Africa power and politics

‘What works for the poor’

Local governance systems and the delivery of maternal health, water and sanitation in two rural districts of Uganda

Bernard Sabiti and
Andrew Kawooya Ssebunya

Background Paper

June 2012

16

Published on behalf of the Africa Power and Politics Programme (APPP) by the Overseas Development Institute, 111 Westminster Bridge Road, London SE1 7JD, UK (www.odi.org.uk).

The Background Paper series makes available detailed research findings and analysis which have contributed to Working Papers and other outputs of APPP research streams.

The Africa Power and Politics Programme is a consortium research programme funded by the UK Department for International Development (DFID) and Irish Aid for the benefit of developing countries. The views expressed in this publication are those of the author and not necessarily those of DFID, Irish Aid or the Programme as a whole.

DEVELOPMENT RESEARCH & TRAINING

'WHAT WORKS FOR THE POOR'

Local governance systems and the delivery of maternal health, water and sanitation in two rural districts of Uganda

This research was done in collaboration with the Africa Power and Politics Programme (APPP), led by the Overseas Development Institute (ODI). Development Research and Training (DRT) is a local Ugandan-based not-for profit organization, established in 1997 to undertake policy research and analysis to inform pro-poor policies and programmes. The organization's overarching objective is the elimination of all forms of poverty particularly chronic poverty. The report was written by DRT staff; Bernard Sabiti (Program Officer, bsabiti@drt-ug.org) and Andrew Kawooya Ssebunya (Senior Program Officer akawooya@drt-ug.org). The field team included Research Assistants John Bosco Mubiru, Annet Nannungi, Dennis Bataringaya and Bernard Sabiti. Fredrick Golooba-Mutebi (fgmutebi@yahoo.com) was the research technical advisor. The report is based on initial drafts by Bernard Sabiti (Maternal Health) Andrew Kawooya Ssebunya (Water) and John Bosco Mubiru (Sanitation). Edited by Warren Nyamugasira (warren.nyamugasira@one.org)

Contents

List of acronyms

ANC: Antenatal Care
APPP: African Power and Politics Program
CP: Conservative Party
DDI: District Drugs Inspector
DHE: District Health Educator
DHI: District Health Inspector
DHO: District Health Office/r
DP: Democratic Party
DRT: Development Research and Training
DWD: Directorate of Water Development
DWSCC: District Water and Sanitation Coordination Committee
GoU: Government of Uganda
HC: Health Centre
I@MAK: Innovations at Makerere
IDM: Inter-District Meeting
JMS: Joint Medical stores
KDS: Kampala Declaration on Sanitation
MCH: Maternal and Child Health
MDG: Millennium Development Goal
MMB: Muslim Medical Bureau
MoES: Ministry of Education and Sports
MoH: Ministry of Health
MOW: Ministry of Water and Environment
NGO: Non Governmental Organisation
NHSSIP: National Health Sector Strategic and Investment Plan
NRM: National Resistance Movement
NWSC: National Water and Sewerage Corporation
PNFP: Private Not for Profit
PPP: Public-Private Partnership
PPPH: Public-Private Partnership for Health
PRAs: Participatory and Rural Appraisals
SWAP: Sector Wide Approach
TFR: Total Fertility Rate
TSU: Technical Support Unit
UCMB: Uganda Catholic Medical Bureau
UDHS: Uganda Demographic and Health Survey
Sh: Uganda Shillings
UPC: Uganda People's Congress
UPM: Uganda Patriotic Movement
UPMB: Uganda Protestant Medical Bureau
VHT: Village Health Team
WUC: Water User Committee
WWD: World Water Day

Basic country information

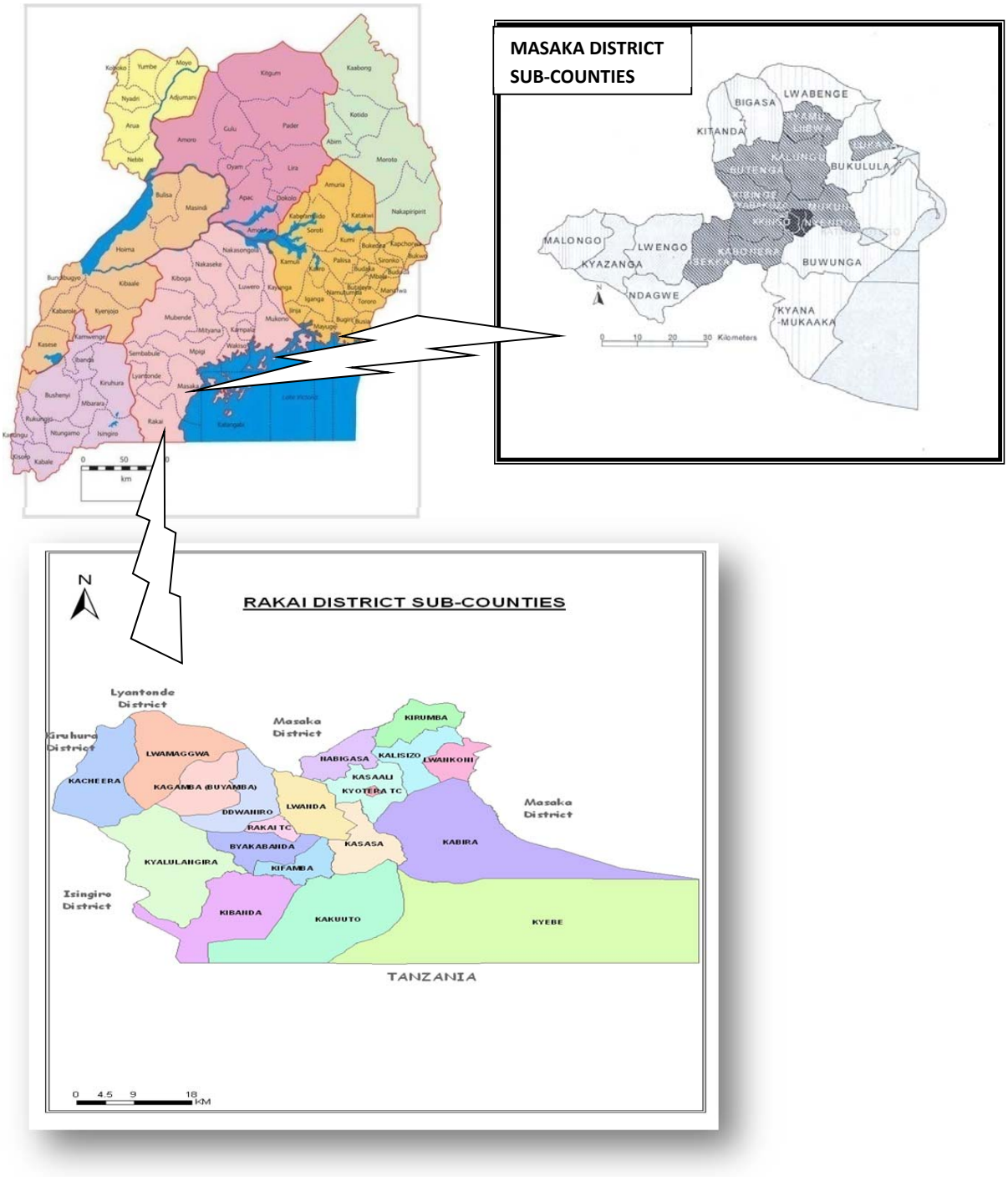
Uganda is located in the Eastern part of Africa and is a low income country.

