to take over and maintain the completed installation. A community-based maintenance system (CBMS) is a part of water development activities.

The basic health messages used in all SWIP training courses concern sanitation and hygienic practices. The sanitation project of SWIP involves casting of latrine slabs for sale at subsidized cost and construction of demonstration ventilated improved pit latrines.

1.4.3 Key Issues

Short definitions of the key issues as meant by the Evaluation Team are provided below.

Human Resources Development (HRD)

A broad concept encompassing but more far-reaching than training. HRD is the combination of training as an activity and the larger environment in which training is conducted, i.e. training plus planning plus management. HRD is closely linked with capacity-building and institution-strengthening.

Project Design

The guiding framework and overall essence of the project. Project design comprises objectives, expected outcomes, activities, inputs, key assumptions, and monitoring indicators and their means of verification. A good project design defines the strategy for implementation and project approaches to be followed.

Integration

The linking together of health, water and community mobilization activities in an effective manner for the purpose of achieving sustainable results. Integration also implies merging of SWIP components with existing and ongoing activities of participating ministries and other formally-established organizations.

Collaboration and Coordination

The underlying basis of an integrated approach. How well both collaboration and coordination are perceived and practiced by central, district and community-level actors in planning and implementation affects the harmony and spirit of cooperation in the project. Means for coordination include regular meetings, usable reporting systems and good personal interactions at different levels, all of which contribute to good collaboration.

Community Participation

The meaningful participation of end users in decision-making, planning, implementation, responsibility-sharing and follow-up activities. Community participation is more than the contribution of labor and materials during construction. Meaningful participation is prerequisite to sense of "ownership" of facilities, an important ingredient of sustainability.

Situation of Women

A situation to be improved. Women constitute more than 50 percent of the community; they should be as equally involved as men in planning and implementing projects that affect them. This is especially important in water and health projects where women are the fetchers of water and the caretakers of children. A water/health project where men are the dominating planners and implementors cannot be said to have community participation.

Capacity-Building

What the project does to contribute to building up of institutions and people so they can take over the planning and implementation of projects as external support is phased out. Both strong in-country institutions and capable human resources are essential to project sustainability and replicability.

Sustainability

The ability of the project to survive. Sustainability requires that institutions, organized groups and individuals have the knowledge, capabilities, resources and financial means to keep a facility they value operating and maintained over the long-term. Sustainability is the true test of whether a project has impact and is a success.

Replicability

The ability to be initiated elsewhere under reasonably similar conditions. Replicability implies appropriate, affordable technology, felt need, a valued product or service, and efficient use of available resources.

Affordability

Concerns the abilities of implementors and end users to pay for what they do, install or receive. If neither implementor nor end user can afford these costs, then project outputs can neither be replicable nor sustainable.

Environment

A broad term that can relate either to protection and management of natural resources, or creation and maintenance of a better socio-economic, people-oriented setting. Both meanings of the word are applicable in integrated water and health projects.

1.5 THE EVALUATION AS A LEARNING EXERCISE

Though the evaluation was conducted as a formal exercise, the Evaluation Team considered it important to try to fulfill the hope of SWIP Management Team members that the exercise could also be "a learning experience with focus on the future" for them. Interaction between both teams, joint participation during field visits, and combined working sessions to discuss "difficult" issues were thus given high priority in the scheduling and carrying out of work.

1.6 REPORT CONCEPT

The Evaluation Team has tried to prepare a document that can be used as "an essential resource document for improving future programme implementation". Recognizing that different audiences having different interests and requirements on level of detail will read this report, it was felt useful to divide it into two parts:

Part I: SWIP Programme Evaluation, which deals with SWIP on a programme level.

Part II: Project Evaluations:

Water and Sanitation, two chapters that deal specifically with the four water and one sanitation projects included under the Programme (Borehole Drilling, Gravity flow Schemes, Handpump Replacement, Spring Protection and Sanitation) in technical detail.

Community-Based Health Care, which deals specifically with CBHC activities.

Part I, contained in Chapters 1 through 4, has as its primary target audience the policy-makers, planners and implementors who interact with SWIP as an integrated health and water programme. Typically, they might be SWIP Management Team members, UNICEF programme/project officers, senior-level officials of implementing and cooperating ministries, and donor project officers and policy-makers. The emphasis is on broad programme-related issues rather than detailed specifics.

Part II -- Water and Sanitation, contained in Chapters 5 and 6, has as its primary target audience the managers and implementors who interact with SWIP more in a water or sanitation technical capacity. Typically, these persons might be SWIP Management Team members and technical officers, UNICEF technical and project officers, technical officers of the implementing ministry, and donor project officers. The emphasis is more related to technical implementation procedures and practices.

Part II -- Community-Based Health Care, in Chapter 7, has as its primary target audience all those who are interested in a more detailed analysis and assessment of CBHC activities carried out under SWIP.

1.7 BOXED TEXT

Health improvement and water development are people-oriented processes. So as not to lose sight of the human perspective, two types of boxed text have been added to this document:

- (1) "Profiles" based on interviews with people involved in the development process, and
- (2) "Issues" that show how issues of concern can be addressed in constructive group settings.

The boxes hopefully provide "slices of life" to illustrate how development is practised and perceived in the Programme area.

As explanatory notes to the boxed text:

- In "Profiles", "we" means a few members from the Evaluation and SWIP Management Teams, and accompanying District staff.
- In "Issues", "we" means a small or large group of Evaluation and SWIP Management Team members working together using visualization and objectives-oriented techniques.
- As background to "Issues" group work, sessions were generally short in duration. The intention of these "short-impulse" sessions was not to develop a final solution to the problem, but rather to systematically brainstorm forth ideas, stimulate thoughts and develop a general approach for going further.

PROFILE: Training of CBHC Trainers in Ndeija

The rain was poring down when we reached the community hall in Ndeija, where people from three communities were being trained as trainers of abahwezi (unpaid CHWs) in their own communities. They were mostly men -- teachers, carpenters and masons by profession. Three women were present. All were housewives who had brought their babies, and some older children who could play with them outside between feeding hours. Some of the participants had been invited from sister organisations that worked with CBHC.

We came unannounced and luckily (for us) it was raining. Otherwise the group had planned to be out in the field. The head trainer, Nancy Serebe, started the day's programme with a session on how to plan a training course.

The trainers were in their third course. Each course is one week, carried out with a couple of months in-between to allow trainees to practice and give feedback to their instructors when they meet again.

Around the walls were large sheets of paper showing topics for discussion during the week. The training was done in a participatory way -- lots of group discussions, role-playing and warm-up exercises. Nancy was assisted by Jolly Barigye and Frances Masuna from the Uganda CBHC Association in Entebbe.

At the the tea break we asked the participants why they wanted to become trainers. "Because I wanted to help people in my community", answered one man. "We have learned that people die of ignorance. So I wanted to learn and help them", added another.

We also asked why there were so few women in the course. Nancy answered that it was their workload and the cultural values that keep them at home. She believed that man must be educated on the role of women in development and that women must believe that they have a value and are not "just housewives", as expressed by one of participants.

But the situation has improved. When SWIP started three years ago it was impossible to find women who wanted to train as trainers. Now there are seven. And in many village meetings there are now more women than men.

Chapter 2

THE SOUTHWEST INTEGRATED HEALTH AND WATER PROGRAMME

2.1 HISTORICAL DEVELOPMENT

SWIP started in Mbarara District in 1987 when drilling operations from the completed UNICEF-assisted Luero Emergency Water Project were moved to respond to reconstruction efforts after the war. A major consideration in selecting Mbarara District and the surrounding southwestern districts was security in the area.

SWIP's first phase, hereafter referred to as SWIP 1987-1990, is described in the document "Project Proposal and Plan of Operation, Integrated Project for Primary Health Care, Community Development, and Rural Water Supply and Sanitation in South-Western Uganda, July 1987-June 1990". SWIP 1987-1990 goals were ambitious, with coverage planned for five districts in the first three years and four more districts the following two years. The SWIP 1987-1990 plan introduced the integration of primary health care (PHC) and community development with water.

Even before SWIP 1987-1990 started, it was realized that resources available for PHC were insufficient, and also that it was not possible to reach the targets for water development. The plan was thus changed to limit work to two districts and make use of lessons learned before expanding into other areas.

The plan of operation was revised in 1988, as reflected in the document "Project Proposal and Plan of Operation, Integrated Project for Community Based Health Care, Community Mobilisation, and Rural Water Supply and Sanitation in South-Western Uganda, July 1987-June 1992". In this plan, targets were revised downwards. In SWIP 1987-1992, the concept of CBHC was introduced to replace PHC. Community/social mobilization replaced community development since it had been found that it was necessary to introduce community mobilization before drilling the boreholes to create a sense of ownership of the water point and an incentive for a functioning maintenance system. Experience from the first year of the project, when drilling was done without sufficient involvement of the beneficiaries, showed that communities were unwilling to take over maintenance responsibilities when they had not been involved from the beginning.

SWIP 1987-1992 was also a major attempt by Government to start CBHC projects. It was hoped a new approach would achieve better coverage than other types of CBHC projects being carried out by non-governmental organizations (NGOs). Efforts were initiated by calling all NGOs that had CBHC in their programmes together to discuss a common approach for the training of trainers, community health workers (CHWs), and traditional birth attendants (TBAs). Efforts were then coordinated so that all CBHC projects would use the same training curricula. A manual for training has since been drafted. Training of CHWs under SWIP began in 1989.

SWIP began in Mbarara District. Activities were extended to Bushenyi, Kabele, Rukungiri and Kasese Districts, in that order. Masaka and Rakai Districts are scheduled for start-up when extension of SWIP activities is considered appropriate.

An internal evaluation of SWIP was carried out in 1989, with focus on construction workmanship, standards of water source maintenance and retention of basic health messages by trained pump mechanics and caretakers. Findings and conclusions from that exercise were taken into consideration during development of the Uganda Country Programme 1990-1995. SWIP is now incorporated into the overall Country Programme, being included as an area-based programme, hereafter referred to as SWIP 1990-1995.

As far as planning and evaluation is concerned, it is important to note that each new plan incorporates, updates and extends the previous plan. For example, targets and budgets for the last three years of SWIP 1987-1992 are replaced by those indicated for years 1990, 1991 and 1992 of SWIP 1990-1995. In addition, it should be mentioned that targets indicated for the first years of each successive plan include all achievements completed since 1987 up to that point.

In the first two plans, SWIP was a "project". In the Uganda Country Programme 1990-1995, it became a "programme". "Programme" is therefore used throughout this report.

2.2 WHAT IS SWIP TODAY?

SWIP is a Government programme assisted by UNICEF and supported financially by the Swedish International Development Authority (SIDA) and the Canadian International Development Agency (CIDA). It is based on an integrated approach to development using clean water in the community as an entry point to long-term improvements in community health.

Problems with water in the southwestern part of Uganda vary in different parts of the area, sometimes being a question of water quality and sometimes a question of water quantity. When SWIP started up in 1987, service coverage in the area was below the national average. Women of the area sometimes have long walks to fetch water for their families from natural dams and springs. The time and energy spent doing so is time and energy taken away from care of children, other activities or just plain rest.

To date, SWIP has assisted in the provision of water to almost 600,000 people in the five-district Programme area. This has been accomplished through borehole drilling, rehabilitation of existing boreholes, protection of springs and construction of gravity schemes. SWIP is now considering expansion to two new districts.

The integrated approach used in SWIP relies on participation and cooperation between many collaborating partners -- Government ministries at national and district level, the District Administrations, the political Resistance Committee (RC) system, non-governmental organizations (NGOs) and other agencies. SWIP endeavors to coordinate development efforts for water and health through an inter-ministerial steering committee that meets twice a year, and collaborates with district staff in implementing the programme. At district level, SWIP activities are supposed to be coordinated through the District Medical Officer.

The SWIP "centre" is Mbarara, where main offices, workshops and stores are located. The staff of Government and UNICEF officers interact and cooperate in a friendly, enthusiastic manner working together on different components of the Programme. Government staff are provided housing within walking distance of the office.

Government believes in the SWIP approach of integrated development. It contributes counterpart funding and staff to the Programme as a commitment to long-term sustainability of programme efforts. As part of the development process, further resource inputs will be planned and budgeted for over time so that Government can progressively increase its share of contribution and responsibility in line with a gradual phasing out of donor assistance.

Now, when planning for expansion to new areas, is an opportune time to review experiences from three years of implementation, identify any weaknesses and act so that performance can be improved. For example, one area in which SWIP has so far not made enough progress is increased participation of women -- at village level, and even in relation to professional staff employed in Mbarara. Admittedly, the situation has improved, but activities need to be planned for. This is one way to help ensure that women are brought into decision-making and planning positions for development. Gender issues can be introduced into SWIP's training programme in such a way that both men and women are willing to support an equal participation of women -- in actions as well as words.

SWIP has its roots as a water supply project aimed at helping the country in its efforts to rebuild. With time has come the realization that mobilization, understanding and commitment are important parts of water development -- not only at village level, but district and national level too.

At community level, social mobilization, which involves all categories of people along the implementation line, has to precede the actual provision of water so that people feel the water "belongs" to them and has not just been given. The process of social mobilization involves education, creation of awareness and change of attitudes and behaviour; it has to be admitted that this requires much time and effort. Especially important are the follow-up and supervision of people who have been trained to help their communities in the care of their health or water source. The sense of ownership of the water source, which is developed through effective social mobilization is crucial to the success of the community-based maintenance system approach, another important SWIP component.

PROFILE: Meeting District-Level Field Staff in Rukungiri

Rukungiri has a population of 380,000 and is one of the areas where CBHC is being implemented. We met DPOs Margaret, Ronny and Eldon in their office in the district centre, along with Jackson, a Government extension staff worker.

They told us how SWIP started, with data collection and meetings with district officials, people involved with health care, NGOs and others. The process took a long time, at least four months. Afterwards, the analyzed information was brought back to the community and presented at public meetings. This was the beginning of the process of social mobilization of the community. Ronny said that people take better care of their wells if they have been involved in the planning and in the actual work. Eldon added that much time is needed for this process because people need time to learn and understand new things. He mentioned that roads in the district are bad, which means much time is needed for travel.

Margaret felt that social mobilization should actually result in people applying for assistance to protect springs or drill boreholes. This in turn would lead to a sense of ownership and better maintenance. In fact this policy has now been adopted by SWIP. Margaret believes that more women need to be identified as pump mechanics and caretakers, and that women's views should be taken into account in the selection of borehole sites.

We talked about the need to involve school children in SWIP and how SWIP can assess whether the school health programme is running smoothly in the area. Maybe children could help with the construction and care of boreholes.

Many schools do not have water nearby, though, which makes it difficult to carry out good hygiene practices. In his visits to secondary schools, Jackson finds that some of the boreholes are not well maintained. On his visits, however, he has not checked the latrines.

With improved health and self-reliance as SWIP goals, it has been natural also to develop a policy for community-based health care (CBHC). CBHC is basically a strategy to enable a community to care for its own health and work together for development. CBHC has been carried out by NGOs and church organisations in scattered areas of the country since the early 1970s, but SWIP is the first large scale Government attempt to implement CBHC. SWIP has taken the initiative to bring CBHC projects together, which is now under the umbrella of CBHC Association. As a result, the different CBHC projects in the area now have a common curriculum and manual for training, and can share experiences to learn from one another. One form of cooperation practised is that participants from sister-organizations are always invited to participate in CBHC training arranged by SWIP.

Presently CBHC activities have been initiated in 22 parishes in five districts, serving an estimated population of 143,000. Sixty-nine trainers, 69 village health committees, 468 community health workers (abehwezi) and 300 traditional birth attendants have been trained. Each abehwezi looks after up to ten homes close to his or her own home. A lesson learned from the pilot CBHC projects is that activities must follow the community's pace if they are to be accepted. Another lesson learned is that CBHC is not a monopoly of health workers, but can be carried out by teachers, community development staff, agriculture extension staff and others with abilities to communicate and organize communities.

