



Towards better sanitation in Uganda

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SANITATION RELATED ACTIVITIES in Uganda have not received adequate attention over the last 30 years. 12.2 per cent of Uganda's population live in urban areas with an urban growth rate of 5.5 per cent per annum. However, no single town in Uganda has a satisfactory sanitation management system. The low-income household living in slum areas are the worst hit. The situation in the rural areas is equally appalling, with latrine coverage in most districts being below 50 per cent while other sanitary facilities are totally lacking.

Out of the estimated 2.5 million tons of refuse produced annually, only 40 per cent is collected and less than 10 per cent is disposed off properly. Furthermore, wastewater disposal and storm drainage is inadequate or absent in most settlements across the country.

The above scenario therefore depicts the poor state of sanitation in Uganda.

The main types of sanitation systems include

- Traditional unimproved pits
- Ventilated improved pit latrines
- Septic tanks and soakaways
- The bucket system
- Full water borne sewerage

Some of these systems are not adequate and are therefore discouraged, such as the bucket system. However, the traditional pit latrine is the most common but even then the latrine coverage is less than 10 per cent in some districts. There is therefore a need of revamping the above situation.

Current situation

Sanitation related diseases such as cholera, dysentery and malaria have until now been on the increase in Uganda. It is therefore no wonder that the biggest expenditure of the health budget is on curative services of these diseases, which could be prevented. As long as the sanitation is not improved, this trend is likely to continue, leading to wastage of resources which could best be utilised elsewhere in health service delivery.

Due to lack of excreta disposal facilities in many areas, the excreta was washed away by the heavy rains (El-Nino) world-wide to most of the water collection points, leading to gross faecal contamination of the water sources. In other areas, the high water table gave way to easy faecal contamination of the ground water through percolation of the El-Nino rains contaminated with excreta. It was therefore no wonder that there was a serious outbreak of Cholera towards the end of 1997 and another outbreak between March and May this year in some districts of Eastern

Uganda. Other modes of infection include transmission of pathogens in dirty hands because of poor personal and family hygiene, that is, no washing of hands after visiting latrine or prior to meals. Furthermore, flies and insects are a common sight in households and carry pathogens from the excreta to food.

Poor surface drainage and indiscriminate housing developments have created common sites of stagnant pools of water. This is coupled with uncontrolled overgrowth of compounds and hedges that have led to infestation of vectors and rodents. Malaria is therefore rampant all over the country especially during the rainy seasons and has also led to the loss of lives.

Solid waste disposal is also a serious problem especially in the urban areas. Due to the large populations within the cities, a lot of waste is generated, which exceeds the capacity the local authorities can afford to collect regularly. It is estimated that only 40 per cent is collected and less than 10 per cent is disposed off properly. Furthermore, the main method of solid waste disposal used is open dumping, as a result of which the disposal sites fill up quickly. This leads to a constraint on land which would otherwise be used for development purposes. The above method also offers favourable breeding ground for vectors and rodents which are a nuisance.

Additional problems identified with the current situation include

Sanitation is not popular:

The topic is uncomfortable, taboo and therefore unattractive. There is also a general feeling that it involves too much hard work.

Lack of a national policy, guidelines and inadequate legislation support:

It had not been possible to develop a national sanitation policy because sanitation had not been given the priority it deserves.

Institutional fragmentation:

There have been hundreds of authorities in the past with nominal responsibility for sanitation. The confusion surrounding whether sanitation should fall under the Ministry of Health or Natural Resources has not until now been addressed.

In the past, tribal leaders and chiefs were respected and used to ensure every family had a latrine. When those institutions broke down in the 1960's in the urban and rural settings, health inspectors who were also responsible for ensuring that communities had adequate sanitation

tion. They would move around homesteads to ensure the availability of a latrine, a drying rack, a clean/hygienic homestead and protected water supply sources. At that time the economy was healthier, the Public Health Act was applicable, law enforcement was strong, home and environment improvement campaigns were undertaken annually and there was a higher ratio of preventive health staff to the population. However, in the 1970's and early 1980's civil strife led to breakdown of authority and consequently brought down the latrine coverage to the lowest recorded level of 30 per cent average in 1983 according to the UNICEF report, 1984. Because of the fragmentation the design of many water and sanitation projects has not adequately addressed sanitation.

Poverty, illiteracy and poor education:

Most of our communities are poor and consequently have poor sanitation because they cannot even afford the basic traditional pit latrine. Illiteracy and poor education have also resulted in ignorance of the consequences of poor sanitation that is poor excreta disposal, poor refuse disposal and poor wastewater disposal among others. In addition, certain cultural beliefs and taboos impede proper sanitation in some areas and therefore pose a serious threat to public health.

The above scenarios briefly outline our current sanitation problem necessitating a need for change. This was aggravated by the El-Nino in November 1997 which led to the outbreak of cholera. Fortunately, the Government had already recognised the need for improving the sanitation and was not left off guard. A National Sanitation Task Force was already in place to spearhead the improvement of sanitation in the country.

The national sanitation task force (NSTF)

The NSTF has broad representation and consists of representatives of various relevant Government Ministries such as the Ministries of Education, Health, Natural Resources, Local Government, Planning and Economic Development and Gender, Non Government Organisations (NGO's), multi-lateral organisations, urban councils, district councils, training institutions and prominent Public Health Experts. In October 1997, a National Sanitation Forum was held at which all district leaders were sensitised about the need and urgency of improving the sanitation status. The Constitution of the Republic of Uganda 1995, Chapter 3-Article 17J requires that every citizen in the country should create and protect a clean and healthy environment. This requirement largely encompasses sanitation promotion, which unfortunately has been marginalised both nationally and globally.