Aspect	Facts and figures	Year
Size	241,551 Sq Km of which 205, 221 Sq Km is land mass and the rest 36, 330 Sq Km is water	
Population	32, 939, 800	Estimate (Est) 2011
Population Structure	Female - 51.2% Male - 48.8% Under 15s - 50.2%	
Administrative Units	Districts - 111 Sub-Counties (LCIII) - 1,323 Villages (LC1) - 57,371 Parliamentary Constituencies – 238	As at 2011
GDP	Sh38,798 Billion	2010/11
GDP Per Capita	USD508.9	2010
Real GDP Growth Rate	6.3%	2010/11
Life Expectancy at birth	53.4 years	2009
Total Primary School Enrolment	8, 325 000	2010
Poverty Statistics	24.5% (p0) of which 20.72 are in rural	2009/2010
Adult Literacy Rate (% of people aged 15 years and above)	76%	2009/2010
Under 5 Mortality Rate	137 per 1000	2005/6
Infant Mortality rate	76 per 1000	2005/6
Maternal Mortality	435 per 100 000 (6 000 per year and 16 per day)[1]	2005/6

Sources: Uganda Bureau of Statistics, Ministry of Education, Sector Annual Performance Review Report 2010: UNICEF 2008; World Bank Africa Development Indicators 2007; UNDP Human Development Report 2011; Mo Ibrahim Index 2011.

[1] Most recent report by WHO, UNICEF, World Bank and UN Population Fund has put the Maternal Mortality figure at 310/100,000

Map of Uganda showing the location of Masaka and Rakai districts



Sources: Main Map of Uganda from www.weinformers.net. Districts Maps obtained from districts headquarters. Graphical manipulation by author

Summary

This report is part of a wider research undertaken in six African countries on local governance and leadership. The main focus of the research was to assess the relationship between the variety of local governance systems and their performance, as gauged by their provision of public goods that are normally under-provided. Furthermore, it was to identify the relationship between the ways local Leaderships are constituted and the ways they perform; how formal rules and de facto norms compete with, supplement or complement one another to create functional hybrid orders and positive outcomes.

In Uganda, the study homed in on three public goods: Maternal Health (safe motherhood); Water; and Sanitation and Hygiene. Carried out in Rakai and Masaka districts from May 2010 to March 2011, the ten months study used ethnographic methods for investigation. This mainly involved observation, formal and informal conversations with both key informants as well as with other members of the community. Hence overt and covert observation techniques were widely applied during data collection, but without total disregard for other traditional PRAs.

The research team stayed as much as possible in the eight field sites across the two districts, interacting with officials and ordinary people, attending as many relevant events as possible, reviewing hundreds of official documents from the districts, sub-counties and lower administrative units, and visiting many service points for the three social sectors.

This report starts with conceptual framework, followed by methodology and then a section on political history context; findings in respect of each of the three public goods and ends with an overall summary.

A variety of governance orders was investigated during the initial phase of this research, as well as the nature and origins of the institutions that underpin them. Four key modes of local governance that interact to produce hybrid arrangements had been suggested at the conceptual stage:

1) Chiefly;
2) Associational;
3) Administrative; and
4) Communal or local-democracy;

In reviewing Uganda's social, economic and political history, all the above modes of governance were found to have existed and been prominent at different times. In addition, *traditional/indigenous* mode was identified as having been critical to be included.

Chiefly was strongest during the pre-independence period having gained recognition when the African Native Authority was passed; but elements of it have remained over the proceeding periods. *Traditional/indigenous* was also strongest during pre-colonial and colonial period as well during the later years of the military rule when modern services were weakening. *Administrative* has been dominant since colonial days but in the current phase has become very much a hybrid. Local democracy has been strengthened under the NRM phase but, as demand for "bringing services closer to the people" has become highly political, it has increased structures while weakening the quality of services at all levels. *Associational* has existed through all the phases.

In terms of delivery of maternal health, the following were found to be the key players: Central Government, Local Government, NGOs/PNFPs, TBAs, Mass Media, community, family members and less directly officials of the Buganda Kingdom. These can be categorised in the order they are strongest:

1) Administrative – Central & Local Government, PNFP

2) Local democracy – Local Government, HC Management Committees and VHTs

3) Traditional/indigenous – Elders, TBAs, Sengas, Family, Spouses and Community

4) Associational – PNFPs/NGOs, Community and Mass Media

5) Chiefly – Buganda cultural institution/Kingdom and its agents at lower levels (they influence cultural beliefs, norms and practices)

While the administrative mode would appear to provide the bulk of the selected public goods, the contribution of and interaction with the other modes of public good provision is significant.
Between the government health centres, PNFPs, NGO as well as TBAs, a sizable number of women are receiving maternal healthcare. However, as attested to by the latest National MDG report (2011), the progress towards attaining MDG 5 on maternal health and Sanitation is still slow. For maternal health, a range of reasons have been identified including inadequate funding, poor work ethic, weak coordination and poor management practices. However, the most significant finding seems to be around expectant mothers' preference for delivery at PNFP facilities, TBAs or home deliveries. This suggests that the traditional/indigenous mode of provision of such services need to be given serious consideration, with the role of the TBAs and Sengas being recognised, integrated into and planned for by government.

Regarding water, sanitation and hygiene, all the different modes of governance are playing a significant role with the exception of chiefly. Unlike 40 or so years ago when the Buganda Kingdom's appointed leaders enforced hygiene laws, especially around the water sources, today, that role has been made redundant.

In the main, the performance of the water delivery is considerably better than that of sanitation and hygiene but both provide ground for corruption (kickbacks) especially at tendering stages; influence paddling by politicians and weak coordination. The culture of neglect of sanitation facilities and the blackmailing of those who attempt to enforce bye-laws is perhaps the most important constraint to improving sanitation.

From the study, it is clear that local governance systems are better able to produce public or collective goods if:

1) They build on other existing forms of legitimacy, authority and accountability and/or 'work with the grain' of local de facto institutional arrangements; and the policy-driven components of the institutional framework of public goods' provision reflect ***a coherent vision;*** so that resources are allocated and incentives are structured in ways that are mutually reinforcing, not mutually undermining. There are institutions enabling local collective action which are ***locally anchored***, in a double sense – the rules they incorporate are geared to local problem solving, and they make use of institutional elements drawing on local cultural repertoires which motivate, enable and guide individuals to take particular actions. For example, maternal health is the most illustrative public good of how people stick with what they know and believe in.

2) The human-resource components of provision are subject to ***corporate performance disciplines,*** even if in other respects the organisational context is severely lacking in the attributes of a well resourced and well regulated bureaucracy. Clearly the government investments in increasing considerably the number of health facilities particularly from Health Centre I to Health Centre III could be better matched by the utilization of those facilities by

expectant mothers if there was adequate allocation of resources, good work ethic and adequate staff.

3) They realized that the challenges that have been highlighted by this study, none of which are new, suggest that the challenges are becoming more entrenched leading to stagnation in the delivery services. There is therefore need for a radical and fundamental shift in the strategy to register a break through. One such action is for government to recognize and take on board the roles and benefits that accrue from other governance systems, especially culturally accepted, trusted and believed in community leaderships and norms.