In the spirit of self-reliance and capacity-building, training has become a major activity within SWIP. Training programmes are planned with technical assistance from the water and health specialists of the SWIP Team, then coordinated with social mobilisation activities. In all training carried out, emphasis is put on development of human resources and ability to take initiatives, analyze situations and put knowledge into action. At district level, District-Based Project Officers (DPOs) trained under SWIP function as trainers of pump mechanics and caretakers of water sources. They also train people from communities to serve as trainers of Village Health Committee members and abehwezi for CBHC. All training provided emphasizes the Basic Health Messages developed by SWIP.

2.3 MAJOR ACHIEVEMENTS

After three years of implementation, SWIP has compiled many credits, some of the major ones being:

- * The first major integrated programme in Uganda to include elements of community-based health care (CBHC), social mobilization, water and sanitation. The approach adopted in the Programme emphasizes multi-sectoral activities and is intended to reflect Government's own philosophy of community-based self-help.

- * The first Government attempt to develop a large scale and workable community-based health care approach. In the process, there has been improved collaboration with district authorities and NGOs, and acceptance of standardized training curricula and basic health messages.

- * A catalyst for building a community-based maintenance system (CBMS) for water sources. SWIP also has an advocacy role for development of a national strategy on organization and management of community-based bore-hole maintenance.

- * A programme that has assisted in providing and rehabilitating nearly 2,500 water points in the southwest area of the country, serving an estimated user population of 583,000.

- * A programme that has assisted in the training of district and community-level personnel (e.g. DPOs, CDOs, CMWs, TBAs, community leaders and pump mechanics and caretakers) to provide health education and also train other trainers.

In monetary terms, SWIP has been a primary channel for UNICEF and bilateral support totalling nearly US\$ 13 million to date, given as vehicles, equipment, supplies, materials, personnel and cash to the Government and the people of Uganda.

2.4 SWIP 1990-95 IN BRIEF

SWIP is described in the Uganda Country Programme 1990-1995 (Kampala, 1989) as an area-based programme that:

"... serves as a testing ground for Government policy in community participation and community financing for water, sanitation and health care, and for initiatives which can increase women's access to income and decision making. The need to try out strategies in a limited area before national implementation is well recognized, and is even more important for issues such as cost recovery which could have adverse social and political effects if poorly designed.

"The emphasis of the programme is on community participation, and the development of services that can be largely sustained by the communities themselves. Women have a special role in providing support to social services in the community so the programme will also emphasize initiatives to support them in carrying this burden."

SWIP's implementing and cooperating ministries are the Ministries of Planning and Economic Development (MPED), Finance (MOF), Local Government (MLG), Health (MOW), Water and Mineral Development (MWD), and Woman in Development (MWD).

The Programme has six main objectives to be achieved by December 1995:

1. Development of policies for sustainable community-based health care and water system maintenance.
2. Provision of protected water points with appropriate community-financed maintenance systems to serve 1.5 million individuals through:
 - A. drilling of 1,895 boreholes
 - B. replacement of 350 handpumps (to be completed by December 1991)
 - C. protection of 4,160 springs
 - D. construction of 20 gravity schemes
 - E. construction of 3,500 family VIP (ventilated improved pit) latrines
3. Provision of health education to 6,200 communities as an introduction to community-based water source maintenance and community-based health care.
4. Development of community-based health care with community financing in 300 communities to serve 500,000 individuals.
5. Development of pilot projects to strengthen women's income earning capacity and support women in decision-making through the RC system.
6. Implementation of recommendations of the Health Financing Task Force concerning community and health centre level financing initiatives and strengthening of district-level health management.

SWIP 1990-1995 comprises seven main project components intended to contribute to achievement of Programme objectives. These are listed in Table 2.1, along with key budgetary information. Detailed descriptions of each component may be found in the Uganda Country Programme 1990-1995.

Table 2.1. SWIP Components and Estimated Input Requirements

Component	Total Inputs, 1990-95 (in millions of US\$)	
	UNICEF/Donors	Govt.
Community-Based Health Care/Income Generation (Including Area-Based Project Support)	3.025	0.210
Social Mobilization	5.345	0.193
Borehole Drilling	16.002	0.218
Gravity Flow Schemes	2.626	0.017
Handpump Replacement (Including Borehole Rehabilitation and Maintenance)	0.383	0.165
Spring Protection	1.821	1.014
Sanitation	1.096	0.128
TOTALS	30.298	1.945

2.5 EXPENDITURES ON SWIP TO DATE

UNICEF's estimated contribution to SWIP to date totals almost US\$ 13 million, broken down by project by year as shown in Table 2.2.

Government's expenditures since Programme start-up are itemized in Table 2.3. In addition to the amounts shown, Government inputs include salaries and allowances for personnel who support SWIP activities on the Government side.

The Evaluation Team did not receive any financial information from any of the district treasurers, though a request was made during each visit.

Table 2.2. Estimated UNICEF Expenditures on SWIP, 1987 Through 1990, in millions of US\$

Budget Category	1987		1988		1989		1990	
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
Social Mobil.	Component of other projects		Component of other projects		Component of other projects		0.280	0.282
CBHC-Office Op.	0.103		1.314		1.187	0.968	0.600	0.455
Borehole Drill.	0.820		1.640		2.260	2.868	2.175	1.975
Pump Replace. & Maintenance	0.165		0.330		0.188	0.121	0.191	0.215
Gravity Schemes	0.140		0.280		0.249	0.093	0.196	0.113
Spring Protect. & Shallow Well Sanitation	0.051		0.102		0.118	0.281	0.246	0.191
	0.076		0.153		0.106	0.059	0.107	0.071
Totals	4.393	1.355	2.903	3.819	4.108	4.390	3.795	3.302
% Total Budget Amount Spent	31.0		131.5		106.8		87.0	

Table 2.3. Expenditures on SWIP by Government of Uganda, Through 1991, in millions of U.Shs.

(Note: No Government funds were approved or released in 1988-89.)

Budget Category	1987-88		1988-89		1989-90		1990-91	
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual
CBHC	0.708	0.229	0.0	0.0	5.120	1.816	5.847	
Social Mobil.	3.544	2.616	0.0	0.0	17.280	6.129	19.733	
Spring Protect. & Sanitation	6.519	7.572	0.0	0.0	31.360	11.123	32.888	
Borehole Drill. & Pump Replac.	0.779	0.855	0.0	0.0	6.400	2.270	7.309	
Gravity Schemes	0.708	0.096	0.0	0.0	1.920	0.681	3.654	
Casual Labour	1.205	1.111	0.0	0.0	0.758	0.617	2.192	
Monitor. & Eval.	0.709	0.503	0.0	0.0	1.396	0.291	1.462	
Totals	14.172	12.983	0.0	0.0	64.234	22.927	73.085	
% Total Budget Amount Spent	91.6		---		36.9			

PROFILE: Meeting with Fifteen Women in Katuhama

From the district centre, which is a one and a half-hour drive from the paved main road, we drove another half-hour to reach Kihumoro School. Fifteen women from Katuhama Women's Group were waiting for us. We went into a classroom, where the president of the group introduced all members. The women there were between the ages of 20 and 60. One was pregnant and another had brought her little baby, whom she breast-fed while we talked. Many of the members had eight or ten children. None had tried family planning. By the end of the meeting though, they were a bit curious. They had heard that women became sick from family planning and wondered if there were any family-planning methods for men.

We asked about the water situation in the area and they answered that they collect water from wells and dams close to their village. Now there were also some protected springs. When they were being protected, both men and women in the village helped to collect stones.

The Community Development Officer has been there to talk with them about water and health and how children can be kept healthy. They thought their children got less ill now that the water was clean. And all the women at the meeting have had their children immunized. We asked about diarrhoea and were given very good description of how to mix the sugar-salt solution.

In their village committee, 15 of the 30 members are women. We asked if other village committees also had equal participation of men and women.

"Before, men thought that women could not be on committees", one woman answered before admitting that representation was usually far from equal. "Many men do not like women to go to meetings", said another woman. And a third added, "There should be a request to the chief that those who do not allow their wives to go to meetings should be fined". It was generally agreed that it might be good if the men on their village committee could have a friendly talk with any reluctant husbands.

How can the situation of women be improved? A bright 30-year old mother of eight, answered with one word -- "Education!" All the others agreed. But they also admitted that if the family had many children and little money, the girls would have to stay at home!

ISSUE: Budgetary Plans for Phasing Out

The scenario was that 80% of SWIP's budget allocation had been secured from district administrations. In a group we discussed how this goal had been reached.

We agreed that a continuous mobilization of the communities and district authorities was the first step in installing a sense of ownership of the programme as well as of the water sources. District authorities needed to feel that they were involved as equal partners in the process of planning and implementation. They should also be involved in the budgeting of activities in order to understand the real costs and eventually be able to include parts of them in the district budget. SWIP and district authorities should jointly identify sources of funding and agree on the annual percentage of district contributions over a ten year period.

Chapter 3

FINDINGS

3.1 INTRODUCTION

This chapter presents the Evaluation Team's findings based on (1) interviews at central, district and community-level, (2) field visits in Kabele, Rukungiri, Bushenyi, Kasese and Mbarara Districts, (3) a literature review, and (4) attendance at the Inter-Ministerial Steering Committee Meeting held 22-23 November in Mbarara.

Most of the findings relate to SWIP as a whole. The Team tried to focus more on "big-picture" Programme-related issues than project-specific details where there already generally is knowledge among SWIP Management Team and Inter-Ministerial Steering Committee members on present shortcomings and ways these can be addressed.

Findings are grouped in two categories (1) "Findings Related to SWIP Implementation to Date", and (2) "Findings Related to SWIP and Its Operating Environment". The latter relate to SWIP but also attempt to put SWIP in the overall context it operates within, i.e. the enabling national-district environment, and to indicate how various national policies and ministries control and have an opportunity to change that environment for the better.

The information contained in this chapter forms the basis for conclusions and recommendations presented in the Chapter 4.

3.2 GENERAL REMARKS

SWIP is well-established after three years of operation. Contacts with district administrations have been established, routines are in place, activities are being planned and implemented, supplies are being ordered, received, stored and delivered, people are being trained, and communities are being organized to receive water and health benefits. Overall implementation in terms of ongoing activities is proceeding pretty much on course.

Based on the first three years of experience, a number of general lessons learned begin to emerge:

- * That sustainable water supply requires strong linkages and successful integration of water, health, health education and community organization activities.

- * That the process of community mobilization is one which involves education, awareness creation, organization, commitment to change things for the better, and desire and understanding to maintain the improved situation at an acceptable level. It involves changes in attitudes and changes in behaviour. This process takes time, and this should be recognized and accepted.

- * That women are a central target group in water and health development projects, being the fetchers of water and the caretakers of families. They are important stakeholders who therefore assume key roles and responsibilities in development.

- * That the sense of ownership of results -- whether these results are plans of action or physical water points -- must be present for sustainability to be achieved.

- * That participation in planning and decision-making on an equal and meaningful basis contributes to sense of commitment to achieve, and ownership of results.

- * That community-based health education can be an entry point into the community mobilization process.

- * That good communication contributes to good collaboration and good coordination between actors in the development process. Without it, there can be misunderstandings or even passive or active resistance that can hinder effective and complete implementation of plans.

- * That monitoring, evaluation and follow-up are important elements of good project planning and implementation.

- * That project dependency will never be removed until there is commitment by the partner being assisted (the Government of Uganda, the District of Mbarara, or the community of Nyongezi) to take over increasing shares of project responsibilities and costs from the "outside" partner providing assistance.

* That District Administrations through their District Health Teams should be more involved in planning and implementation of SWIP activities.

* * * * *

As a general introduction to the findings present in this chapter, three statements of general observation seem appropriate:

(1) While there are shortcomings that need to be worked on at national level concerning appropriate levels of resource inputs from Government and UNICEF, and to improve better communication and collaboration, as a whole the enabling environment surrounding SWIP is positive and improving.

(2) SWIP may be characterized as an activities-driven programme, as opposed to an objectives-driven one. That all major Programme and project indicators are related to quantities and physical results, e.g. number of water points installed and number of people trained, reinforces an overall focus on quantities rather than quality.

(3) The Programme seems to be learning from experience and making adjustments as more experience is gained.

3.3 FINDINGS RELATED TO SWIP IMPLEMENTATION TO DATE

3.3.1 Major Achievements to Date

After three years of operation, SWIP's major achievements include the following:

* Project infrastructure is firmly in place. This relates both to the physical infrastructure of buildings, workshops, stores, houses, vehicles, supplies and equipment, and the human resources infrastructure. SWIP is well endowed with externally-provided transport, supplies and equipment. A SWIP team of UNICEF and Government personnel has been recruited and posted to Mbarara and other locations in the Programme area. At present, almost all posts are filled. Nationals fill many of the senior management positions, though a number of technical positions are filled by expatriates. The Programme Manager, a Ugandan national and a medical doctor, has been with SWIP from the start.

* Water has been provided to an estimated 583,000 people through the installation of 628 boreholes with handpumps, 254 rehabilitated boreholes with new handpumps, 1,569 protected springs, and two gravity schemes.

* Integration of mobilization, health and water activities has been initiated. Using water as an entry point, social mobilization has become an integral part of the development process, with high priority given to training. Training curricula and training materials have been developed for use in the Programme.

* CBMS procedures have been established, 243 handpump mechanics and 581 handpump caretakers have been trained, and districts are being equipped with stores and handpump spare parts available for sale to communities.

* An overall CBHC approach has been developed in the SWIP area, training curricula are adopted and CBHC activities have been initiated in 22 parishes in five districts serving an estimated population of 143,000.

* That the SWIP Team has begun to work through district and RC structures. Cooperation with district-level officials is steadily improving.

* Flexibility in development and implementation of approaches for some project components has been demonstrated, confirming that SWIP is a "testing ground for Government policy".

3.3.2 Main Implementation Shortcomings Observed

While social mobilization has been initiated as a process, there is more work to be done. Based on random interviews at village level, there are some communities and individuals who do not understand their roles or responsibilities. Further, they do not view the water scheme as theirs; rather it is Government's or UNICEF's or SWIP's. SWIP Team members themselves say that while social mobilization efforts have improved, mobilization efforts in some communities are not given enough time before commencement of technical activities.

Certain Programme activities -- sanitation (utilizing improved latrine technology), women in development, and income generation -- are far from well established at this point. There seems to be lack of clear understanding about what these activities entail and in which direction they should go.

It appears that the Programme could do more to explore ways for collaboration, especially related to introduction and reinforcement of health messages. Potential links might be providing water and latrines at all schools as a matter of policy, liaison with the School Health Education Project (SHEP) on teaching health education and personal hygiene in the classroom, organizing mass media campaigns and competitions.

Systematic, regular monitoring, evaluation and follow-up do not seem to be well-enough established in the Programme yet. This is a general statement, but it is especially relevant to training, project management and field-level supervision. It appears that everybody is supposed to do these things, yet nobody has a full overview. Nor is there a person designated as main focal point within the SWIP Team with responsibility to coordinate activities being carried by different people at different levels.

There is little written down on paper in terms of overall Programme strategies and approaches. Activities are done, and "everybody knows" how things are supposed to operate. That there is no project handbook with established organograms, overall policies and routines and job descriptions is a deficiency that needs correction in the interest of good management practice.

There are parallel structures created under SWIP that people are very aware of because of the different salary-allowance packages offered by the different agencies:

- At district level: the District Team and the SWIP Team (including project-recruited District-Based Project Officers).
- At SWIP level: Government and UNICEF staff

Such parallel structures can quickly become latent sources of friction, especially when one group is much better remunerated or enjoys much higher status than the other.

There is a heavy UNICEF "presence" in SWIP in terms of Programme-salaried personnel (eight international staff, two national professional officers, and seven administrative/finance/supplies/transport staff based in Mbarara). In addition, there is provision for two UNVs and one Dutch volunteer to be attached to the SWIP Team.