The NSTF spearheaded by the Ministry of Health has initiated a number of workshops to determine strategies for accelerated sanitation initiative. It also plans to hold a series of National Sanitation Fora as a follow up to the first one that was held. Meanwhile, a concept paper on Sanitation was developed and a **Draft National Sanitation Policy** and

Sanitation guidelines have been prepared. A **National Accelerated Sanitation Improvement Programme** has also been prepared.

The new approach for improving the Sanitation situation includes interventions in the following areas:

- Policy and Legislation frame work.
- IEC (Information, Education and Communication) for behaviour change.
- Research and Technology
- Human Resource development and Financial resource allocation to sanitation.

Policy and legislation frame work

The purpose of the policy is to guide and facilitate individuals, institutions, community leaders of all kinds and all levels, families and communities to contribute to achieve optimal, sustainable sanitation standards and thereby improve the health and quality of life of the whole population.

The policy document highlights strategies for implementation which include;

- Creating an enabling environment
- Strengthening the institutional frame work
- Capacity building
- Research and Technology development

It also includes the policy guidelines and outlines the institutional framework and the policy indicators. The sanitation policy components in summary include;

- Hygiene Education
- Human resource development
- Environmental protection
- Technical considerations
- Monitoring and evaluation and
- Financial resource mobilisation. With the sanitation policy in place, a programme is to be implemented to test the application of the policy.

Information, education and communication (IEC)

IEC will be a very important ingredient of the National Accelerated Sanitation Improvement Programme. The idea is to create an educated and motivated person who will adopt safe hygiene practices and put in effort and resources to establish appropriate sanitation facilities. Generally, it will also increase awareness and knowledge of the health benefits of safe sanitation practices to the individual, family, community and institutions. The Sanitation promotion capacity of all levels will also be strengthened.

The strategies to be adopted include:

- Use of existing local channels of communication that are appropriate and relevant at different levels such as radio stations (including FM stations), television sets for panel discussions, writing of newspaper articles on sanitation and sensitisation of journalists on sanitation through workshops.
- Strengthen the sanitation promotion capacity at national, district and community level. This will involve identification and recruitment of a National IEC Co-

ordinator on IEC promotions, identifying and training sanitation promoters at all levels and not leave it entirely to Health inspectors and their assistants. The strategy is to build on what is already existing like the Local Council system where each level of local council should have a Sanitation Promoter.

- Use of Community Based Organisations (CBO's) and religious institutions in sanitation promotion at community level. This will involve organising and conducting sanitation campaigns within religious institutions and CBO's.
- Use of cultural institutions in community mobilisation and advocacy for Sanitation activities.
- Use of role models within the communities. This may also involve conducting Sanitation and Hygiene competitions at all levels.

Research and technology:

Research on sanitation issues will be promoted in order to develop more affordable and acceptable sanitation technologies. This could be done through creation of a research unit. The Uganda National Health Research Organisation may co-ordinate this, in liaison with organisations such as the Faculty of Technology at the University and the Institute of Public Health. Better management of sanitation information will also be promoted through establishment of an appropriate data management system. Meanwhile sanitation technological options have been compiled for the various areas of sanitation. These include:

- Excreta disposal
- Solid and liquid waste disposal
- Safe water chain
- Vectors and rodent control

The guidelines are to be used in the implementation of the accelerated sanitation improvement programme.

Resource mobilisation:

The financial resource allocation to sanitation will be increased and financial support from donors will be sought for developing programmes. Human resources for sanitation will be strengthened and the institutional framework will be clearly defined.

Individual level

Primary responsibility for the provision of household sanitation rests with the household itself.

Local Authorities

Services have been decentralised and implementation of sanitation services lies with local authorities i.e. the district level downwards. In particular, they are responsible for:

- co-ordination of all sanitation activities in their area including those of CBO's and NGO's.
- Provision of services and maintenance
- Supervision and enforcement (see fig.2)

The overall responsibility for Health services lies with the District Health Officer. Hospitals are headed by Medical Superintendents while Primary Health Care under which

sanitation lies is headed by a Medical Officer/Co-ordinator. The responsible officers at the different levels are as identified in fig.2.

Central government

The mission of the Ministry of Health is to provide the policies and ensure provision of Health services to improve the Health status of the entire population. With respect to sanitation services, the Ministry of Health will liaise with other stakeholders in Central Government such as the Directorate of Water Development under the Ministry of Natural Resources, with various projects in progress dealing with water and sanitation.

The roles of Central Government include:

- Provision of policy guidelines and standards of service
- Co-ordination of all activities
- Control and management of epidemics and disasters

NGO's and CBO's

These will supplement households, communities and local authorities in the demand for and provision of sanitation facilities by providing appropriate services at competitive rates.

Private sector

Will also supplement households, communities and local authorities in the demand for provision of sanitation facilities by providing appropriate services at competitive rates.

Problems anticipated in the new approach include :-

- Delay in implementation of the programme due to ongoing activities to stamp out cholera to begin with.
- Limited financial resources for implementation from Government so implementation will be donor dependent and there is anticipated lack of sustainability..
- Lack of sanitation related data in the districts (not covered by projects) so before implementation data will have to be collected and compiled for use within the programme.

Conclusion

With the above approach implemented, through the programme in the four different areas, sanitation will greatly be improved. The NSTF will spearhead the programme but intersectoral co-operation at all levels is necessary to build the multi-disciplinary approach essential to the success of any sanitation programme. Better sanitation is indeed a responsibility for all and if we are determined, we can make a difference.

References

- Draft Sanitation Policy Document, NATIONAL SANITATION TASK FORCE, DEC. 1997
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