4) They recognize that the arrangement currently in place is fallacious, has distorted the motives and the incentives leaving both politicians and 'voters' to manipulate each other. This makes the service subservient to other interests and perceived gains. For example, there are many cases where political influence is used to undermine authority and communities blackmail politicians and also try to dupe the system. Water and sanitation are perhaps the most illustrative of mixed outcomes of political intervention and of taking 'power belongs to the people' too far.

   There is need to return to the sources of real legitimacy and real authority which in the past would make a community respond to the sounding of the drum.

5) Accept that without intentionally bringing other modes of service delivery, administrative decentralization alone, is not able to take the public good focused in this report on maternal health, water, sanitation and hygiene to another level necessary to meet the MDG targets. It is a fallacy for the country to claim to have 'good policies' which it persistently fails to implement.

1 Conceptual framework: research stream on local governance and leadership

1.1 Summary

The Research Stream on Local Governance and Leadership was conceived to address the questions; under what institutional conditions do local leaderships act in ways that are relatively less predatory and relatively more developmental? Specifically, which local institutional arrangements, modes of governance, hybrid political orders, and forms of authority, legitimacy and accountability are more (and less) conducive to leaders' acting to correct the under-provision of vital public goods in their jurisdictions?

In other words, the research questions focus on the relationship between the varieties of African local governance systems and their performance, as gauged by their provision of public or club goods that are normally underprovided.

The study investigated this variety by establishing an initial typology of local governance arrangements, focusing on different forms of hybridity and the articulation between at least four modes of local governance:

1) The chiefly mode
2) The associational mode
3) The administrative mode
4) The communal or local-democracy mode

The study started from the 'hunch' that local governance systems are better able to produce public or collective goods when they build on extant forms of legitimacy, authority and accountability and/or 'work with the grain' of local de facto institutional arrangements in some other sense.

The research was divided into four overlapping phases:

- Preparatory phase research, to survey the types of local leaderships of relevance to APPP and to select ethnographic sites
- Two preliminary studies to understand the 4 public goods and 3 variables. At this stage also lead researchers met to design a comparative research framework
- Historical studies of the economic and institutional embeddedness of local authority relations
- Ethnographic data collection through observation and interviews

1.2 Research problem and justification

While many of the sources of lagging development performance in sub-Saharan Africa are national or transnational, others are sub-national. While macro-level shortcomings in governance often attract most notoriety; the failures of local governance and local leadership are in some ways more fundamental. Whether or not there is effective provision of the essential enabling conditions for economic enterprise and human development within local-government areas is a major determinant of success in development at the national level. The calibre of local leadership and governance measured in these terms is therefore a central topic for the overall research.

1.3 The 'hunch' to be explored

The Local Governance and Leadership research stream starts from the observation that, while a good deal of local governance in Africa today is inept and ineffective at best, this has not always been the case. Within living memory, in several countries, local leaderships commanded stronger authority and greater legitimacy, and exercised their power in less predatory and more developmental ways. The various waves of administrative 'modernization' and democratic decentralization that have taken place in these and other countries have, more often than not, weakened rather than strengthened accountability and effectiveness. They have put in place political logics and incentives that stifle local initiative and weaken key public disciplines, such as those associated with public health, infrastructure maintenance and environmental conservation.

However, the degree to which this has happened varies from place to place, across and within countries. This Research Stream takes this variation in institutional patterns and outcomes as the basis for investigating which forms of local leadership and governance might be worthy of being promoted, as positive instances of 'working with the grain' in African governance. It is clear that in the present as in the past the prevailing structures of local governance have been complex hybrids of more or less indigenous and other, more or less imported, forms of leadership. The task before us was to use empirical research and comparative analysis to try to distinguish between the hybrid orders that appear to work for development and those that do not.

Furthermore, the variables to be explored to explain where there are differences in outcomes of public goods delivery seemed to be connected in the first instance with the degree to which:

1) The policy-driven components of the institutional framework of public goods' provision reflect a coherent vision, so that resources are allocated and incentives are structured in ways that are mutually reinforcing, not mutually undermining;
2) The human-resource components of provision are subject to corporate performance disciplines, even if in other respects the organisational context is severely lacking in the attributes of a well resourced and well regulated bureaucracy; and
3) There are institutions enabling local collective action which are locally anchored, in a double sense – the rules they incorporate are geared to local problem solving, and they make use of institutional elements drawing on local cultural repertoires which motivate, enable and guide individuals to take particular actions.

1.4 Initial approach

A variety of hybrid political orders were investigated during our initial phase of research, as well as the nature and origins of the institutions that underpin them. Four key modes of local governance that interact to produce hybrid arrangements had been suggested:

1) Chiefly
2) Associational
3) Administrative
4) Communal or local-democracy

Any other mode that is locally significant was to be added to this list.

The study has attempted to investigate how local political systems in different localities have varied across time, paying attention to both informal (*de facto*) norms/rules and formal (official) institutional arrangements. It has explored how the different modes compete, undermine, usurp, supplement or complement each other; with what implications for legitimacy, authority and accountability, and performance as measured by whether essential public goods are provided or not.

1.5 Selection of public goods

In answering the question: what are the critical public or club goods that are significantly under-provided under current forms of local leadership or governance, and whose proper provision would constitute an important positive outcome, Uganda homed in on: Maternal health (safe motherhood) and Water and Sanitation.

1.6 In summary

The focus of our research, then, is to identify the relationship between the ways local Leaderships are constituted and the ways they perform.

Specifically, the nature of leadership would be explored by analyzing:

1) The characteristics, over time, in the same space, of the various forms of local leaderships, including their origins and degree of authority and accountability
2) The key formal and informal (or 'practical'/de facto) institutions upon which local leaderships are constructed, and where these norms have come from
3) People's perspectives of the role and value of local leaderships

On the other side of the equation, performance would be gauged in terms of:

1) The types of private and club goods produced, or not produced in spite of evident need
2) People's assessments of the nature of the goods produced/not produced
3) How members/groups decide whether to press for public as opposed to private or club goods – i.e. what causes a community to aspire for more than narrow and personal gain?

2 Scope and methods of research

DRT in conjunction with the Africa Power and Politics programme investigated selected public goods in Uganda with the aim of figuring out the institutional arrangements and conditions that would deliver services better in the country.

2.1 The study sites

The first phase of the research, which took three months, identified the three public goods and two study sites. This scoping phase was carried out in the districts of Ntungamo (South Western Uganda), Kumi (Eastern Uganda), and Masaka and Rakai districts (Central Uganda). Administratively, the district is the first unit at sub-national level. Below the district are the sub-county and then parish.

2.2 Selection criteria

The two selected districts were similar in terms of population size, local economic resources and ethnic diversity. However, the two sites also differed in respect to the presence, and role in provision of the four types of public goods, in different types of leadership, especially 'traditional' and governmental (Booth, 2008)

Ultimately from the four districts scoped, the districts of Masaka and Rakai were selected because they best fitted the criteria. The two districts are similar in the sense that they used to be one district until the 1970s. The two are part of Buganda kingdom and in 2008 they emerged among the best performing districts in the national performance assessment under the Local Government Sector Investment Plan (the Local Development Grant and the Capacity Building Grant)[2]. This exercise was highly technical and was conducted by an independent consultant who follows an agreed upon set of indicators and a checklist.