Some concerns cited by SWIP Management Team as hindering their efforts to carry out work most effectively are:

- Pressure from above to meet targets.
- Lack of a Programme organogram that clearly establishes and shows functional relationships. (The present organogram is basically a reflection of who pays the salaries.)
- Instances of UNICEF personnel by-passing the chain of command.

There are communications gaps concerning roles, responsibilities and general Programme-related information -- vertically, horizontally and at all levels. Though some gaps will always be present, the number of occasions that they became apparent during interviews and discussions was greater than the Evaluation Team had expected. In some districts, officials stated they were not fully involved in SWIP planning or implementation. Nor did they know what has been expanded in their districts, either by SWIP or themselves.

3.4 FINDINGS RELATING TO SWIP AND ITS OPERATING ENVIRONMENT

3.4.1 On Collaboration and Cooperation

As with any area-based programme working at field level, SWIP is affected by a number of vertical sector programmes that can sometimes create competitive situations for personnel, resources or recognition, duplication of effort and non-effective utilization of human and material resources. There is always need for better communication and coordination between agencies working in the area, and agencies affecting work in the area.

SWIP experiences collaboration problems both horizontally and vertically, but on the positive side, one mechanism that should help alleviate many such problems is already in place -- the Inter-Ministerial Steering Committee (IMSC). The IMSC actually serves the two large-scale water sector projects in Uganda -- SWIP and RUMASA (Rural Water and Sanitation East Uganda Project, DANIDA-assisted). It includes in its membership the Permanent Secretaries (PSs) of all implementing and cooperating SWIP/RUMASA ministries, UNICEF officers, representatives from the SWIP and RUMASA Management Teams, and District Executive Secretaries of project districts. It meets on a semi-annual basis, alternating meetings between the two project areas.

At the IMSC meeting observed by the Evaluation Team, there was good attendance by high-level policy-makers of participating ministries and donors. There was no hesitation in making "on-the-spot" decisions concerning implementation constraints brought up by the SWIP and RUMASA Teams. In addition, the meeting served as a useful forum for project implementors to come together, discuss common problems and exchange experiences.

This is not meant to imply, however, that communication-collaboration problems are solved. In interviews at national level, the Evaluation Team noted that some senior officers of central ministries, who were expected to have a good knowledge and close involvement with SWIP, in fact did not. And though SWIP is a Government programme, there did not seem to be the sense of ownership that might have been expected.

ISSUE: Implications of AIDS for SWIP

SWIP is operating in some of the areas of Uganda which have been hardest hit by AIDS. In accordance with the Government policy that information on AIDS be given at all public gatherings, SWIP has included basic messages on AIDS in its training courses. But the implications of AIDS for the programme had not previously been discussed. We had this discussion in plenum and each of us wrote out a card stating a point.

The range of statements made was wide. Some people thought that AIDS would affect social mobilization adversely and consequently slow down the implementation of SWIP. Others thought that AIDS would reinforce social mobilization overall, thus strengthening the SWIP mobilization efforts. It was generally felt that there was a need for flexibility in the plan of operation to cater for change of emphasis depending on the local AIDS situation. In a hard-hit area CBHC may include home care of AIDS patients. As most of the HIV-infected people are in the most productive age groups, SWIP may suffer a loss of staff.

The conclusion was that SWIP needs to take AIDS into consideration, identifying local needs and working out a strategy for collaboration with local AIDS activities.

PROFILE: Interview with a Women Politician

We met Zeridah Sendegeya -- a mother of five, dressed in a white traditional dress and looking much younger than her 34 years -- at the office of the District Medical Officer in Kabale. She is the Secretary for Women on the RC 5 (district level) executive. (There is a Secretary for Women in each RC at each level.)

Zeridah's political career began when she was elected by her village RC 1, the lowest level in the RC system. This was, she thought, because she had a diploma in teaching and the village trusted her to talk for them.

Now she has advanced to district level and has a better chance to work to improve the situation of women. She feels that women need to be more self-reliant, and she organizes meetings in her area to make them more aware of their resources and how to use them. Women in Uganda are interested in cultivation, she says, but there is not enough land. Therefore, women need to learn other skills in order to get an income. They need tools that can lessen their workload. She told us about a group of women who joined together and bought a grinding mill so they could save time and earn some money. She also said that some women's groups collect money and give it to each other, in turn, or lend without interest, so that their sisters can buy something they would not otherwise be able to afford, like a sewing machine.

Zeridah feels that women are encouraged by the Government to participate in politics and that they are treated fairly by the men. But still there are very few women sitting in district councils in Kabale -- five out of 57 seats! But in the neighboring district, Rukungiri, the District Administrator is a woman, so Zeridah is sure the situation will change!

3.4.2 On Decentralisation and Institution-Strengthening

At district level, two areas of weakness that stand out as major constraints are the districts' lack of capacity to plan and their weak financial position. These weaknesses affect SWIP implementation, and implementation of other district-based activities as well. They have obvious implications at national level seen in the context of decentralization.

Though decentralization of authority has been Government policy since the mid-1980s, in practice a number of constraints continue to hinder its effective implementation -- lack of professional personnel to post at district level, lack of institutional structures, weak financial bases at both central and district level, verticalized sector programmes, and so on. Problems are slowly being addressed, but it seems only realistic to assume that full decentralization will take time.

3.4.3 On Improving Women's Situation at District Level and Below

National women in development (WID) policy and strategies for its implementation do not appear to be well enough conveyed to district authorities. Consequently, opportunities to introduce gender awareness into training activities being organized and carried out, for example under SWIP, are not being taken advantage of.

3.4.4 On Public Sector Salary Levels

Low salaries for public sector employees are a major problem that affects SWIP and every other development programme in the country. Government salaries are typically far below even a modest cost-of-living level, which means that public employees must have supplementary sources of income, seek attachment to externally-funded projects offering better compensation, or leave Government service to join the private sector. Particularly in the case of externally-funded projects, there can be parallel situations created where two equally-qualified persons work side-by-side and perform similar duties, yet earn vastly different incomes. The effects of such a situation are obviously demoralizing. The problem is worsened by a high rate of inflation.

It can be pointed out that Government, with the assistance of international agencies such as World Bank and UNDP, is attempting to deal with the general salary issue and related ones concerning civil service and cost-effectiveness. Some of the main studies and actions underway are:

(1) A Public Service Review and Reorganization Commission has been established. The Commission was formed in 1989 with a mandate to review and develop recommendations on salaries, allowances and conditions of service for civil servants. Its first report was recently submitted to the Ministry of Public Service and Cabinet Affairs for consideration.

(2) UNDP is supporting Government's efforts by sponsoring studies on support to the Uganda Civil Service. The first draft report of a commissioned study, "Rationalization of Financial Support to the Civil Service of Uganda" (May 1990), has been submitted to both Government and UNDP for comments.

(3) The World Bank has recently carried out a study on the conditions, salaries, allowances and structure of the Uganda Civil Service. The completed report has been submitted to Government for consideration.

(4) Since 1987, Government has taken steps to try to improve public service remuneration and effectiveness:

(a) Several increases in salaries and allowances have taken place. The most recent adjustment was this year, when salaries were increased 22% for all public employees and additional special allowances were granted to professional-level civil servants.

(b) Attempts are being made to streamline the Civil Service by reducing the number of group employees (casual labourers) to levels Government feels it can adequately maintain. A directive to cut staffing by 50% has been issued to all Government departments, and even further cuts may be requested in the future.

(c) Government is working on a strategy to request donor assistance to fill the gaps between what are "reasonable" wages in line with today's cost of living, and what it can afford to pay. Such assistance will be requested as a temporary measure and in accordance with a sliding scale where Government will take over increasingly larger shares of its obligation as the national economy improves with time.

3.4.5 On Payments by Users

The stated goal of SWIP is that there be at least partial payment or contribution by users for services received or goods provided. The introduction and promotion of payments and user charges, at least as related to water and sanitation, is therefore an important part of SWIP social mobilization activities. On the water side, the concept of some payment seems generally well accepted. On the health side and as a national policy, it may perhaps be more difficult. The sixth development objective of SWIP 1990-1995 (see Chapter 2, Section 2.3) refers to implementation of recommendations on financing initiatives by the National Task Force on Health Service Financing. In fact, this Task Force has already recommended a policy of user charges for Government Health Unit services, but Cabinet was not prepared to accept it in its proposed form.

3.4.6 On Budgeting and Expense Accounting

In general, it is difficult to get budget and expenditure figures from any of the organizations that are operationally involved in SWIP (Central Government, UNICEF and districts) in a form that allows for cost-effectiveness analysis or potential use as a control tool in project management.

From the UNICEF side, both UNICEF Kampala and UNICEF Headquarters are aware of this constraint relating to use of external funds -- from their own as well as from Government's view.

An international consultant has been engaged for a study to develop a method to cost-monitor water and sanitation interventions and coverage and impact achievements. The study, "Cost Analysis/Standardization Study on UNICEF WATSAN Interventions", is a global one. Its objectives are to analyze how costing is undertaken in different water and sanitation projects and develop a simple personal computer-based program that can breakdown and analyze costs related to water, sanitation and hygiene interventions. It is intended that the reporting methodology proposed highlight sustainability and not end up promoting the concept of outputs as ultimate objectives.

Five countries have been selected for in-depth study -- Pakistan, Benin, Sudan, Honduras and Uganda. Together they are believed to represent a mix of different geographical and cultural situations. A final report and operational computer software are expected to be available in 1991.

3.4.7 On Pressure From Above

Rightly or wrongly, SWIP Team members sometimes feel under heavy pressure from above (from UNICEF and Government) to meet targets. When this happens, they feel they do not have enough time or acceptance/support to focus more on quality and long-term impact issues.

On the UNICEF Kampala side, UNICEF Project Officers perceive that donors are interested in target achievement, and that such achievements are used to monitor the degree of success of their contributions. On the Government side, Government officials express the hope that safe water can be provided to as many people as possible as quickly as possible.

3.4.8 On Programme Replicability, Assuming External Support

An indication of SWIP's replicability as a donor programme is reflected in the decision by Government and DANIDA to incorporate certain fundamental SWIP concepts (e.g. working through district organizations, integration of water, health education and mobilization activities, and CBMS) into RUMASA project design. This is encouraging, since SWIP and RUMASA are the two largest water programmes in the country. (Note: There are also some basic differences in approach -- e.g. SWIP is implemented by a separate Programme Team based in the Programme area that includes UNICEF technical officers, whereas RUMASA works through the Water Development Department (WDD), using advisory services provided by a consulting firm.)

Now that RUMASA is under way and because collaborative links are already established through the Inter-Ministerial Steering Committee, there should be ample opportunities for each project to share experiences and learn from the other. This should have a positive effect on both programmes.

Chapter 4

RECOMMENDATIONS**4.1 INTRODUCTION****4.1.1 Overall Conclusion on SWIP as a Programme**

SWIP is a well established and well accepted project. Contacts with district officials have been established, physical infrastructure is in-place; there is an enthusiastic project team of Government, project-supported and UNICEF staff; routines are established, activities are being planned and implemented; supplies are being ordered and received; people are being trained; and communities are being assisted.

As with any development project, SWIP experiences implementational problems and a number of constraints, but nothing insurmountable or life-threatening. There are improvements that can be made with respect to activities underway, strategies and overall project management/supervision monitoring, but the SWIP approach is basically sound and programme infrastructure functions.

4.1.2 General Remarks Concerning Recommendations

A number of specific conclusions and recommendations can be drawn from the findings presented in the previous chapter. Some are internal to SWIP as a programme, which means that the SWIP Management Team can do something about them directly and on their own. Others imply that several parties must collaborate if better conditions or results are to be brought about. The SWIP Management Team is usually one of the parties; other parties can be MPED, MLG, MON, MOF, MWID, MAMD/MDO, District Administrations, the Inter-Ministerial Steering Committee (IMSC), UNICEF, SIDA or CIDA.

Two types of recommendations are thus made -- "Recommendations (SWIP)" and "Recommendations (Others)" -- to distinguish those issues internal to SWIP from those which are more collaborative in nature.

So as not to lose sight of the key issues identified in Chapter 1, Section 1.4., recommendations made are linked back to these issues, plus one additional one, "Project Management", which relates to general project management, organization and administration.

Main areas where improvement can be suggested are (1) better communication and collaboration at and within all levels, (2) increased emphasis on objectives-orientation during both planning and implementation, and (3) need to make a full transition over to a long-term development programme that includes sustainability, replicability, capacity-building and gradual donor phase-out objectives.

Each recommendation is numbered for easy reference. Each requires that a specific action be taken. With few exceptions, they can be acted upon immediately. All are considered realistic, feasible and achievable, and all, if done in satisfactory manner, can help to improve on the present situation. These recommendations are considered by the Evaluation Team to be key ones, in that they embrace other findings, conclusions and implied actions as well. The Evaluation Team believes if there is focus and action taken on these recommendations, a number of other problems will be addressed and solved at the same time.

Specific recommendations related to water, sanitation and CBHC are contained in Chapters 6 and 7 of Part II of this report.

4.2 RECOMMENDATIONS

Key Issue: Human Resource Development (HRD), Including Capacity-Building, Training, Development of Materials

Recommendation No. 1: (SWIP)

Develop a conceptual framework for SWIP, with this framework identifying all groups that should receive training under SWIP -- villagers, community leaders pump mechanics, DPOs, etc. Don't forget SWIP Team staff -- all levels -- who must be trained with donor phase-out of technical assistance in mind. Specify by group, training needs, training strategy, type of training to be given, and type of training materials to be used. Set up training plan and target completion dates.

Recommendation No. 2: (SWIP)

Related to the above recommendation and as one area of follow-up, produce, test and distribute any additional training materials required.

Recommendation No. 3: (SWIP)

Introduce a formal feedback cycle into the training process, i.e. all training carried out under SWIP. Triple A (assess, analyze, action) could be one way to do this. Remember the objective, which is performance-oriented training.

* * * * *

Key Issues: Integration, Collaboration, Coordination**Recommendation No. 4: (SWIP + MPED + UNICEF + all cooperating ministries + District Administrations)**

Continue to capitalize on every opportunity to use IMSC meetings as means to strengthen communication and collaboration between all involved parties.

Recommendation No. 5: (SWIP)

Introduce objectives-oriented planning at district-level. This type of planning should be designed to be done as participatory exercises.

Recommendation No. 6: (SWIP + District Administrations)

As follow-up to above recommendation, conduct objectives-oriented planning workshops in Districts, with output being a plan of operation for each district.

Recommendation No. 7: (SWIP + District Administrations)

Meet on regular and at least quarterly basis to review progress, discuss workplans, activities for future, progress. Make as regular agenda points: (1) expenditure reports for past quarter from each side, and (2) workplans for next quarter.

Recommendation No. 8: (SWIP)

Assess possibilities for supporting teaching of health education in school classrooms. Follow up as appropriate.

Recommendation No. 9: (SWIP)

Establish general policy that all schools and health units be provided water point and demonstration latrine. Follow up.

Recommendation No. 10: (All ministries)

Inform UNICEF and SWIP whenever senior Government staff are to be transferred out of one of SWIP districts.

Recommendation No. 11: (MWD/IDD)

Post senior Water Engineer to one district within SWIP area as a pilot effort to have more of technical activities channelled through the district.

Recommendation No. 12: (SWIP)

Send SWIP expenditure reports to MPED on quarterly basis. Ensure SWIP accounts staff are able to use available computerized reporting systems as these will facilitate their task.