In terms of differences, Rakai is slightly less naturally endowed, with some parts devoid of natural wet lands, leading to water shortages during the dry season. In terms of epidemiology, Rakai was the epicentre of HIV/AIDS, which was first identified at Kasensero, one of its fish-landing sites on Lake Victoria. This left its economic and social infrastructure devastated, with a large part of its population comprising of child and grand-parent-headed households. Otherwise because the two districts are in close proximity, the differences are not very pronounced.

Furthermore, in the other districts, during the scoping exercise, no direct link was found between the historical governance systems and the local governments and councils. On the other hand, in Masaka and Rakai, the traditional leadership, embedded in the reverence people have in the *Kabaka*[3], is quiet strong. It was thought this would provide an important angle to the understanding of the interaction between the different governance systems.

The research was therefore carried out in Masaka and Rakai, two districts in the central Buganda region which were chosen on the assumption of socio-economical, cultural similarity,

[2] This performance assessment is a very technical tool based on the minimum conditions and performance measures derived from the GoU laws and guidelines including, among others, the Local Governments Act, Finance and Accounting Regulations, Local Government Tendering and Procurement Regulations, the National Gender Policy, the National Environment policy, the HIV/AIDS policy, as well as guidelines for implementing sector specific conditional grants. It is conducted by an independent consultant.

[3] King of Buganda

geographical proximity and public service delivery, as established by the district performance assessment report.

The research, carried out between May 2010 and April 2011, further identified smaller units of administration. In Masaka, two sub-counties, namely, Lwabenge and Buwunga were selected. Going lower, in each of the sub-counties, two villages were selected. In Lwabenge, the following village local councils were selected: Kasambya, Kiwunga, Kyakibuta and Lwemiwafu; while in Buwunga, the local councils chosen were: Kyabumba and Nakasojjo-Kabuchunchu as the bases for the researchers. In Rakai, Kabira and Dwaniro sub-counties were selected. In the former, two villages, Kabira and Bikira were chosen while in Dwaniro, Bigando C and Kasansula were selected.

While the researchers pitched camp in villages, districts headquarters were the focus of multiple back and forth visits during the study. Visits were to clarity and cross check facts and other issues that required official clarification. For an in-depth study of different aspects of the public goods delivery, we focussed on service delivery points in these different areas. Hence we closely studied health centres, observing and interacting with health workers, TBAs, and as well as politicians, community, religious and other opinion leaders.

2.3 About the researchers and their preparation

The Research team comprised of research assistants Bernard Sabiti, John Bosco Mubiru, Annet Nannungi and Dennis Bataringaya. The research was coordinated by Andrew Kawooya Ssebunya with Fredrick Golooba-Mutebi as the research advisor.

The researchers' selection process involved examination of applications and resumes and administering both written and oral interviews. Ultimately successful candidates were those with relevant academic qualifications (Development studies or related subjects at post graduate degree level); experience with the research methods to be used in the study; a good local language facility and skills in interacting with and willingness to work in teams and to spend extended periods in the local communities.

There was preliminary reading around the selected public goods and the districts of study to have a deeper understanding of the situation therein.

The researchers moved in pairs. This was systematically swapped after each village to avoid monotony and for the teams to effectively share information by complementing on each other. Whenever a team could reach a village however, each person would visit different homesteads to interview ordinary folks of his own, while his or her colleague would also do the same. At the end of the assignment, they would meet to compare and share notes.

After recruitment, a series of trainings were conducted for the researchers, including:

1) Four training each lasting for 5 days (organised at Entebbe, Masaka and Accra-Ghana) which re-introduced to the researchers a series of participatory methodologies specifically case study methodology, situational analysis, observation skills and actual application of the research tools.
2) The second training (Masaka) focussed on ethnographic methodology (observation) led by Jan Van Kees Donge, a recognised expert in ethnographic methodology. Trainees took time off to practice the methods in Masaka town.
3) The third and further trainings took place in Accra and Entebbe, to cater for new research assistants that had joined the team.

2.4 Understanding the public goods

Researchers studied in detail the administrative structure of the goods, different providers of the goods, level or status of provision. They undertook an extensive review of documents to get a clear understanding of the public goods situation before emersion into the real field work.
Under maternal health, researchers sought to understand the health care system, and the structures in place to ensure safe delivery through the top bottom decentralised chain of delivery. Specifically we studied:

- The different levels of health centres from HC1-5 and the services provided there
- The different aspects of maternal health and how they fared under the different systems - family planning, antenatal care and level of enthusiasm to it;
- Patient-provider relations
- State of health units
- Availability of drugs for maternal health
- Presence/absence of health workers
- Other service providers of maternal health services

On water and sanitation, the study focussed on:

- The different water sources in the area
- The level of functionality and non functionality of these water sources
- The management of community water sources
- The managerial hierarchy of the water sector from the district to the local level
- The different providers of water and sanitation services

2.5 Political orders and institutions that underpin public goods delivery

Socio-political and historical context to leadership and public goods delivery in Uganda

Uganda will celebrate 50 years of independence on 9 October 2012. Public goods delivery in Uganda is intertwined with the country's political history.

By the time Uganda was colonised by the British, kingdoms provided some form of administrative and other infrastructure, including local government structures. However, the degree and level of organisations between different kingdoms and chiefdoms varied. In Buganda, under which the study areas fall, there were chiefs at four levels below the head of the Buganda Kingdom administration – Saza (county), Gombolola (sub-county), Muluka (parish) and the Butongole/Kyaalo (village). This structure became the machinery for establishing authority and legitimacy.

The colonial government adopted the Buganda Kingdom governance structure for much of the rest of Uganda and in fact recruited Buganda chiefs to administer the system throughout the country. A characteristic approach to provision of public goods was the '*Bulungi bwansi',* a way of mobilising the population for provision of public goods such as constructing and maintaining roads, pathways and water points. For example, during that period, a M*utongole* (village chief) was responsible for the installation and maintenance of water wells. He would mobilise the community members to clean the well monthly or appoint someone to do it on a more regular basis in return to being exempted from payment of certain mandatory dues.

The values, legitimacy and authority that were created under this system became so entrenched that it remains the kind of benchmark for modern administrative structures.

Another characteristic was that religious establishments that emerged during the colonial period also became heavily involved in the provision of services particularly education and health. Beginning with the Anglicans in 1897, who were quickly followed by Roman Catholics in 1899, health and educational institutions have been part and parcel of faith organisations. At the invitation of the Anglican Bishop Tucker, Dr Albert Cook and his wife Katharine started what is now known as Mengo hospital. Two years later in 1899, Roman Catholics opened Rubaga Hospital followed by Nsambya hospitals in 1903. This delivery of public goods became a form of winning over converts and using the system to inculcate different beliefs of different faiths. Protestants, Roman Catholics, Muslims and Seventh Day Adventists have all used this method of spreading their faith through provision of services (Carlson, 2004).

The first piped water systems were completed in the 1930s while water-borne sewerage was introduced after 1937. The construction of new facilities increased between 1950 and 1965 under the framework of the National Development Programmes (Nilsson, 2006).