Recommendation No. 13: (MOM)

Strengthen the Health Planning Unit by assigning trained personnel to enable the Unit to fulfill its roles. Furthermore, review the structure of MOM with a view to establishing a strong executive unit with the power and capacity to coordinate all health programmes/projects. (Action: PS + DMS)

Recommendation No. 14: (MOM)

Establish technical forum that allows managers of related programmes, including SWIP, to meet regularly to review progress, objectives, targets, etc. of programmes. (Action: PS + DMS)

Recommendation No. 15: (MOM)

Ensure that senior health officials (Programme administrators and managers) are informed about implications, required actions of decentralization policy, and ongoing Government efforts to strengthen management at district level. (Action: PS + DMS)

* * * * *

Key Issues: Situation of Women, Capacity-Building**Recommendation No. 16: (SWIP)**

Within the framework of the national strategy, develop a SWIP strategy for women in development. Include objectives, outputs, specific activities, inputs, indicators. Adopt. Then promote and carry out, including regular monitoring and evaluation.

Recommendation No. 17: (SWIP)

Identify and encourage qualified women to apply for SWIP Management Team positions as openings occur. Give preference to qualified females when they apply.

Recommendation No. 18: (NWID)

Arrange that SWIP DPOs be given training on gender-awareness issues and necessary knowledge and tools so they can introduce gender-awareness into their training curricula for all people trained at district level and below.

* * * * *

Key Issues: Sustainability, Replicability, Affordability, Integration, Capacity-Building, Community Participation

Recommendation No. 19: (SWIP)

Review the pre-conditions to be met by communities before water supply assistance commences (e.g. formal written request, money in the bank, contribution to offset costs, etc.). Then select reasonable, uniform pre-conditions that always apply. Then strictly enforce them.

Recommendation No. 20: (SWIP)

Rethink the sanitation project. Is the present strategy realistic? Is the VIP solution affordable? What really is the end objective? Number of latrines, usage, personal hygiene? Is research needed? Then reformulate the project if appropriate.

Recommendation No. 21: (NPED)

Post senior planning officer to each of five districts in SWIP area, plus in any districts that SWIP will move to in near future.

Recommendation No. 22 (NPED + UNICEF + SWIP)

As part of mid-term programme reformulation exercise, develop ten year plan for complete phase-out of donor assistance.

Recommendation No. 23: (UNICEF + NPED)

Inform NPED whenever international staff to be recruited to fill positions on SWIP Team. Periodically review UNICEF posts in SWIP occupied by international staff to see if positions can be filled by qualified nationals.

Recommendation No. 24: (SWIP + NPED)

Periodically review DPO posts to see if it is possible to convert them to Government posts.

Recommendation No. 25: (SWIP)

Periodically review "programme support budget lines" with view to minimize expenditures.

Recommendation No. 26: (SWIP + NPED)

Examine ways to channel more funds directly to districts to assist districts in implementation of planned activities.

Recommendation No. 27: (NPED)

Ensure timely release of Government counterpart funding by ensuring that Government requests are submitted to MOF on time using donor-funded expenditure reports to justify importance of timely release of funds.

Recommendation No. 28: (NLG)

Allow districts to widen their revenue base so they can take on more responsibility for planning and managing SWIP activities.

Recommendation No. 29: (NLG)

Actively promote use of existing machinery (RCs and administrations) for improved community organization, mobilization, responsibility-shouldering.

Recommendation No. 30: (NLG)

Take all required actions to ensure speed-up of decentralization process and strengthening of district management.

Recommendation No. 31: (NLG)

Support, encourage, require districts to plan comprehensively and make best use of resources.

Recommendation No. 32: (District Administrations)

Through District Health Teams and District Development Committees, take initiative to become more involved in planning, budgeting and implementation of SWIP.

Recommendation No. 33: (District Administrations)

District Teams and Planning Committees should meet on a regular basis to review projects, targets, achievements and impacts on general district development.

Recommendation No. 34: (District Administrations)

Include SWIP activities in annual district budgets.

* * * * *

Key Issues: Environment, Sustainability**Recommendation No. 35: (SWIP)**

Decide what is meant by "environment" and identify what SWIP can do to promote its enhancement, management and protection. Develop policy, training curriculum, indicators, etc., as appropriate.

* * * * *

Key Issues: Project Design**Comment:**

In many respects, SWIP has not made the transition over to long-term development, still being very activity-driven (vs. objectives-driven) with emphasis on fulfilling quantitative targets. The Evaluation Team believes there is sufficient experience with which to do long-term water-health planning, and that now is an appropriate time for SWIP to make the transition away from a water project over to a full-fledged long-term development programme.

Recommendation No. 36 (SWIP + UNICEF + NPED to initiate process; this recommendation is linked to the next one.)

Make transition away from activities-driven, testing-ground project over to long-term development programme. Use objectives-oriented planning techniques to reformulate Plan of Operation. In selecting objectives, be sure to ask such questions as: Is water best entry point for SWIP? Would another point be better? How important is capacity-building? Important enough to have as stated objective? What new indicators can be used to measure behavioral changes, actual impacts, quality of outcomes?

Recommendation No. 37 (NPED + UNICEF + SWIP)

Carry out mid-term programme reformulation exercise, with output being revised objectives-oriented Plan of Operation 1991-1995.

* * * * *

Key Issue: Project Management / General Implementation**Comment:**

There are always many things that can be done to improve management of projects and people, and general project implementation. A number of them are directly linked to knowing what is expected, clear definition and acceptance of roles and responsibilities by all, and good communication. Many simple things that should help considerably can be recommended:

Recommendation No. 38: (SWIP)

Propose new project organogramme based on function, not employer, for consideration by NPED and UNICEF.

Recommendation No. 39: (NPED + UNICEF + SWIP)

As follow-up to above recommendation, approve/revise proposed new project functional organogramme. As follow-up, review periodically to ensure organogramme always reflects what needs to be done.

Recommendation No. 40: (SWIP)

Assign responsibility for monitoring and evaluation of all SWIP activities to one person. If appropriate, create a new position and fill it.

Recommendation No. 41: (SWIP)

Develop new indicators to measure impact and quality of results to complement those already in use. Use them.

Recommendation No. 42: (SWIP)

Assemble a Project Handbook that includes implementation strategies, project organogramme, procedures, routines, job descriptions, in other words, everything that implementors need to know. Then distribute the handbook to all who need it. Don't forget to send a copy to each District Administration. Formally review it periodically and update as necessary.

Recommendation No. 43: (SWIP)

Carefully plan how SWIP will move into Masaka and Rakai. Be sure to allow adequate time for required social mobilization work, water resources surveys, water development plans and comprehensive health plans first, before any technical activities start up. Involve District authorities in planning process.

Recommendation No. 44: (SWIP)

Step back from day-to-day activities every so often and use couple of hours to reflect and do critical review of programme activities as a whole. This useful exercise as check that everything is remaining on track.

Recommendation No. 45: (SWIP)

Drop the income generation component from the Programme. This requires tremendous resources for relatively little impact. Reallocate those resources and use them for widespread gender-awareness training. Document this action and have it approved at INSC meeting.

Recommendation No. 46: (UNICEF Officers)
Observe chain of command of SWIP organization to avoid potential situations of conflict or misunderstandings. This will also strengthen role of programme management.

Recommendation No. 47: (UNICEF)
As soon as possible, make available copies of the "Cost Analysis/Standardization Study on UNICEF WATSAN Interventions" report to MPED and MUMD. If appropriate, share the computer programme with MPED and MUMD, providing assistance to help install and use the software if needed.

Recommendation No. 48: (SIDA, CIDA)
If appropriate, give assurances that achievement of quantitative targets is not the only criteria used to evaluate project success and requests for (continued) funding.

* * * * *

Lastly and importantly:

Recommendation No. 49: (MPED)
Coordinate that all involved parties submit plans, propose deadlines for taking actions on the above recommendations. Put them into an overall workplan, then distribute it to all parties. Give the workplan to the IMBC for follow-up.

Recommendation No. 50: (IMBC)
Follow-up.

PROFILE: Interview with a School Teacher

Kihumuro Primary School is a low thatched building made of wattle and mud. We met Douglas, the science teacher, and talked about how school children can learn more about water and hygiene. Though he had received some training on the subject through the UNICEF-assisted School Health Education Project of the Ministry of Education, he found it difficult to teach since the school had received only one training kit.

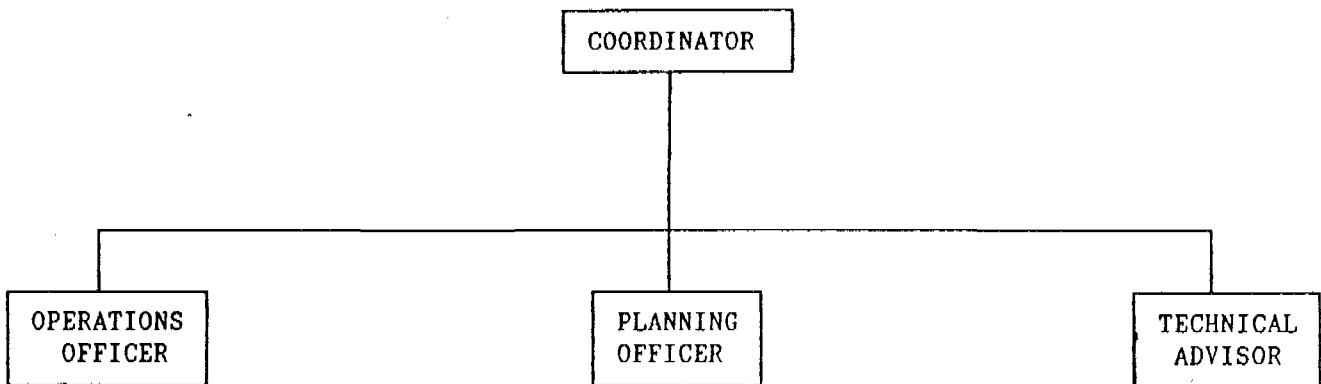
He was, however, very keen to "do" something and felt that the school could do more to educate children about water and health than just give lessons on personal hygiene in the first classes of primary school. But it was difficult to teach hygiene at a school with no water! "Children need to be able to wash their hands after going to the latrine if health education messages are to be reinforced!"

He thought the school should have a borehole so the children have access to clean water and can be taught how to take care of the water and the pump. As far as maintenance, he suggested that the school should be responsible, with a teacher serving as caretaker, together with students.

ISSUE: Functional Organograms

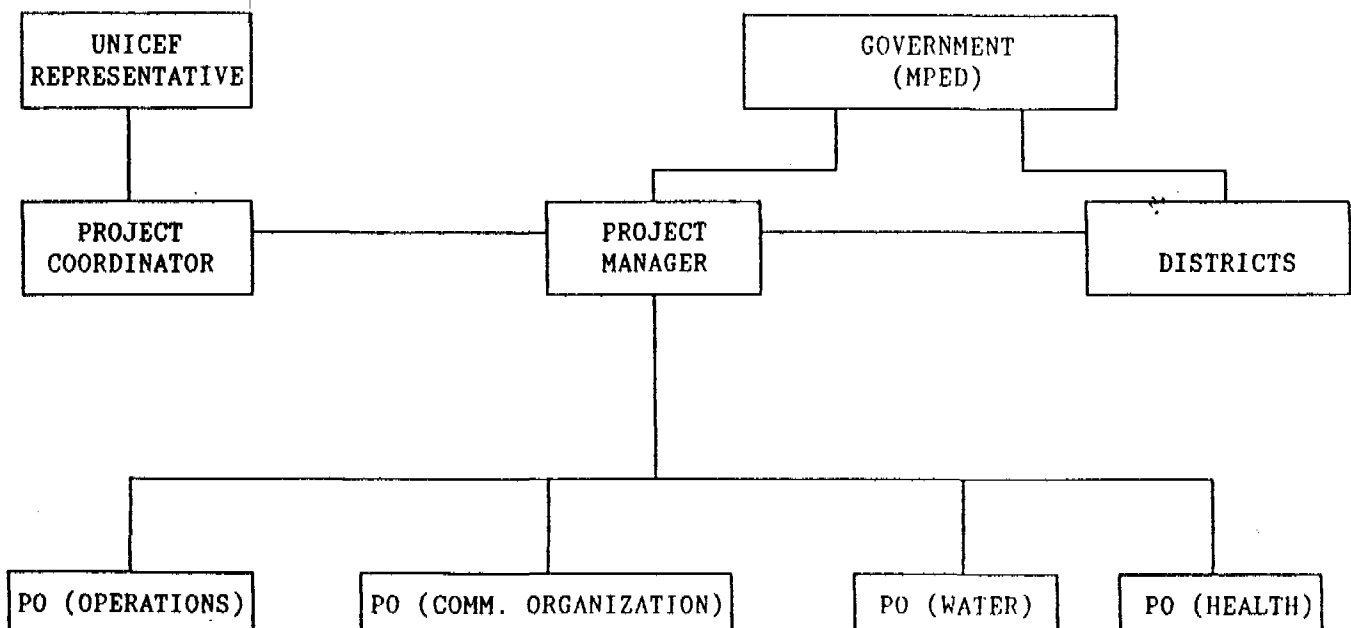
Our first task was to develop an organization chart for the SWIP Team in Year 2000, assuming that decentralization is basically working and Districts are getting stronger in their abilities to plan and manage SWIP activities. We decided that the SWIP Team, in that case, would basically be in an advisory role to the Districts. Much smaller in size also. Our organogramme for Year 2000 looked like this.

SWIP FUNCTIONAL ORGANOGAM - 2000



Next, we were asked to do the same for 1991, knowing what we know now. We discussed this a long time, going back and forth, and trying many possible combinations. In the end we were in agreement. Our solution:

SWIP 1990/1991 FUNCTIONAL ORGANOGAM



PART II

PROJECT EVALUATIONS

WATER AND SANITATION -- ACHIEVEMENTS AND OUTPUT

5.1 PROJECT DESCRIPTION

5.1.1 General

SWIP aims at providing 1,084,000 rural people in five districts with at least 20 litres of safe water per day through drilling of new boreholes, rehabilitation of existing boreholes, spring protection and gravity flow schemes.

The sanitation component aims at constructing 840 (plan for 1993) Ventilated Improved Pit latrines (VIP), through sale (at subsidized cost) and distribution of VIP slabs cast at district casting yards (10,000 slabs planned for 1993).

5.1.2 Set-up and Approach

The provision of safe water and sanitation activities is preceded by social mobilization which covers choice of source, location, selection of caretaker and pump mechanic, remuneration of pump mechanic, hygiene education and community participation.

New Boreholes

The drilling of new boreholes is done by four high speed down-the-hole hammer drilling rigs manned by crews provided by WDD. Each two units are supervised by a Master Driller provided by UNICEF. Pump installation is carried out by four pump installation units (one per rig). Siting of boreholes is carried out by the hydrogeological section headed by a hydrogeologist provided by UNICEF.

Borehole Rehabilitation

Borehole rehabilitation is carried out using borehole rehabilitation crews provided by WDD. UNICEF also provides a UNV Supervisor.

Spring Protection

Spring protection is carried out by a team from MOH and WDD using locally trained "fundis" (masons) with labour input from the beneficiaries. There is a Project Officer provided by UNICEF, who also supervises the sanitation component.

Gravity Flow Schemes

Gravity schemes are developed from spring sources and extended through a distribution system which generally comprises 10 - 30 taps. The SWIP Project Engineer, assisted by WDD and a Dutch (SNV) Volunteer, carries out the surveys, designs and overall supervision. The communities provide labour and meet some costs. Materials are provided by SWIP and WDD.

Sanitation

Sanitation includes re-education of the health inspectorate staff and community administrators, construction of demonstration VIP latrines and provision of VIP slabs at subsidized prices to encourage even low income families to own latrines. Casting of slabs is done at district level with inputs by SWIP. For demonstration VIP latrines, the communities contribute labour.

The Hydrogeological Section

The hydrogeological section has been strengthened and is now equipped to give support, especially to the drilling activities (pumping tests, water analysis and soon geophysical surveys). UNICEF has provided a hydrogeologist to train local counterparts and to provide assistance to the programme.

Mechanical Workshop

A mechanical workshop is located in Mbarara and provides necessary mechanical support to all SWIP equipment. UNICEF has provided a Maintenance Engineer, while WDD has provided a counterpart and the support staff.