This two-pronged expansion of modern health services, although running parallel to the traditional mechanisms of providing services, tended to nullify and overshadow but never completely wiped them out. In the first decade after independence, Uganda was administered through a regional district and local government system largely along the lines left by the colonial system but adapted to satisfy growing demands for administrative structures that met local and sometimes ethnically based needs under what is sometimes referred to as the nationalism project. There was an expedited program to provide regional referral hospitals as well as schools. In this phase, twenty two (22) new rural based hospitals were constructed under the first 5 year development plan (Okello, 2012). To expand access, government took over church founded educational institutions.

In the 1967 constitution, kingdoms were abolished and it became illegal for anyone to be called king, queen, prince or princess but the borrowed system of decentralised chiefs remained.

During the military rule of Idi Amin (1971-1978), the administrative structure was militarised and most expatriate professionals and entrepreneurs were expelled, this constrained the provision of health and educational services and while standards were retained in the referral hospitals the system of service delivery in general deteriorated. Each time this happened there was a revival of the traditional system of providing the affected services which in a way also undermined the modern provision.

During the current phase under the National Resistance Movement, there has been a restoration of kingdoms which has re-energised the chiefly line of authority and legitimacy. During this period, there has been a major expansion of health and educational services and well as of water but this rapid expansion in quantity has not always been matched by improvement in the quality of those services. A dual administrative system has obtained as civil servants are deployed alongside popularly elected structures of local councils and Parliamentarian as the Parliamentary constituencies have also become increasingly smaller with the multiplicity of districts. The roles of all these players have become conflated. This, while increasing democratic and accountable governance, brings confusion and overlap in roles and responsibilities, which in turn makes accountability difficult to deliver. For example it

is not uncommon for members of Parliament to be intimately involved in public goods delivery particularly during the heightened period of elections.

The multiple accountabilities also have led to weaknesses in oversight which results in poor quality of services and mis-appropriation of resources. Because of the size of administration and a fairly large standing army, a lot of resources go to salaries and administration instead of going to actual delivery of services. This has resulted in low pay, poor morale among staff and increased cases of diversion or mismanagement of resources, including medical supplies that go to private practices owned and even operated by staff of public services.

Typology of orders

During Uganda's social, economic and political history, the following modes of governance have existed and been prominent at different times.

1) Chiefly
2) Traditional/indigenous
3) Administrative
4) Local democracy
5) Associational

Chiefly, used to refer to the well-organised semi-formal system of organising within the cultural institutions, such as Buganda Kingdom, was strongest during the pre-independence period but elements of it have remained over the proceeding periods. *Traditional/indigenous,* used here to refer to localised traditions and practices such as elders, TBAs, Sengas, and do's and don'ts that are known and recognised only by the 'insiders', was also strongest during pre-colonial and colonial period as well during the later years of the military rule when modern services were weakening. *Administrative* has been dominant since colonial days but in the current phase has become very much a hybrid. Local democracy has been strongest under the NRM phase but, as demand of "bringing services closer to the people" has turned political, it has weakened the quality of services at all levels. Associational mode has existed through all the phases.

2.6 About the two districts selected as focus of the research

Between 1978 and 79 Masaka and Rakai districts got caught right in the middle of a war between Uganda and Tanzania that eventually ousted Idi Amin from power. Having used the Districts' proximity to Tanzania to carry out his military incursion into the Kagera Salient, a part of Tanzania that neighbors that part o Uganda, when Tanzania forces responded, Masaka especially bore the brunt of the war. It was pounded in 1979 and was almost totally burnt to ashes. This pushed public services so back that most of the havoc wrecked by this war is still evident in several parts of Masaka town in form of destroyed buildings and other destroyed economic and social infrastructure.

Masaka District lies immediately below the equator, in the southern zone of Uganda, with the district headquarters 120 km from Kampala. It is bordered by Mpigi in the North, Rakai to the South, Kalangala to the East, and Sembabule to the West. The district covers an area of 4560 square KMs, of which about 30% is water and swamps. Its population is estimated at 289,000 as of 2010.

Administratively the district is divided into 4 counties (Kalungu, Bukoto, Bukomansibi and Masaka municipality). These are further sub-divided into 23 Sub- Counties, 127 parishes and 1,333 villages each of which contains an average of 200 homesteads.

The study was carried out in two Sub- Counties namely Lwabenge Sub County in Kalungu County and Buwunga Sub-County in Bukoto County[4].

Rakai district is located in South-Western Uganda at the border with the Tanzania to the South; Mbarara and Kiruhura Districts to the West; Masaka and Lyantonde Districts to the North; Sembabule District to the North-West and Kalangala District to in the South-East. The District Headquarters are at Rakai Town, which is about 190km from Kampala. Administratively, the district has three counties namely; Kooki, Kyotera and Kakuuto which are all Parliamentary Constituencies. Out of these are 18 sub- counties, 103 parishes and 746 villages. With a population of 404,326 persons, the district was the epicentre of the HIV epidemic that hit the country in the 1980s and early 1990s. To-date, its impact is still hard to miss as one traverse the district.

[4] Masaka has since July 2010 been subdivided into three other districts namely Lwengo, Kalungu and Bukomansimbi.

3 Delivery of public goods, 1: maternal health

3.1 Background to maternal health in Uganda

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period (WHO). According to the 2006 UDHS[5], a Ugandan woman is capable of giving birth to at least seven children in her life time (TFR)[6]. This is one of the highest birth rates in the entire world, second only to the West African nation of Niger. This is partly explained by the fact that young women of Uganda still marry at an early age and there seems to be low utilisation of family planning. High rates in poor economic situations lead to serious difficulties for families, in some situations, in terms of properly feeding and educating their children and for women to enter the labour force.

In Uganda in general and poor districts in particular, many women still die during childbirth, with the UDHS of 2006 putting maternal mortality at 435 in every 100,000 women giving birth. The latest indicators shows that the country will almost certainly not meet the MDG goal number 4 which aims at improving maternal health from 506 mortality ratio (1995) to only 131 mortality ratio (by 2015).The goal also aims at improving the proportion of birth by skilled health personnel from 38% to 100% by 2015.

In Uganda, the unmet need for family planning is also still high, and at 41%, is the third-highest rate in the world and the highest in East Africa. Only 18.5% use modern contraceptives. Whereas 94% of all pregnant women make one visit to antenatal clinics, only 42% make the recommended four visits. Among those who make it they have their first antenatal visit late in the pregnancy—at a median of 5.5 months—which is too late for some to benefit and to make follow-up antenatal visits7. Only 41% of Ugandan mothers deliver from health centres with some sources indicating that 44% deliver at home while 17 percent are delivered by TBAs. At 62 deaths per 1000 live births, infant mortality is also very high and falls short of the MDG target of 30 percent less by the year 2015.

Table 1: Uganda's progress on some of the MDG 5 targets

Year	MMR	Attended by Skilled health worker	Contraceptive prevalence	Unmet need of FP	ANC first visit	ANC 4th Visit
1995	506	38%	15%	29%	91%	47%
200/2001	505	39%	23%	35%	92%	42%
2005/2006	435	42%	24%	41%	94%	47%
2015 target	131	100%				

Source: MDG Report for Uganda, 2010

[5] Demographic and Health Surveys collect and disseminate nationally representative data on health and population dynamics.