Laboratory

A basic laboratory is being established for analysis of water samples, especially from new water sources and also monitoring of water quality generally.

Social Mobilization

Social mobilization, a necessary component of all SWIP activities, precedes all water activities through District-Based Project Officers (DPOs), Community Development Officers (CDOs) and extension staff, to enhance sense of ownership of water points.

Community-Based Maintenance System (CBMS)

CBMS, a component within the SWIP program to ensure sustainability of protected sources, works closely with social mobilization to train pump mechanics and caretakers. Provision U-II/U-III hand pumps spare parts depots at district level is also part of the component.

ISSUE: An Optimal Community-Based Water Source Maintenance System

First we identified five conditions that we felt helped define what characterized an optimal community-based water source maintenance system. Then we looked at what was necessary to create the desired condition. Our results are presented below:

Condition 1: The community meets the full cost of maintenance.

- . Maintenance funds are established.
- . Cash is deposited prior to construction.
- . A regular levy is paid by users.

Condition 2: Pump mechanics are dedicated.

- . Pump mechanics are selected by RC 3.
- . Pump mechanics are trained.
- . Pump mechanics are supported by RC 3.
- . There is regular follow up/support by field extension staff.

Condition 3: The Water Source Committee (WSC) is active.

- . There is community involvement during the planning stage.
- . The WSC is formed prior to construction.
- . WSC members are trained.
- . The WSC is involved during construction/installation.
- . The water source is handed over to the community.
- . There is regular follow-up and support by extension staff.

Condition 4: Water points are well maintained.

- . Caretakers are well motivated.
- . Caretakers are selected by the local committee.
- . Caretakers are involved during construction.
- . Caretakers are trained.
- . Caretakers are supported and assisted by the WSC.

Condition 5: Women are involved

- . Women are members of the WSC.
- . Women's concerns are discussed in community meetings.

5.2 ACHIEVEMENTS

Findings

Water has been provided to an estimated 587,000 people through the installation of 656 boreholes with hand pumps, 243 rehabilitated boreholes with new handpumps, 1,569 protected springs and two gravity schemes. The breakdown is as follows for the three and half years of activities up to 20 November, 1990.

Component	Water Points	Persons/ Point	Population Served
Borehole drilling	656	300	196,800
Borehole rehabilitation	243	300	12,900
Protected springs	1569	200	313,800
Gravity schemes (2)	27	130	3,500
Total			587,000

* Three and a half years of activities up to 20 November 1990.

Borehole drilling, borehole rehabilitation and spring protection operations are established and are reasonably efficient and effective in terms of production.

Gravity schemes were delayed in the program but the organization has been strengthened and the program is on its way.

PROFILE: Interview with a SWIP Water Engineer

Ian Arebahona is a water engineer and has been with SWIP for one year now. Previously he worked with rural water supply but wanted to work with SWIP because the community is the centre of activity there. As he is from Bushenyi, he knows the area well and is often out in the districts and subcounties for meetings concerning the new water sources. He regards this process of social mobilization as very important for the development of community ownership of the water point. Ian hopes that now that communities have to apply for assistance and make a commitment to share costs, people will also be more interested in maintaining the system.

5.3 TARGETS AND OUTPUT

Noting that there have been three plans of operation - SWIP 1987-1990, SWIP 1988-1992 and SWIP 1990-1995 - general status, targets and achievement of the program are presented in summary form below, according to the SWIP 1990-1995 plan. Information presented below is based on available documentation, with table column including targets set in all three plans of operation, as appropriate.

5.3.1 Borehole Drilling

The established target for borehole drilling and hand pump installation was 1,050 in both SWIP 1987-1990 and SWIP 1987-1992. Using this as a base figure, 62% of the originally set target has been achieved. Looking only at 1990, a target of 248 was set; production this year has only been 50% of target.

Project targets and outputs since 1987 are shown on figure 5.A, while more detailed information is presented in table 5.1.

To complete the 1,050 boreholes by June 1992, 394 successful boreholes need to be equipped (i.e. 450 to be drilled over 16 months working period, assuming a success rate of 85%). This means that each drilling rig will have to complete a minimum of 6 successful boreholes per month.

Fig. 5.A: Borehole Drilling - Targets and Output

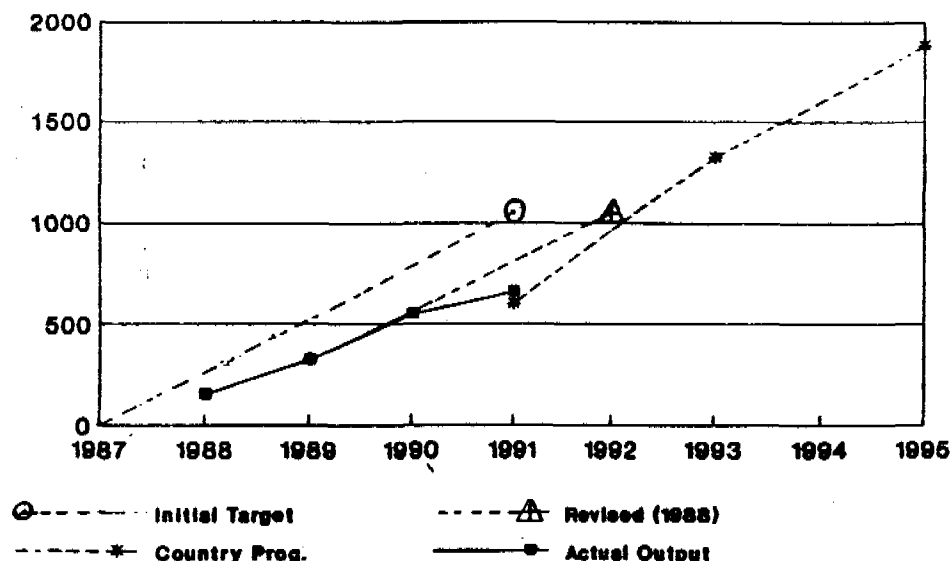


Table 5.1: Borehole Drilling Output and Targets, up to 20 November 1990

District	Year	Drilled	Not Equipped or Dry	Pumps Instal'd	Plan 1990-1992	Achieved %
Mbarara	1987	135	22	101	350	96%
	1988	95	10	82		
	1989	127	18	109		
	1990	50	7	43*		
Total		407	57	335		
Bushenyi	1987	4	0	4	250	99%
	1988	137	20	115		
	1989	136	7	129		
	1990	1	0	4		
Total		278	27	249		
Kabale	1987	0	0		150	37%
	1988	0	0			
	1989	18	0	16		
	1990	46	8	40		
Total		64	8	56		
Rukungiri	1990	16	0	16	150	10%
Total		16	0	16		
Total		756	94	656	1050	62%

*Exact quantity to be determined. A survey was going on at the time of the evaluation.

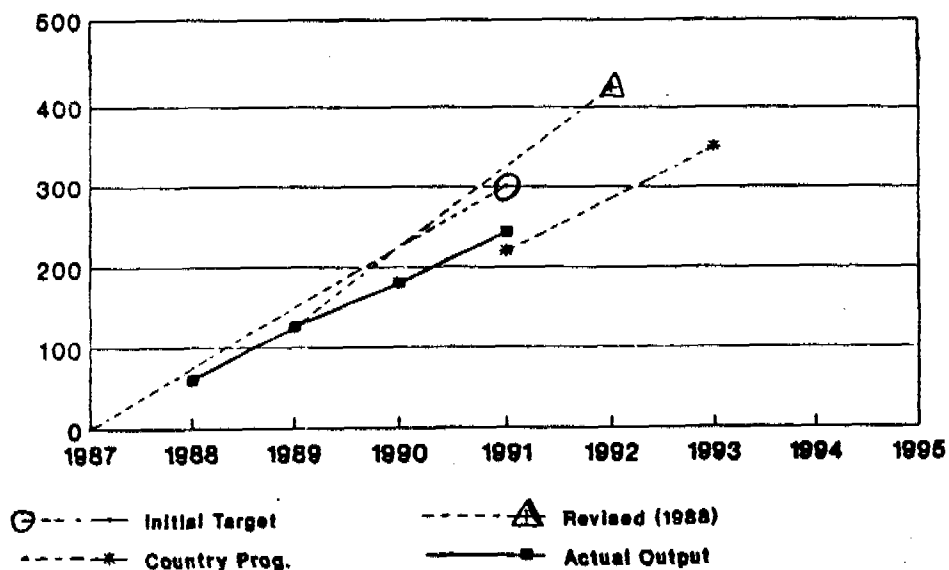
*Three and half years of activities to 20 November 1990.

5.3.2 Borehole Rehabilitation

As shown in figure 5.B below, project targets have been adjusted three times since 1987. According to SWIP 1990-1995, 350 of 424 old boreholes in the program will be equipped with U-11 pumps.

By November 1990, 243 old boreholes had been equipped with new U-11 hand-pumps.

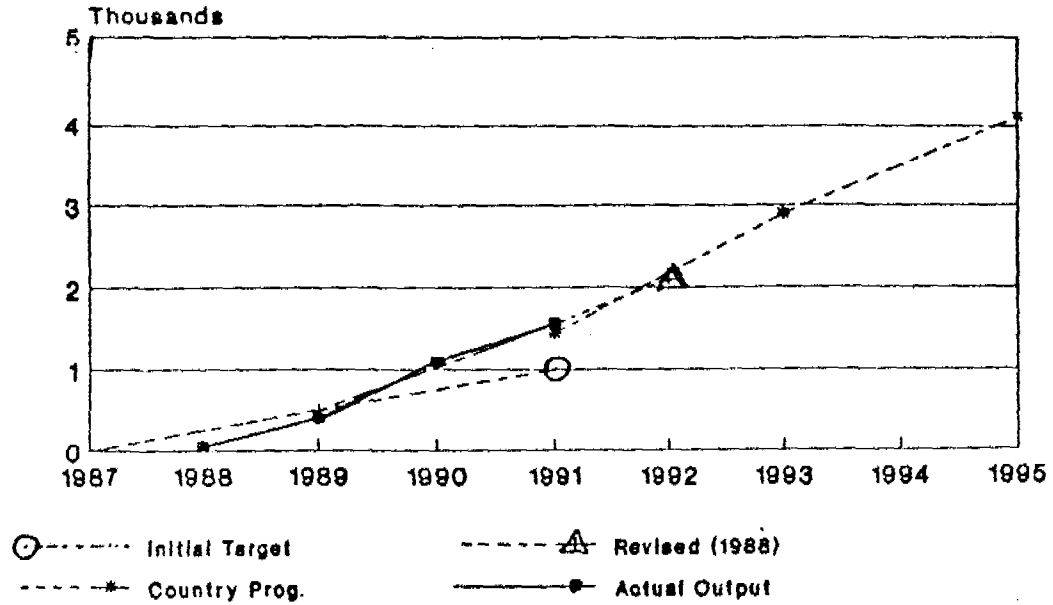
Fig. 5.B: Borehole Rehabilitation and Handpump Replacement - Targets and Output



5.3.3 Spring Protection

As of September 1990, a total of 1569 springs have been protected. The general trend of protected springs implementation is in line with established targets, as is apparent in figure 5.C. Social mobilization training of caretakers commenced in 1989, and to date, caretakers have been trained for 60% of the protected springs.

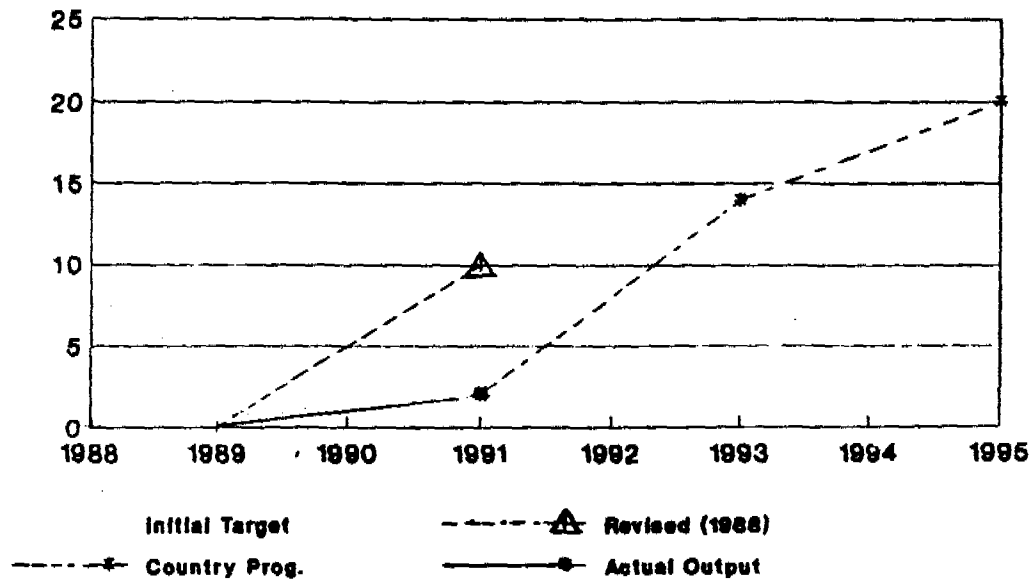
Figure 5.C: Spring Protection - Targets and Output



5.3.4 Gravity Flow Schemes

There was no target for gravity flow schemes in SWIP 1987-1990. The established target in SWIP 1987-1992 was ten schemes by mid-1990. To date two schemes have been completed (in Kigungu and Naboresa parishes of Mbarara district). A total of 40 gravity flow scheme sources have been identified and earmarked for development by the five districts in the program area. Project targets and outputs since 1987 are shown in figure 5.D.

Fig. 5.D: Gravity Flow Schemes - Targets and Outputs



PROFILE: Interview with a Pump Caretaker

The caretaker, Philip, was trained for his job together with members of the Water Source Committee. He is a married 29-year old farmer with three children. He can read and write his own language and understands a little English. As he lives close to the borehole, he can easily keep an eye on it and clean up the surroundings when needed. He also checks that the water is not being misused. Sometimes he has to chase away children who like to play with the water.

During the two days of training he received, Philip learned how important good water is for people's health, and he still remembers the basic health messages. When we ask him what people think of the borehole water he says "they used to suffer a lot, but after the repair of the borehole they are happy".

ISSUE: Sanitation

Our assignment was to discuss how the sanitation component can be improved by identifying its objectives. First we had to decide what we meant by "sanitation". We defined it to be the safe disposal of feces and garbage and hygiene practices in connection with defecation.

The overall goal of SWIP is "improved health", but for sanitation we wanted indicators that are easier to assess. We tried to find a different entry point to sanitation than latrine construction, and agreed on "improved home hygiene", with subgroups of indicators related to:

- safe disposal of human excreta,
- safe water chain,
- safe garbage disposal, and
- hygiene practices

We agreed that sanitation cannot be seen in isolation, but must be linked together with access to water. We also discussed what makes people want to keep their houses and surroundings neat and clean, and the possibility of using competitions for promotional purposes, for example a "Healthy Village/Healthy Baby" campaign.

Good sanitation can be promoted and reinforced by public health by-laws and "sanitation police", but the process really has to start at community level, possibly through group pressure. We finished by looking at possibilities for social mobilization and health education via mass media and schools programmes.

5.3.5 Sanitation Programme

1993 and 1995 targets as presented in the Uganda Country Program 1990-1995 are included in table 5.2. Figures in the "present" column represent status to date.

Table 5.2: Sanitation Project Targets and Outputs (from UNICEF Uganda Country Programme)

Cumulative Output Targets	Present	Plan 1993	Plan 1995
. Health Inspectorate/Community Development staff trained	140	240	400
. Slab casting yards established	4	14	16
. Demo. VIP latrines constructed	100	840	1,160
. Latrine slabs cast	1300	10,000	12,000

5.3.6 Social Mobilization

Targets as presented in the Uganda Country Program 1990-1995 are included in table 5.3. From the figures, it is not possible to determine the impact of social mobilization activities against number of water points provided. This has to be measured in the field. An in-house survey revealed that 70% of the springs had a water source committee (WSC). The percentage for boreholes is not reported.

Table 5.3: Social Mobilization Project Targets and Outputs (from UNICEF Uganda Country Programme 1990-1995; Pump Mechanics and Pump Caretakers taken from other water project outputs.)

Output Targets	Present	Plan 1993	Plan 1995
<u>Annual Targets:</u>			
. Handpumps maintained by user communities	40%	75%	90%
. Protected springs maintained by user communities	45%	80%	95%
. Pump mechanics trained in basic health messages (BHM)	88	155	183
. Spring/pump caretakers and WSC chairpersons trained in BHM	746	7255	8880
. Community leaders trained in mobilization and preventive health skills	650	1500	2800
. Communities supporting income generating projects	8	38	58
. DPOs trained	15	4	4
<u>Cumulative Targets:</u>			
. Pump mechanics trained & equipped	243	155	183
. Pump/spring caretakers trained	581	4053	6197

5.4 INPUTS

5.4.1 Personnel

The SWIP personnel involved in the water and sanitation components are both Government and UNICEF employed. The breakdown is as follows:

Government (MOU)

Borehole drilling	59
Workshop (support staff)	37
Borehole rehabilitation: Mbarara	15
Kabele	12
Total	123

UNICEF

Pump replacement	1	
Hydrogeologist	1	
Springs/sanitation	1	
Gravity flow schemes	1	
CBMS	1	
Workshop	1	
Master Drillers	1	(A second one is being recruited.)

Total 7

There are also two government counterparts, the Project Engineer and a Maintenance Engineer plus one Field Assistant for gravity schemes.

5.4.2 Equipment and Materials

Borehole Drilling

UNICEF set up consists of four NALCO V-666 high speed down-the-hole hammer drilling rigs and four hand pump installation teams plus a hydrofracturing unit, mobile workshop, seven XRH Atlas Copco and Ingersoll Rand Compressors and all necessary accessories and support equipment. Two pumping units have recently been introduced in the project (generator, pumps, tripod and accessories), one with hydrofracture unit.

Handpump Installation

Each of the four installation teams operates independently of the drilling unit and is equipped with special tools for measuring the static water level and installing the hand pumps. The pump pedestal is installed and the concrete slab and drain are constructed to approved standards. Basic information related to hand pump installation is supplied by the pump testing units.

Rehabilitation of Existing Boreholes

The rehabilitation work is carried out by the WDD Borehole Maintenance Unit (BMU) with technical assistance from UNICEF. The project has two pump installation teams backed up by a service rig to remove the old handpumps, clean out the borehole to original depth and obtain water sample for analysis. On completion of the work, the borehole is capped until the hand pump installation team comes to install the pump.

Water Quality Analysis

In the project area, safe water supplies are limited to the existing boreholes now functioning and the protected springs, which actually cover about 1% of the rural populations. With the completion of the project, this proportion should be brought up substantially but no definite figures were provided by UNICEF.

UNICEF is now in the process of setting up a laboratory for basic water testing in Mbarara for chemical and microbiological analysis. These tests were supposed to be done in Kampala, but because of transportation problems and long delays, the analysis is not always done on a regular basis. However, the districts have been provided with portable field kits for simple tests (pH, color, chloride, turbidity and faecal coliform). These kits come up with refills good for 1,000 tests.

Casting Yard

UNICEF has helped establish four casting yards for latrine slabs in Mbarara, Bushenyi, Rukungiri and Kabale Districts. Each slab (two are required for a latrine) is sold at a subsidized price of U.Sh.400/=. This represents approximately 25% of the real cost.

Workshop and Infrastructure

To support these activities, UNICEF has built large workshops in Mbarara. The workshops are quite impressive and well organized. They occupy about two hectares of land and comprise:

- Repair shop and garage with approximately 12 bays
- Welding shop
- Large warehouse where all the spare parts are kept within locked containers
- Large stocking area for vehicles, piping and parts.

UNICEF has now about US \$2 million of spare parts on stock and approximately 100 vehicles. The workshop is also supporting 40 extra vehicles (labor support). SWIP now occupies new offices in Mbarara.

5.4.3 Cost Breakdown

The total estimated expenditure for the period 1987-1990 is as follows:

Social mobilization	\$287,658
CBNC	\$2,839,635
Borehole drilling	\$7,304,158
Pump replacement	\$830,236
Gravity schemes	\$626,567
Spring protection	\$624,242
Sanitation	\$360,009
Total	<u>\$12,866,490</u>

According to these figures, the overall cost per capita for population served is US \$22. Spring protection seems to represent the lowest cost per capita (US \$2).

The costs associated to gravity schemes are not representative of the services offered. They are much too high for the works performed up to now. It is probably due to allocation of expenditures not related to the proper component, which seems to be an accepted practice in the project. For these reasons it is not possible to determine realistic unit prices. For example, borehole drilling activities are supporting other components (fuel, parts, office furniture). This practice should be modified if cost efficiency is to be determined.

Unit cost per borehole is reported by UNICEF to be US \$7,000, infrastructures and support excluded (US \$11,000 if these are included, according to figures).

5.5 EXPANSION OF SWIP TO MASAKA AND RAKAI DISTRICTS

According to the SWIP schedule of activities and workplan presented to the IMSC, it was understood that water components activities are supposed to move to Masaka and Rakai districts in September 1991. A hydrogeological survey has already been initiated. It is also understood that if SWIP has to move to a new district, a water plan has to be established taking into account both technical and sociological aspects in order that the site selection process and social mobilization be completed before borehole drilling and spring protection implementation. However, it is also foreseen that supplementary boreholes will be drilled in districts where there is still some appreciable demand, as in Mbarara. The planning for supplementary drilling should be done jointly with district authorities.

WATER AND SANITATION - FINDINGS, LESSONS LEARNED, AND RECOMMENDATIONS

6.1 INTRODUCTION

This chapter presents the Evaluation Team's findings and recommendations for water and sanitation in areas where improvements could be appropriate. There are numerous fields of activities in the water programme that are effective and efficient in terms of production and achievements; they were presented in Chapter 5.

General findings and recommendations are first exposed. More specific findings and possible actions that could improve the quality of the programme are presented afterwards. The points of interest are organized under the headings "Findings", "Lessons Learned" and "Recommendations"; these are presented together for each area of concern.

6.2 GENERAL FINDINGS AND RECOMMENDATIONS: WATER AND SANITATION PROJECTS

6.2.1 Planning

Findings

In the past, borehole drilling was carried out in areas (Mbarara and Bushenyi Districts) where it would have been much better to have done technical surveys first. The result was a high rate of unsuccessful wells. Drilling was done according to number allocated per district. Allocation did not always correspond to need; the result was that some boreholes were drilled in areas where other water sources already were being used by the local population. This suggested a need for more thorough planning and proper investigation work beforehand, plus better coordination with district officials and those working on the social mobilization side. (This problem should be partly avoidable in the future. The present procedure is that site selection is based on hydrogeological analysis of three sites chosen by the RC 1. If the site needs to be moved, it is to be done in consultation with the RC 1 and technical personnel).

Lessons Learned

In areas where there are several possible sources of water, differences in source water qualities, and various types and costs of solutions, the time and money invested in preparing a general resources survey/water master plan may pay for itself many times over during the implementation phase.

Recommendation

- Perform and establish on a regular basis and prior to moving to new districts, a water survey investigation that incorporates both technical aspects (hydrogeology, access) and social aspects (needs, preferences and sociological factors).

6.2.2 Social Mobilization/Sustainability

Findings

Installation of water points can be carried out faster than social mobilization can foster the community's willingness to participate. Installation of water points without community participation does not encourage a sense of ownership. At the time of the evaluation, boreholes were still being drilled without social mobilization in Kabale. In Rukungiri, social mobilization was done two months in advance.

Lesson Learned

Social mobilization directed to water supply activities should be paced with water programme achievements.

Recommendations

- Social mobilization should be started six to nine months prior to installation.
- Social mobilization should be expanded through extended use of district staff, NGOs, churches and schools.
- SWIP should establish pre-conditions that an organized community must meet before any work will be started; such pre-conditions might include the establishment of a fund earmarked for maintenance and repairs and/or formal written requests through RC's or the district administration.

6.2.3 Sanitation

Findings

The construction of VIP latrines as proposed in the project design is not affordable to the majority of the local rural communities.

Lesson Learned

Sanitation systems should be adapted to local capacities in order to be adopted and sustained.

Recommendations

- Build demonstration latrines made of local materials.
- Promote improvement of local pit latrines when VIP is not affordable.
- Concentrate sanitation project in specific counties as entry points to increase coverage instead of spreading and dispersing the efforts in different areas of the districts.

6.3 SPECIFIC FINDINGS AND RECOMMENDATIONS

6.3.1 QUALITY OF BOREHOLES AND PUMP INSTALLATION

Findings

It has been found that the continuation of CBMS activities could be adversely affected by even a low percentage of non-functioning handpumps and poor quality workmanship on aprons and channels.

Lesson Learned

Quality control is essential in construction and installation.

Recommendations

- Establish a quality control programme that verifies the quality of work and construction on a regular basis.
- Transfer officially to district level the outputs of the water programme once the quality control is fully completed.

6.3.2 Dry and Unsuccessful Boreholes

Findings

Boreholes equipped with handpumps were reported not functioning or to be dry particularly in Lake Mburo (1988) and recently (October 1990) in Bushanyi district. Surveys of the problematic boreholes revealed that approximately 50% of these boreholes have pump breakdown, 25% showed signs of siltation or are giving silty water, 20% have low yield (less than 300 litres/hour or 5 litres/minute) and the remaining 5% are really dry.

Lessons Learned

Full consideration of appropriate technical and engineering design and application is essential for system sustainability.

In the cases of the reported inoperative hand pumps, inappropriate borehole design led to siltation in loose formations. Not performing pumping tests on a regular basis leads to the installation of handpumps in low yield boreholes or, worse, in dry boreholes.

These lessons have been learned late in the project. Corrections implemented in mid-1990 include pumping tests to determine borehole yield and water quality and a new borehole design to solve siltation problems.

Recommendations

Regarding borehole failure due to inappropriate design technology, actions have already been taken. They concern use of mud rotary when necessary, installation of screens, gravel pack and cementation. To improve efficiency of the borehole design, the following recommendations are made:

- Modify the gravel pack actually used (crushed stones) by standard sieved sand and/or gravel.

- Improve cementation procedures by using the tremie pipe method which is the placement of the cement slurry by pumping it in place.
- Modify the cementation recipe by using a standard slurry mixture of cement (1 bag), water (+ 20 l) and bentonite (+ 4%).
- Use proper screens diameter and hole opening in unconsolidated deposits in order that thickness of gravel pack is according to standard (at least 5 cm).
- Consider, where possible, a design with an open hole in bedrock not using screens when hard bedrock is at a relatively shallow depth, permitting deep drilling with 110 mm DTH hammer.
- Consider training the drillers in-charge according to their qualifications to avoid the duplication of the role of the geologists are not available.

Regarding Lake Mburo, where half of the 26 boreholes were reported dry or silted, a hydrogeological investigation performed by a UNICEF Consultant in 1989 recommended that a comprehensive hydrogeological survey be carried out and that drilling should be performed with improved well design in the northern part of the area. These recommendations be carried out to tentatively respond to requests for water supply.

6.3.3 Training of Technical Personnel for Improved Borehole Drilling

Findings

Drilling crews and operators are not convinced of the appropriateness of the new borehole design, particularly the use of screens, the placement of a cemented plug and the diameter of bedrock drilling.

Lesson Learned

In translating needs into technology selections, it is important that the implementors be given a clear understanding of the basis and ramifications of each choice in simple but not patronizing terms. There is need for theoretical and illustrated training with those responsible for each drilling crew. It is understood that this has already been planned but is not yet fully implemented.

Recommendations

Devote specific efforts on the training of MDO staff responsible for the drilling with respect to basic borehole design approach, working methodology and security through regular sessions or workshops performed in the field.

6.3.4 Quality of Borehole Water

Findings

The water quality of boreholes has been verified systematically since mid- 1990 when pumping tests were introduced. However, the parameters analyzed (temperature, conductivity, turbidity and pH) are still incomplete. It was understood that major ions, hardness and coliform will be checked when equipment and materials become available.

Lessons Learned

There is need for quality control.

Recommendations

- Analyze the quality of the water from unverified boreholes through a systematic monitoring programme.
- Consider disinfection of boreholes showing coliform content.
- Perform spot checks of water quality at water source and at user points in order to monitor water transport and storage habits.

6.3.5 Operation and Maintenance of Handpumps

Findings

Pump mechanics have been trained to repair basic breakdown. For cases where pipes and rods were dropped in boreholes and in cases of siltation, (e.g. ten cases reported in Bushenyi in October 1990 and also in Lake Mburo area in 1989), pump mechanics could not perform the repairs.

Lesson Learned

There are some operation and maintenance tasks requiring a higher level of skill than can realistically be created at the community level.

Recommendations

- Arrange for access to a higher level of expertise for pump repairs. This may be handled in three alternative ways: at district level, by the private sector, or through WDO maintenance units.
- Viable operation through the private sector is the long term alternative. There are no trained personnel and equipment actually at the district level. Assisting WDO in this matter seems to be the short term alternative. Train and equip restricted numbers of pump mechanics with tripods and tools to perform fishing out and borehole cleaning.

6.3.6 Pump Mechanics and Communities

Finding

Most pump mechanics seem dissatisfied with the fees they have received up to now. On the other hand, communities also seem dissatisfied with the sub-county pump mechanics, who are accused of charging high prices and profiting from their monopoly.

Lesson Learned

The level of service offered must be geared to what the users want and are willing to pay for. The communities must be informed of the costs of services in order that funds be raised accordingly and administered by them.

Recommendations

- Set up standard prices for services.
- Design a mechanism to train and replace pump mechanics when they are not performing well.
- In order to increase competition, allow pump mechanics to operate in more than one sub-county.

PROFILE: Interview with a Pump Mechanic

The rain was pouring down when we visited the borehole in Buyenje. We invited the pump mechanic into the car for a chat. He told us that his name was Simon and that the existing borehole had been rehabilitated by SWIP. After the rehabilitation, the people in the community had held a meeting and elected a Water Source Committee of six members to be responsible for the maintenance of the borehole. One of the WSC members is a woman.

The Committee chose Simon, a married man of 28 years with two children and the head cook at a neighboring secondary school, to be trained as a pump mechanic. He went to a three week course which gave him the skills to repair broken-down pumps and the knowledge about how dirty water can make people sick. He found the training very good. Simon was given a bicycle and tools by SWIP to be able to reach the four boreholes he is responsible for. "But the bicycle belongs to the village", he said. "I just borrow it for my work".

Simon is not paid for his work, but normally when he has done a repair, he is offered a meal. Also he is exempted from other forms of communal work in the village. He is respected by the villagers, he says, because "if I am not there to fix the pump, there will be no water".

6.3.7 Spring Protection

Findings

The coverage of protected springs compared to springs that can be protected is in the order of 20-40% in most SWIP districts (Mbarara 50%). Protected springs have been standardized in such a way that it requires 10-12 bags of cement to complete one spring, which communities cannot now afford.

Lessons Learned

There should be more flexibility in using and imposing standards, particularly if new approaches, along with the use of truly appropriate technologies, are to lead to lower costs and thus to greater coverage and increased sustainability.

Recommendations

- Promote alternative spring protection designs using local materials such as clay for the retaining wall.
- Implement the new spring protection design on a short term basis in pilot areas.

6.3.8 Monitoring of Water Quality at Protected Springs

Finding

Inventories of water quality of the protected springs in some areas of Rukungiri and Bushenyi districts showed that the presence of faecal coliform is quite normal. The presence of faecal coliform is reported in more than 50% of the protected springs in 1990.

Lesson

There is need for quality control.

Recommendations

- Perform quality control of these springs using SWIP equipment and laboratory that will be soon available and installed in the workshop.
- Verify procedures used by districts for water quality analysis.