[6] Total Fertility Rate of a population is the average number of children that would be born to a woman over her lifetime if (1) she were to experience the exact current age-specific fertility rates (ASFRs) through her lifetime, and (2) she were to survive from birth through the end of her reproductive life. It is obtained by summing the single-year age-specific rates at a given time.

[7] MDG report for Uganda, 2010

3.2 Maternal Health in Masaka and Rakai Districts

In Masaka and Rakai district, the figures on maternal health largely mirror the national averages. Sometimes, however, they are significantly poorer. For example, for the years 2007-2009, the proportion of mothers delivering in health units in Masaka and Rakai was 24 percent and 25 percent respectively, compared to the national figure of 33% in the same period[8]. In the financial year 2008/9 alone, average maternal deaths stood at 30 for Rakai and 75 for Masaka[9].

One study[10] of maternal health indicators in Rakai found that Forty four (44) percent of the sample of women studied had delivered at home, 17% at traditional birth attendant's (TBA) facilities, 32% at public health units, and 7% at private clinics. It should be noted that there is lack of adequate data to fully corroborate independent studies on the state of public health provision in general and maternal health services in particular in the said districts. In terms of data, Masaka does slightly better than Rakai when it comes to documentation. However, in both cases there is insufficient capture of key data that would provide the critical information on maternal health.

There are several reasons to this. According to the researchers, some health workers intentionally refuse to record maternal deaths to avoid "soiling the name of their health units". In the HMIS forms that each health centre is required to fill and submit monthly to the DHO, the column for maternal death rarely reflects anything other than a zero.

3.3 Organization of the health services system in Uganda

Maternal health provision and health services in general, like any other public services delivery mechanisms in Uganda are designed along a decentralized administrative system. Each level of local government or administrative unit has a corresponding health unit. Ministry of health plays a key role in the provision of an institutional framework and resources to the health units. Maternal health services are provided under the office of the District Health Officer (DHO) through the Assistant DHO in charge of maternal health. Services are also provided through Not-For-Profit-Private facilities run by Faith-Based Organisations and NGOs, with a subsidy from government. The level, quality and state of provision of maternal health services in these two districts depends on the final provider, the level of health units and other factors as will be discussed below.

8 Rakai Statistical abstract 2010

9 MoH Statistical Abstract (2008/9)

10 "Factors influencing choice of delivery sites in Rakai district of Uganda" by B. Amooti-Kaguna and F. Nuwaha.

Women await the arrival of health workers at Kasambya HC3 in Masaka district

Public health centres are organised in such a way that there are hierarchies along the local administration levels of authority.

Health Centre one (HC I) is the lowest level unit, and is community based and promotive. It is located at a village (Local council one), and serves a population of approximately 1,000 people. This level of health service delivery is managed by a Village Health Team (VHT) and is mostly used for mobilization purposes. This level does not provide curative services. The main support provided here is advice by members of the Village Health Team who are selected by the community (a combination of communal and democratic modes). Each VHT member is allocated between 20-30 households each, to educate fellow villagers about the importance of such health practices as mothers delivering at the health units, proper nutrition, and maintaining hygiene at home.
There are several VHTs in the two districts where this study focussed.

HC II is found at a parish (Local council 2) level serves approximate 5000 people. This level is responsible for providing preventive, promotive, some outpatient curative health services and outreach care. It mainly is a dispensing unit and patients with complicated cases are referred to a higher level health centre. Due to some factors like long distances to a higher level unit, however, HC IIs were found to be offering services that ought to be offered at a higher level health centre. These include delivery and other maternal health services. Ironically some were also found to be better equipped than health centre IIIs especially those that were found to be private not for profit (PNFP) types.

HC III; This is located at Sub-County (Local Council 3) level and is supposed to serve a population of approximately 20,000, offering preventive, promotional, out-patient, curative, maternity, in-patient health and laboratory services. HHC3 has a staff establishment of 16, including two clinical officers, nurses and laboratory assistants. Even though this is the official establishment, none of all health centres APPP researchers visited had laboratory services. They all lacked other key requirements to perform their full complement of roles. These would include key amenities like water, electricity and a full staffing capacity.

HC IV: This is a Health Centre found at county (Local Council 4) serving a population of approximately 100,000 people and offers promotional, out-patient curative, maternity, in-patient health services, emergency surgery, blood transfusion and laboratory services. This is

also the administrative centre of a health sub-district, which is supposed to be the highest level of a government health centre in a political constituency (highest level below a referral hospital). In addition to what a health centre III has, HCIV is supposed to have an operating theatre and two medical officers, one of whom should be a resident doctor. The conditions on the ground however vary significantly.

HC V; this is a Health Centre found at the district (local council 5), also known as a district hospital. It serves an approximate population of some 500,000 people. All HC Vs offer all services offered at HC IV in addition to in-service training, consultation and research in community based health care programmes.

Beyond **HC V** are regional referral hospitals serving a population of about 2 million people and covering 3 to 5 districts. In addition to services offered at a district hospital, they offer specialist services like Psychiatry, Ear Nose and Throat (ENT) services, Ophthalmology, Dentistry, Intensive Care, Radiology, Pathology, higher level surgical and medical services.

Beyond this are national referral hospitals. In addition to services offered by the regional referral hospitals, they offer comprehensive specialist services and are involved in teaching and research. The delivery of Maternal Health Services is concentrated in HCs I-IV where the majority of the population lives. Accordingly, this research went no further than the HC IIIs in its data collection, except to seek clarifications. Even then, it was done only on two occasions when we visited 2 HC IVs under whose jurisdiction fell two HCIIIs that were the focus of our research to seek clarifications on some issues that had arisen. However, it should be noted that Masaka district's health staffing strengths currently stands at 35% of the recommended strength (Masaka District Integrated Health Plan 2010). This potentially has a bearing on the entire health service delivery in the district.

Table 2: Status of health workforce staffing in Masaka

Service point	**Recommended**	**Present**	**Gaps**
At District Health Office	12	7	5
At the 8 HC IVs	368	119	249
At the 15 HC3s	342	130	212
At the 31 govt, and 21 NGO HC2s	216	47	169
Total	**938**	**303**	**635**

Source: District Integrated Health Work plan, Masaka 2010

As can be seen in Table 3, Rakai posts a similar situation.

Table 3: Rakai health staffing status

Cadre of staff	*Numbers as per new structure*	*Number filled*	*Numbers Vacant*
Medical Officers	*15*	*11*	*4*
Nurses/Midwifes (all grades)	*340*	*234*	*50*
Clinical Officers (all grades)	*64*	*36*	*28*
Allied health professionals	*110*	*37*	*23*
Laboratory staff	*56*	*10*	*46*
Nursing Assistants	*186*	*146*	*40*
Other cadres	*388*	*212*	*116*
Total	*1,159*	*696*	*463*

Source: Primary Health Care Work Plan and Budget for Financial Year 2010/2011, Rakai District Local Government, District Health Office.