6.3.9 Gravity Flow Schemes

Findings

The level of community participation required for the implementation of gravity flow schemes is very high compared to other water components. A lack of social mobilization for the two schemes that have been completed up to now resulted in prolonged completion period (two years). A BPO has been assigned just recently to carry out social mobilization for gravity schemes implementation.

Lesson Learned

Social mobilization should proceed differently for mobilizing communities for gravity schemes compared to other water components such as boreholes and springs.

Recommendations

- Intensify social mobilization from the beginning of surveys.
- Put in more effort and resources to achieve the targets set in the plan of operation, as was done for the other components (springs, boreholes and borehole rehabilitation).

6.3.10 Shallow Hand-Dug Wells

Findings

SWIP never incorporated in its targets (Plans of Operation of July 1987, December 1988 and Country Program 1990 - 1995) the construction of shallow, large diameter wells. Two shallow wells were reported in Bushenyi District and one was visited and found operational. One was done by MDD and the other by a church organization. Five wells were reported in Rukungiri District. They were constructed by MDD/MON with materials provided by UNICEF through MDD. Requests have been made by MDD, district and planning officers to construct dug wells where they are feasible.

Some potential for dug wells exists in the current project area, judging from the number of permanent and perennial local wells.

Lessons Learned

The Plan of Operation never allowed for flexibility in the use of other technologies. New technologies should be introduced, especially if they enhance the objectives of supplying clean water to the rural population and are affordable.

Recommendations

- Consider the introduction of a dug well component into SWIP activities. This component could be implemented by SWIP or by SWIP supporting interested NGOs or both.
- Prior to implementation of a dug wells program, carry out a hydrogeological survey to establish potential sites, possible targets, logistical inputs, cost and budget.

COMMUNITY-BASED HEALTH CARE

7.1 INTRODUCTION

After social mobilization and water development, community-based health care (CBHC) is introduced in the community as the last of the SWIP components. CBHC has been designed to build on the gains made by the first two components, the most important of these gains being the health awareness that is created when communities are organized to carry out water supply projects.

7.2 OBJECTIVES AND TARGETS

The main SWIP objectives served by CBHC are the development of a national strategy for CBHC by 1995 and coverage of a target population of 500,000 people living in 300 communities in the Southwest.

As well as developing national strategies, SWIP's CBHC project aims at developing programs for training of trainers (TOT), developing training curricula and materials, establishing a community-based data collection and monitoring system and establishing liaison with other on-going health related programs at central and district levels (e.g. UNEPI, CDD, AIDS prevention).

The planned outputs are 2000 trained community health workers (CHWs), 200 trained community health committees, and 240 health workers trained as trainers of CHWs.

7.3 TRAINING ACTIVITIES

The CBHC process consists of a series of meetings and discussions, visits, data collection and analysis, training and retraining taking place over a flexible period of time. They are aimed at supporting communities to adopt healthy life-styles.

The basic structure of training is a cycle consisting of series of workshops alternating with long periods of field based activities. This strategy provides for repetition, correction and incremental learning which can be adjusted to the pace of the learner.

There are three target groups for training:

- The first consists of DPOs and other district level officers. Their training is aimed at developing a core of resource persons for other training activities.
- The second consists of trainers and village health committee members. They are drawn from county and sub-county level and from the communities themselves. This group is regarded as an essential link between the community and the formal health system. The quality of individual members and the number available determine both the quality of CBHC in the communities and the pace of expansion to other areas.
- The third group consists of community members who are identified by the communities to be trained as abahwezi (unpaid CHWs) and TBAs. Their dedication and motivation determine how long the project can be sustained in a given locality. Each abahwezi has responsibility for up to ten homes.

All learning/teaching sessions use participatory adult learning techniques. At community level, great emphasis is placed on the use of appropriately designed pictures to initiate discussion on important health issues. Learners are encouraged to discover 'answers' for themselves.

Training is based on a curriculum developed by the Ministry of Health and the Uganda Community Based Health Care Association (UCBMCA). In SWIP's CBHC project, training in the use of essential drugs will be considered after a community has demonstrated good collective management and a strong commitment to preventive and promotive health activities.

During visits to TOT sessions, it was observed that resource persons used their skills appropriately to achieve effective group interaction and communication. Community health committee members and CHWs expressed positive views about their training, though some had raised questions about remuneration.

The rate-determining steps in the whole process are the early stages when interest and commitment of communities are being calculated. The shortage of suitably qualified and motivated trainers is recognized as a constraint.

PROFILE: In the Head of a CBHC Trainer

"It is not so easy to be a trainer", said Ephraim Mugisha when we met him at the trainer refresher course in Kabuhohe. He showed us the list of problems that he encounters in his work training abahwezi and members of the Village Health Committee in Buyanja, where he is the headmaster of a primary school.

"First we have the problem of the time for the meeting. You inform them but they don't come or they don't come at the right time. You ask them to come at 9 and they arrive at noon, and if you arrange a meeting in the afternoon they may not come at all. You expect 40 people and 8 will come... Sometimes you get a bit discouraged.

"Then we have the problem with alcohol. There are men who start drinking already early in the morning. They don't even work; they don't contribute. Women and children are suffering. What can we do? Approach them at the bar? But then they will be drunk and won't listen.

"It is difficult to put the things you learn into practice. Even among us trainers there are people who fail. They may tell others to boil drinking water but won't do it themselves. But I try - my wife has boiled water for drinking in the house.

"In the area where I live many people are still ignorant. Even some of the leaders don't understand how important clean water is for the health of people. Often there is a power struggle between the chief and the RC Chairman and if they don't assist it is very difficult to make people listen and understand.

"It is now half a year since we had the last part of the training course and in the meantime I have trained abahwezi and done the community survey. It took a long time to do it because sometimes people were not at home and you had to come back. And some people did not understand why we asked these questions and refused to answer or gave the wrong answers. It has been good to meet the other trainers. We have shared experiences and we try to support each other. It seems we all have similar problems and we try to sort out the ones that we can tackle."

7.4 FINDINGS

7.4.1 ACHIEVEMENTS

After two years of implementation, the project has evolved a CBHC approach to health development. CBHC activities have been initiated in 22 parishes serving an estimated population of 143,000 people in five districts; 468 abahwezi, 300 TBAs, 142 trainers and 60 community health committees have been trained.

In the process, a number of key constraints have been identified, criteria for identification and selection of communities have been developed, and the sequence of essential steps required in the establishment of CBHC has been defined. Furthermore, a core of trainers with skills in adult learning techniques has been developed; training strategies and methodologies have been refined and a number of practical training manuals have been developed and are used by almost the entire membership of the Uganda Community Based Health Care Association (UCBHCA).

There is good cooperation among NGOs involved in CBHC in the project area and at field level. The project has fostered growing intersectoral co-operation among technical staff; village health committees are multidisciplinary, often involving chiefs, RC members, school teachers and religious leaders.

Health committees and trainers are able to conduct community surveys and to analyze their results, which in turn are used in training of CBHCs.

The activities of abahwezi have led to concrete changes in home hygiene practices. For example, homes have better maintained bathing shelters, improved pit latrines, boiled drinking water and drying racks for cooking utensils.

Although there are no parish-specific EPI results, there are anecdotal accounts from mothers and community health committees about increased uptake of immunization, which they attribute to awareness acquired through interaction with the project.

7.4.2 SHORTCOMINGS

Against these achievements are a number of shortcomings, as listed below.

At its present rate of implementation, CBHC is expected to cover no more than 15 new parishes a year - a total of about 80 parishes by 1995 in an area which registers over 500 parishes. There is an unmet demand from communities in neighbouring parishes. District health authorities have expressed reservations about what they regard as a slow rate of coverage.

In spite of its objective of developing a national strategy for community-based health care, there are no established procedures or formalities for adopting project lessons into a national strategy. Liaison with national health programmes and projects is weak.

District authorities and staff lack a sense of ownership of the project; they regard it as an outsider's responsibility to which they may lend occasional support.

In the specific case of TBA training, there is a potential conflict between project strategies on one hand and UNFPA/MOH strategies on the other.

7.5 LESSONS

In the course of implementing CBHC, a number of general and specific lessons have emerged:

1. Community uptake of preventive and promotive health is slow and in order to establish CBHC successfully, one should move at the pace of the community.
2. The investment in training community health committees is important. Training them so that they are clear about their roles and responsibilities is crucial for ensuring sustained support of CHWs.
3. Expansion of CBHC based on demand by a community is useful rule of thumb; such demand is usually a sign of awareness and commitment.
4. An active RC system is a catalytic structure in developing CBHC.
5. CBHC is not a monopoly for health workers. It can be done as well or better by others with ability to communicate and organize communities. Examples are teachers, community development staff, agriculture extension staff.
6. Training many abahwezi so that each looks after up to ten homes reduces the burden on such workers and makes them less likely to insist on remuneration.

7.6 CONCLUSIONS

SWIP's CBHC project has important achievements over the last two years.

It has set its pace at the pace of the community in order to ensure successful uptake.

The greatest challenge facing the project and government in the immediate future is the development of procedures for adoption of project achievements into a national strategy for country-wide replication.

7.7 RECOMMENDATIONS

1. SWIP has demonstrated that CBHC can work; it is time to move from the learning stage into expansion phase.

A critical requirement for going from project stage to scale is a clear policy framework that will make CBHC a legitimate responsibility of all related ministries.

It is recommended that MLG, MOH and SWIP work together to establish an inter-ministerial/intersectoral committee to develop national policy and guidelines for CBHC implementation.

2. The abahwezi concept as practised resolves or avoids many of the problems associated with 'traditional' PHC village health worker programmes. It is recommended that MOH adopts the abahwezi concept as one of its key strategies for realizing its goals of Health for All.

3. Even before national guidelines for country-wide replication become available, the scope for expansion in the project area will be greatly increased if a basis is laid down for CBHC activities to become a part of the formal functions of district staff.

One way to do this is for the relevant ministries (MLG, MOH, MOE, MDA and MWD/MDO) to direct their district staff to regard CBHC as part of their regular functions and to collaborate with SWIP personnel in its implementation. SWIP for its part should respond by giving increased support and control of resources to the districts. In this way a greater sense of ownership and responsibility can be fostered in district officers and their staff.

4. In many CBHC projects, the early introduction of drugs and curative activities has diverted attention from the far-reaching and longer lasting gains of good personal and hygienic practices. The decision of SWIP to phase in drugs and curative activities only at a later stage in the programme appears well considered and should be tested over the next two or three years.

APPENDIX A

TERMS OF REFERENCE

AND ITINERARY

MID-TERM EVALUATION OF THE UNICEF ASSISTED
AREA BASED PROGRAMME IN UGANDA
12TH - 30TH NOVEMBER 1990

South West Integrated Health & Water Programme (SWIP)

TERMS OF REFERENCE

SUMMARY

According to the UNICEF-UGANDA COUNTRY PROGRAMME 1990-1995 a mid-term evaluation of the Area Based Programme in Uganda, the South West Integrated Health & Water Programme (SWIP) is planned for 12-30 November 1990.

The evaluation team will include representatives of the major donors to the programme (SIDA and CIDA), a consultant identified by the programme, and selected Government officials.

This Terms of Reference has been developed by Officials of the Ministry of Planning and Economic Development, the Programme Management Team and UNICEF staff to identify the key programme aspects where the evaluation team will direct their expertise.

This document will serve as the basic reference for the evaluation team. The framework of the evaluation is to consider the management and operations of the Area based Programme - SWIP against the background of the programme's plan of operation. It is anticipated that the final report will become an essential resource document for improving future programme implementation.

OBJECTIVE

The overall objective of the evaluation is to review the performance of the programme toward achieving the programme objectives, to document achievements and shortcomings, and suggest appropriate improvements, particularly in the following areas:

- 1 Integration of health and water activities/sanitation related activities and the balance between the different components.
- 2 Community participation/particularly in planning/decision-making, operation and maintenance, with particular attention to gender related issues.
- 3 Affordability, sustainability and replicability of the programme activities.
- 4 Inter-sectoral cooperation with national programmes supported by the ministries of health EDF/Rural Health Programme and Water and Mineral Development.
- 5 Relationship between SWIP and other programmes in the programme area especially EDF/Rural Health Programme and other health activities.
- 6 Relationship between SWIP and national policy development institutions especially in the areas of PNC, development of water source maintenance and health service integration.
- 7 Improvements in programme activities to maximise the realization of the programme's objectives with particular attention to opportunities for integration and cooperation between the programme elements, especially at district level and below.

BACKGROUND TO AREA BASED PROGRAMME - SWIP

The Area Based Programme-SWIP was conceived out of the recognition by the Government of Uganda that the only practical way to address rural health problems is through integrated and strengthened intersectoral collaboration and community involvement in all processes. Government also acknowledges the fact that the mere provision of safe water sources or sanitary facilities may have no impact on health if users are not educated on the proper use of these facilities.

A protocol was signed between UNICEF and the Government of Uganda in 1987 as a supplement to the Country Programme in which UNICEF undertook to assist Government to implement a pilot programme in five southwest districts, integrating water supply activities with other health interventions. The seven components of the Programme are:

- Community base health care
- Social mobilization
- Borehole drilling and handpump installation
- Borehole rehabilitation and handpump replacement
- Gravity flow schemes
- Spring protection
- Sanitation

The Programme started in late 1987 with the primary objective of improving the health status of the population in the programme area, particularly mothers and children, through:

- (a) Implementing a community based health care system with the aim of empowering communities to take more responsibility for their own health, through dissemination of basic health messages and eventually leading to changes in attitudes and behaviour regarding water use, basic sanitation, and immunization.
- (b) Using safe water supply as an entry point to improved health by:
 - Protecting springs,
 - Rehabilitating old boreholes and installing new handpumps,
 - Drilling new boreholes in areas without adequate surface water, and
 - Constructing a few gravity flow schemes where possible.
- (c) Assisting communities to set up and operate a self-reliant maintenance system for their water sources.

It was envisaged that SWIP, as the first Area Based Programme of its kind in Uganda, would serve as a testing ground for programmes that would later be replicated in other parts of the country.

BACKGROUND TO THE EVALUATION

According to the UNICEF-UGANDA COUNTRY PROGRAMME 1990-1995, a mid-term evaluation is planned for late 1990. In addition, members of the Programme Management Team are committed to the improvement of programme activities through an objective evaluation after three years of field implementation.

The programme is in transition because most technical "hardware" components, such as borehole drilling and pump replacement, are likely to be over by early 1991 in four out of five districts. Much more intensified activities will then focus on the "software" components, such as follow-up support and community mobilization/education, so that more communities are organized to be active in the prevention of disease, promotion of health, maintenance of water sources and to ensure sustainability in all programme activities. The evaluation is therefore at the appropriate time to address the following questions: How will the Programme expand to other districts and maintain software support? How to plan for the sustainability of operations as the Programme moves? What is realistic for the Districts to undertake and what Programme support will be required? What will be the relations between central ministries and the districts as the programme phases out?

The Programme Management Team will benefit from the evaluation exercise, particularly from suggestions regarding future strategies, research and evaluations.

MAIN EVALUATION QUESTIONS

1. ORGANIZATIONAL ASPECTS

- A Lines of authority:
 - National Steering Committee
 - Programme Management Team
 - District Administration
 - Community Level.
- B Decision making process with reference to reaching at-risk and target groups and addressing gender issues.
- C Channels of communication between communities, districts, programme management and central government.
- D Competibility with national policy for the decentralization of authority toward district level and the trends in the national health policy toward the integration on health activities.

E UNICEF's role in programme activities and their relationship to central and district administrations and communities.

F Supply delivery system: ordering, storage and distribution.

2. PROGRAMME PROCESS

A Identification of felt needs.

B How identified needs are developed into final implementation, operations, and maintenance systems.

C How technical and social aspects are coordinated.

D Implementation: Levels of district and community involvement in planning, implementation and maintenance of water, sanitation, health and social mobilization activities.