It should be noted that despite the above staffing situation, options for those seeking healthcare have increased considerably, with many health centers constructed by government (at least one per Sub County) in the last five or so years, while a number of private facilities have also sprung up all across the country. The average distance to the nearest health facility in Uganda has as a result reduced significantly over the years. However, the reason as to what inhibits pregnant women from seeking health care when their time to delivery approaches remains puzzling to many a researcher (Sabiti, 2008).
Government is not the sole provider of maternal health services. Other providers include:

- Private providers (private for profit-health centres, clinics, drug shops and Private Not for Profit (PNFPs) which are mainly NGO funded or faith-based health facilities.
- Traditional Birth Attendants
- Home deliveries

The private sector plays an important role in the delivery of health services in the country. The private health system comprises of the Private Not for Profit Organizations (PNFPs), Private Health Practitioners (PHPs) and the Traditional and Complementary Medicine Practitioners (TCMPs), the extent of the contribution of each category vary widely. The PNFP sector is more structured and prominently present in rural areas. The PHP is fast growing and most facilities are concentrated in urban areas. TCMPs are present in both rural and urban areas. Government recognizes and even subsidizes the PNFP. The PNFPs are categorized into Facility-Based (provide curative and preventive services) and the Non-Facility Based (provide preventive, palliative, and rehabilitative services). Nearly 70% of the facilities are owned by the UCMB and UPMB. The Government subsidizes PNFPs and the level of subsidies has remained constant at around 20% of total revenue for the PNFP facilities over the last few years.

PNFPs charge user fees as a strategy of raising funds for running their facilities. PNFPs also depend on donors to finance their activities.

3.4 Portraits of two health centres studied

Portrait of a public health centre

Buyamba Health centre III (Rakai district)

Buyamba health centre III was constructed in 1982 as a **community** initiative to bring services near to the people. The nearest health unit was located in Rakai town (approximately 15 Km away). The unit is managed by a clinical officer (in-charge) supported by a nursing assistant, an enrolled nurse, a laboratory assistant and a records assistant. Maternal health services are managed by the enrolled nurse and a nursing assistant. This health unit provides basic preventive, curative care and supervises the community and HC II units under its jurisdiction. The unit also has a provision for maternity care which is the first point of referral in the sub-county (Ministry of Health, 2009)[11].

Maternity services offered by the unit include antenatal, delivery, postnatal, family planning and child immunisation. An antenatal card is issued to expecting mothers to indicate records of obstetric, menstrual, contraceptive history and medical examination history. This card is demanded for every subsequent visit. To women, getting the card is one way to avoid being told off by nursing staff. Therefore many expectant mothers visit the HC once (to get the card). Even though one day per week is set aside for ANC, most mothers never attend the on the other four clinics. As a result, at this unit, most cards have partial information.

In the last 2 years, 12 Mama Kits[12] per quarter are provided to the health unit. This however together with other related drugs are not enough compared to the number of women that seek the service. Therefore women are required to come with their supplies; otherwise they would not be attended to. This discourages some mothers who resort to TBAs who do not ask for such requirements.

Buyamba HCIII also offers family planning services, particularly pills, condoms and injectables. Marie Stopes supports the unit to offer Norplant and IUDs which are not offered by the government.

Despite the understanding that public health services are free, women claim that they are asked to pay unofficial charges such as UGX 2,000/= for a pregnancy test and 1,000/= for a card. On many occasions women are asked to come with 4 pairs of gloves, 3 pieces of strings, a gauze, polythene sheet, cotton wool, needle and syringe, a razorblade and funds for emergence transport in case of complications during child birth that may necessitate referral. Women also pay 1,500 for family planning services and for deliveries. However, this charge does not seem to be standard and is contested by the health workers and some of the mothers.

Post-natal care services are supposed to be given to the child and a mother within six weeks after delivery. During this time, both the mother and child receive thorough medical

[11] Ministry of Health (2009) Annual Health Sector performance report 2008/2009. Kampala Uganda

[12] A Mama kit is a package supplied by ministry of health for the purpose of delivery. The package includes a towel, soap, tetracycline, cord, cotton wool, surgical blades, gloves and polythene sheet.

examination to ensure that both are healthy or for the unit to address the health problems that are diagnosed. At Buyamba HCIII, there is no special day for Post-natal care and generally attendance is poor, "*women only turning up when the child develops serious health complications*", reported one of the health workers.

Table showing women that benefited from maternal health services at Buyamba HCIII between 2006 and 2010

Year	Antenatal services beneficiaries				Deliveries	Still birth	Miscarriages	Neonatal death
	1st visit	2nd visit	3rd visit	4th visit				
2006	25	9	1	-	11	-	2	-
2007	66	27	9	6	17	1	1	1
2008	121	69	35	31	33	2	9	-
2009	181	72	33	16	45	2	3	-
2010	156	88	52	35	65	1	7	-

The Health Unit Management Committee is composed of a group of people[13] that plays a management role. Buyamba Committee has 6 members with the in-charge serving as the secretary. The committee is supposed to supervise and advise on the day-to-day delivery of the services at the unit. However, according to a community member, some committee members are faced with a challenge of not having adequate technical knowledge regarding health issues, which limits their performance. This is made worse by supervision gaps from the DHO who likewise claims financial limitation to do consistent visits.

Internal supervision is also weak. The research team for example only met the in-charge at the health unit once in the two months they were interacting with the health workers and community members of Buyamba. Partly because of this, the unit opens to the public at 11:00 am and is closed by 4:00 pm daily, giving the public barely five hours to seek and receive services.

Lack of electricity has implications to preservation of vaccines. Gas-powered freezers were provided by government but sometimes the unit runs out of gas. Lighting at night during delivery also becomes a problem and so mothers are asked to buy fuel for the lamps. Buyamba health centre lacks a weighing machine for mothers and babies and there is only one delivery kit. The health unit does not have aprons for the midwives to wear when delivering mothers. They have no gumboots or buckets.

The health unit does not have any transport means (ambulance) which has significant implications to referrals and transportation of vaccines. In situations of emergency, a mother is told to organize her own transport. The health centre does not have adequate water supply and only relies on rain water harvesting using water tanks installed besides the building. Patients therefore are required to come along with their own water especially during the dry spells.

There are also claims of health workers being rude. One woman of Buyamba who because she could not afford new baby clothing turned her '*Gomesi*' (a *Kiganda* traditional dress for women) into baby clothes and was "insulted" by a midwife because of this for having brought rags at the health unit.

[13] Members of this committee are required to be able to read and write, respected by the community and must be apolitical.

In addition, health workers are absent at night and during weekends. Because Buyamba health unit does not have a midwife, the unit utilises the services of student nurses not only in the maternity ward but also other departments. One woman reported that she lost her twin child simply because she was attended to by a student nurse who could not properly read the scan to note that she had twins. She further complained that they are used as experiments by student nurses.

Portrait of a private not-for-profit health centre

St Andrew Bikiira HC III

St Andrew Bikiira HC III is a catholic based health unit located in Kabira sub-county (Rakai district). The unit provides maternal health services which include ANC, family planning, delivery, postnatal services and immunisation. The days for accessing ANC are not limited to once in a week but anytime a mother comes to the unit, she is able to access the service.

The ANC package includes health education (proper feeding and health hygiene), signs of labour pains, medical examination, intermittent malaria treatment, administering of iron tablets and de-worming and HIV-AIDS PMTCT services. During ANC, men are encouraged to come along with their wives. However, just as in public health units, men do not turn up. This is not enforced and so men do not comply.