E Appropriateness of the sanitation component.

F Training of staff, district officials and communities.

G In-built monitoring and evaluation.

H Constraints at community, district, and national level to programme implementation.

3. FINANCIAL AND ECONOMIC ASPECTS

A Community contribution: - Financial
- In kind

B District Contributions: - Personnel
- Finance

C Planning and budgetary aspects at national and district level.

D Potential long-term effects of performance bonus and incentive system.

E Utilization of programme resources, including budgeting, accountability programme and financial control at all levels.

F Sustainability of communities' and districts' capacities to mobilise and manage sufficient resources to support an integrated community-based health and water programme.

G Cost-effectiveness.

4. TECHNICAL ASPECTS

A. Choice of technology for water component, including the selection of type of water source for each location and the review of the type of borehole drilling system in operation.

B Repair & maintenance; supply of spare parts.

C Capacity utilization.

D Training and skill building.

E Use of local resources.

G Sanitation cost and technical aspects in relation to local conditions.

5. COVERAGE

A Objective coverage: distribution of the services in relation to target population.

B Strategies for reaching vulnerable groups.

- C Replicability.
- D Advice on plans for expansion of the programme area.

SELECTION OF PARTICIPANTS

It is essential that the members of the evaluation team have experience in the fields of water, sanitation and primary health care, and preferably have worked in developing countries.

The evaluation team's assignment will reflect a range of expertise within the elements of Primary Health Care including programme management, water source development, community based water source maintenance and community based health care.

Agencies and Government Ministries are requested to identify individuals with the specific skills listed for that agency and Ministry (see table below), and to provide their curriculum vitae and samples of previous work to the Programme Management of SWIP and to the Ministry of Planning and Economic Development Social Services Sector through UNICEF-Kampala so that the evaluation organizers can ensure that all skill areas are represented on the evaluation team.

<u>Agency</u>	<u>Skill Area</u>
SIDA (Team Leader)	Programme management. Should have experience in evaluating area based programmes
SIDA	Community based health care
CIDA	Hydrogeology
CIDA	Community based water source maintenance
WDD	Water development
MPED	Social mobilization
MOH	CBHC and health planning & management
MLG	District health service management & policy development
SWIP Consultant	Health planning & management, primary health care

Programme officials will work closely with the evaluation team to provide information and to learn from team members. They will not, however, participate in the drafting of the evaluation report.

To achieve the objectives of the evaluation all members of the evaluation team must clearly understand their assigned activities and roles within the exercise. It will be the responsibility of the team leader to manage these assignments and insure that the various stages of work are completed on schedule.

BACKGROUND DOCUMENTS

Background documents will be supplied to provide information on the development of the programme, the selection of strategies, and the progress made to date toward reaching the programme targets. The initial background documents to be sent to each participant are:

- o Programme Proposal and Plan of Operation 1987 - 1992
- o Programme Annual Reports 1988, 1989, 1990
- o South West Integrated Programme 1990 Workplan
- o Relevant pages of the UNICEF-UGANDA Country Programme 1990 - 1995 on Area Based Programme-SWIP
- o Situation Analysis of Women and Children in Uganda
- o Mbarara Baseline Survey 1998

During the evaluation, participants will receive the preliminary results of a safe water survey conducted in August 1990. The study will provide useful quantitative and qualitative data on boreholes drilled and springs protected as well as maintenance aspects. Participants will also receive brief background reports on each of the functional elements of the programme (Borehole construction & rehabilitation, Spring Protection, Gravity Flow schemes, Sanitation, Social Mobilization, Community Based Water Source Maintenance and Community Based Health Care). Relevant reports of previous evaluations will also be made available.

These documents, combined with the main evaluation questions, should provide the team members with an adequate background to programme activities to begin to formulate field questions.

SCHEDULE OF WORK

A draft schedule of work will be prepared and presented to the participants upon arrival. It will include time for the review of background documents, team building and assignments, interviews with central personnel, field visits, data analysis, report writing, draft report presentation, editing, and final report presentation. Arrangements for additional or alternative field visits and interviews can be made for the team if requested.

To secure agreement on the design of the evaluation with programme management, the team will be asked to prepare a draft outline of the evaluation report for comment before beginning the field work.

DATA COLLECTION

The scope of the evaluation will be to establish the activities and operations undertaken by the programme against the background of the original programme plan of operation. Data will need to be collected on the status of programme activities and opinions and views of key personnel and beneficiaries.

To that end, desk reviews, directed interviews, observations, and questionnaires may be utilized. These instruments will be designed by the team members based on the main evaluation questions presented in the final Terms of Reference.

To secure frank information from interviewees, large group meetings should be minimized and an emphasis placed on individual interviews. This approach can help maximize the number of persons interviewed. As team members can break up to hold one-to-one interviews and small group discussions.

The evaluation team should be sure to interview national level staff, including the managers of national health and water programmes and senior operations staff in the Ministry of Health, the rural water section of the Ministry of Local Government, and LDD. To support contact with national level personnel the preliminary interview schedule will include time with key staff based in Kampala and Entebbe.

FIELD VISITS

The evaluation team will visit relevant officials at the national, district, and local levels including UNICEF-Kampala, BDF, Rural Health Programme and relevant DANIDA staff, as well as programme staff and programme beneficiaries.

Visits to water sources, user communities, district administration and district health offices, and interviews with beneficiaries and key personnel will be arranged for at least five days of the review. These field visits should provide adequate time for team members to get a feel for the overall project activities and to develop an in-depth impression of specific issue areas.

A timetable for arranged visits with key central level officials and project staff will be prepared and the necessary appointments made before the arrival of the participants. Field visits will also be arranged in advance but every effort will be made to accommodate unplanned visits to implementation sites and ad hoc interviews with local-level implementation staff and project beneficiaries as the review team sees fit.

The aim is to make optimal use of the participants' field time by prearranging basic administrative details and identifying the key areas of investigation in advance.

PRESENTATION OF THE FINAL REPORT

The final report will be presented to the Ministers and Permanent Secretaries of Planning and Economic Development, Water & Mineral Development, Health, and Local Government as well as Project Management SMIP and UNICEF. An oral presentation will be conducted on the final day of the review to summarize the main issues of the final report which will be submitted at the same time. Following the presentation, members of the review team will avail themselves to project personnel for consultation on specific findings and recommendations.

To ensure acceptability of the final evaluation report to Government and UNICEF, a debriefing meeting attended by the members of the evaluation team and concerned Government and UNICEF staff will be held 48 hours before the final report is to be presented.

The final report will include a timetable for the implementation of recommendations and for the periodic review of actions taken by project staff to act on the recommendations of the review team. This timetable should be included in the debriefing review.

ADMINISTRATION AND LOGISTIC SUPPORT

MPED shall provide a coordinator for the evaluation. The coordinator will be supported by UNICEF-Kampala and SWIP-Mbarara will provide administrative support to all participants in the evaluation and will make arrangements for accommodations and transport. Secretarial support for the preparation of the evaluation document will be provided by the Programme (SWIP) and UNICEF.

BUDGET

Donors will be responsible for expenses incurred by participants fielded for the evaluation exercise. Consultants and national participants will be supported by SWIP.

ITINERARY AND TIMETABLE FOR SWIP MID-TERM EVALUATION

11 - 30 NOVEMBER 1990

Sunday 11 November

Arrival of External Participants in Kampala
1900 Informal Get-Together for Evaluation Participants

Monday 12 November

0830 Team Members Meeting
1400 Meet UNICEF Representative and Senior Project Officers
1600 Meet PS MLG and Commissioner for Community Development

Tuesday 13 November

0830 Depart for Entebbe
0930 Meet PS MON and Director of Medical Services
1100 Meet UNEPI and CDO Managers, ADMS (HE), ADMS (P), ADMS (MCH) and UCBHCA Manager
1400 Depart for Kampala
1500 Meet PS M&MD and Commissioner for MDD
1600 Depart for Mbarara

Wednesday 14 November

0830 Meet SWIP Management Team
1600 Meet EDF-RNP Management Team

Thursday 15 November

0800 Depart for Kabele
1000 Meet District Officials
1400 Visit Programme Activities in the Field
1900 Return to Kabele

Friday 16 November

0800 Depart for Rukungiri
1000 Meet District Officials
1400 Visit Programme Activities in the Field
1900 Return to Mbarara

Saturday 17 November

Queen Elizabeth National Park, Game Viewing
Stay for the Night

Sunday 18 November

Optional

Monday 19 November

0830 Depart for Kasese
1000 Meet District Officials
1400 Visit Programme Activities in the Field
1900 Return to Kasese

Tuesday 20 November

0830 Depart for Bushenyi
1000 Meet District Officials
1400 Visit Programme Activities in the Field
1900 Return to Mbarara

Wednesday 21 November

0930 Meet District Officials
1200 Visit Programme Activities in the Field
1800 Return to Mbarara

Thursday 22 November and Friday 23 November

0830 Attend Inter-Ministerial Steering Committee Meeting

Saturday 24 November and Sunday 25 November

Informal field visits and start of write-up

Monday 26 November and Tuesday 27 November

Evaluation Team Meeting and write-up

Wednesday 28 November

0900 Presentation and discussion of draft report with SWIP Management Team, Government and UNICEF

Thursday 29 November

0800 Depart for Kampala

1100 Finalization of report by team members

Friday 30 November

1000 Presentation of evaluation report to MPED

APPENDIX B

LIST OF PERSONS MET

LIST OF PERSONS MET BY THE EVALUATION TEAM

UNICEF KAMPALA		
Sally Fegan-Wyles	-	Representative
Colin Glennie	-	Senior Project Officer, Health
V. Lukyamuzi-Mbidde	-	Asst. Programme Officer, Health
Ivone Rizzo	-	Project Officer, PNC
Livingstone Byarugaba	-	Project Officer, MCH/CDD/AIDS
Juhani Alanko	-	Project Officer, EPI/Emergency
Michel Nowacki	-	Senior Project Officer, WES
Grace Ekudu	-	Asst. Programme Officer, WES
Stephen Adkisson	-	Programme Officer, POME
Lauchlan Munro	-	Asst. Programme Officer, POME
MINISTRY OF HEALTH		
Kwaga-Abungi	-	Acting Permanent Secretary
E.G.N. Muzira	-	Director of Medical Services
C.A. Abola	-	Under Secretary (Planning and Administration)
A. Nzabanita	-	Asst. Director of Medical Services (Health Planning Unit)
Jonathan Gaifuba	-	ADMS (Health Education)
Fred Musonge	-	CDD Programme Manager
John Barenzi	-	UNEPI Programme Manager
UGANDA COMMUNITY BASED HEALTH CARE ASSOCIATION		
Adoniya Kyeyune	-	Programme Manager
MINISTRY OF LOCAL GOVERNMENT		
J. Ruchogoza	-	Acting Permanent Secretary
J.M. Ruabeire-Baira	-	Commissioner for Community Development
MINISTRY OF WATER AND MINERAL DEVELOPMENT		
Nathan Oboi	-	Permanent Secretary
B.K. Kabanda	-	Commissioner, Water Development Department
Edward Wanda	-	Assistant Secretary, Rural Water
S.M. Mutono	-	Project Coordinator, RUMASA, MDD/DANIDA
William Odoi Owor	-	Senior Economist
J.B. Odul	-	Director of Drilling, MDD
SOUTHWEST INTEGRATED HEALTH AND WATER PROGRAMME - SWIP		
John Ndiku	-	Project Manager/CDC Officer
Jan van der Horst	-	UNICEF Project Coordinator
Birendra Shrestha	-	UNICEF Project Officer, Springs and Sanitation
I.P. Arebahona	-	Project Engineer
Phoebe K. Baddu	-	Project Officer, Social Mobilization
Seburya Kius L.	-	UNICEF Asst. Project Officer, WES
Stefan Gyorgy	-	UNICEF Hydrogeologist
Ronnie Ruwanja	-	District-Based Project Officer (DPO), Bukungiri District
Margaret Katono Mbazira	-	DPO, Bukungiri District
Eldad Walakira	-	DPO, Bukungiri District
Vincent Atayomizah	-	DPO, Kabale District
Edward Buungya	-	DPO, Bushenyi District
Joyce Zirabamuzale	-	DPO, Bushenyi District
Mark B. Muina	-	DPO, Mbarara District
Jolly Berigye	-	DPO, Mbarara District
Haimul Islam	-	WW Pump Installation Supervisor
KABALE DISTRICT TEAM		
V.R. Berigayomwe	-	District Administrator
Samuel Katchangwa	-	Asst. District Executive Secretary
Mushaija	-	District Medical Officer
Martha Bekiita	-	District Health Visitor
David B. Bakiiza	-	Water Field Officer
John M. Birija	-	District Community Development Officer
Bik-Bat Kasimbezi	-	Borehole Maintenance Supervisor
Elisha John Kakurumatsi	-	BC 5 Chairman
Zerida Sendegaya	-	BC 5 Secretary for Women
A. Nzabakurikiza	-	District Health Educator

RUKUNGIRI DISTRICT TEAM	-	District Administrator
B. Birigwa	-	Personnel Officer
Aspol Kwesiga	-	District Community Development Officer
P. Waako	-	District Information Officer
M.A. Mbabazi	-	Field Officer, Medical Entomology
Michael Bifurenda	-	District Treasurer
Alfred Ruobusheru	-	Supervisor of Works
Johnson Turyagyenda	-	District Health Educator
Francis Ndaazarwe	-	District Health Visitor
Constance Mary Izongozah	-	Health Inspector
Herbert Isabirye	-	Deputy District Health Inspector
D.T. Bigirwa	-	In-charge of Adult Education and Projects
Jackson Turyazayo	-	
BUSHENYI DISTRICT TEAM	-	Deputy District Administrator
Peter W'ochengenga Odoko	-	Asst. District Executive Secretary
C.M. Kiberu	-	District Treasurer
Eric Babigarukamu	-	Asst. Supervisor of Works
Sethi Beshubiza	-	District Community Development Officer
J.B. Rutahwaire	-	District Health Visitor
Betsy Baharanganah	-	Chairperson, District CBHC Association
Ephrance Nwamanya	-	Senior Health Assistant
John Kajungu	-	Water Field Officer
George Okot	-	Sanitation Coordinator
K.S. Ahimbisibwe	-	District Health Inspector
N.R. Tumusiime	-	Acting District Medical Officer
A. Kagwisagye	-	
KASESE DISTRICT TEAM	-	District Administrator
Peter T. Lokeris	-	District Health Inspector
Jean-Marie Masereka	-	Asst. District Executive Secretary
Dan Kalule	-	District Community Development Officer
Lammel Bwengye	-	District Medical Officer
Kanya Basaza	-	
EDF RURAL HEALTH PROGRAMME	-	Project Coordinator
Thomas van der Heijden	-	Project Coordinator Counterpart
Mitimana-Lukanika R.C.	-	
MBARARA DISTRICT TEAM	-	District Administrator
N. Rwigyema	-	Town Clerk
David Beshokara	-	RC 5 Secretary
Y. Gucwamangi	-	RC 4 Chairman
A.B. Tibeswiga	-	Asst. District Treasurer
Charles Nimbisa	-	RC 5 Secretary for Women
Idah Mahangye	-	Asst. District Executive Secretary
Isaac Mulwany	-	Mass Mobilizer
D.R. Npobeitsi	-	District Medical Officer
P.R. Byaruhanga	-	District Community Development Officer
Inelda Rwumucopo	-	District Health Inspector
Charles Tumwaza	-	Health Inspector
James Kwesiga	-	
MINISTRY OF WOMEN IN DEVELOPMENT	-	Commissioner, Women in Development
R.P. Tumusiime	-	
MINISTRY OF FINANCE	-	Senior Finance Officer
D.G. Turyahabwa	-	
UDD/DANIDA	-	Chief Advisor
J.B. Nansen	-	Community Development Consultant
Peter Dankaine	-	DANIDA Counsellor
Birger Friederiksson	-	