Table showing women that benefited from the maternity services offered by Bikiira HCIII (2006-10)

Year	Antenatal services beneficiaries				Deliveries	Still birth	Maternal death	Miscarriages	Neonatal death
	1st visit	2nd visit	3rd visit	4th visit					
2006	464	345	-	-	165	4	2	33	4
2007	332	177	115	160	180	2	1	35	7
2008	370	214	141	160	221	4	1	40	4
2009	396	243	170	131	247	12	1	35	4
2010	431	280	183	166	280	7	2	44	6

The table indicates falling number of women that seek antenatal services as well as those that deliver at the health unit.

Because the health unit is a not for profit, it receives funding from donor institutions which helps it to subsidize services with particular components made free. For instance Marie Stopes has facilitated Output Based Aid (OBA) for the last two years offering mothers free maternal health services. (This offer phased out in 2011, leaving great uncertainty as to what will happen afterwards). Because of this free service, many women were able to seek services from this health unit. Women are very happy with the services offered by the health unit. The cost for the delivery at the health unit is Sh10,000 to 15,000/=. At the health unit, health workers and drugs are always available all the time.

St Andrew HC offers some family planning methods. However, because PNFP are catholic based, they only encourage natural family planning methods such as moon beads, temperature monitoring, withdrawal and breastfeeding. According to one health worker working at the health unit, "most women are negative towards the modern family planning methods because the methods have side effects (back ache, loss of weight and infertility). Women actually do not differentiate between methods.

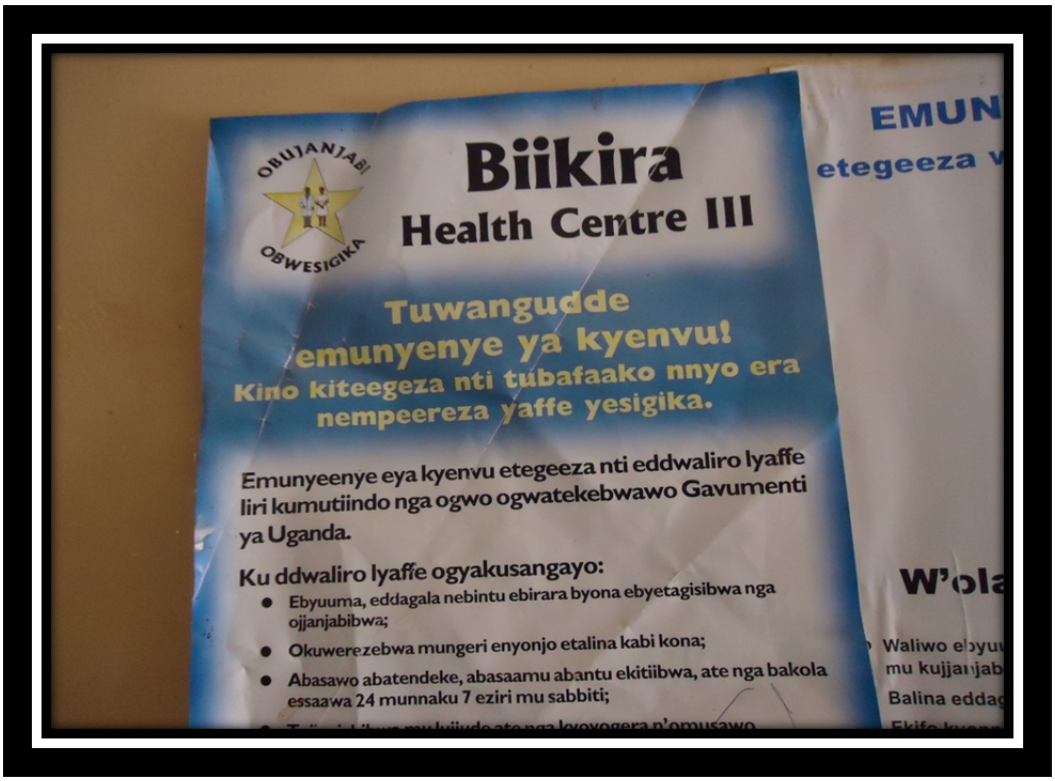
St. Andrews Bikiira HC has electricity and solar power which makes service delivery relatively better compared to the public health unit. In the same way, water supply is sufficient, made so by availability of a 100,000 litre tank used for harvesting enough water to supply the unit throughout the year.

It is very clear that the level of women that seek antenatal services (considering the fourth visit between 2006-10) from the public health units is lower than those that seek the same services from the private not for profit health unit by a ratio of 1:7. The same applies to deliveries. The numbers of women that deliver at public health units are significantly lower than those that deliver at PNFP by a ratio of 1:6. It should be noted that Bikiira has a bigger catchment area than Buyamba and therefore it is better to compare the percentages of first visit versus the fourth visit and the first visit versus delivery as in the two tables below.

Table 4: Percentage of First Visit ANC attended who end up coming for delivery

Health Centre	2006	2007	2008	2009	2010	Average total
Buyamba HC111	44	25	27	24	41	32.2
Bikiira HC111	35	54	59	62	65	51.4

Source: Authors' calculation based on the figures obtained from the two health units



This poster found at Bikiira HC3 in Rakai District announces the health centre's "Yellow Star Award", a prize given by DISH[14] for good performance. The score card rated health centres on Drug Logistics Management, Health Information Management Systems, Supervision and Quality Assurance and Health Planning and Management

Over the five years preceding our study, only 32.2 percent of the mothers who attended a first ANC visit at Buyamba delivered from there while the number was 51.4 percent for Bikiira (it is likely that these numbers do not necessarily reflect the actual women who initially come for these visits. It is common practice for new visitors to be added to the number or earlier ones not returning).It is also possible that some who are recorded to have given birth from a health centre had attended ANC visits from elsewhere and just came to give birth, or had never even attended an ANC visit. On the other hand, it is not a given that those recorded as having attended the ANC second visit are the same women who came for the first. Indeed in some cases, the numbers for later visit may be higher than a previous visit, as evidenced in Bikiira's 2007 and 2008 fourth visit figures

However, these anomalies do not discount the importance of the message these two portraits give on the differences between the qualities of provision in between the two providers.

Table 5: Comparing the first to the fourth visit:
Percentage of ANC first visitors who end up turning up for the fourth visit

Health centre	2006	2007	2008	2009	2010	Average total
Buyamba HC111	4	9	47	8	22	18
Bikiira HC111	-	48	43	33	38	40.5

[14] The Delivery of Improved Services for Health (DISH) II Project was a USAID funded project committed to improving quality, availability and utilization of reproductive, maternal and child health services, and enhancing public health attitudes, knowledge and practices in Uganda. It phased out in 2009

Note that data for 2006 was not available for Bikiira so the average is calculated using four years. Also in the comparison of these cases, one needs to factor in other aforementioned issues like poor record keeping in government health units, staff malaise, and the like.

3.5 Other factors in maternal health

Public provision of health services

All services offered in government health centres are supposed to be 'free'. However, because there are several instances when there are no drugs, and users complain that the service is of poor quality, many analysts and local beneficiaries question the 'free' tag that is always used to describe services provided at government health centres. Having visited a total of 8 health centre IIIs, four of them PNFPs, and four governments owned and operated, the researchers came to the following conclusions:

a) The challenge of supervision

In the two districts, staff supervision is weak. Facilities that are supposed to open 24hours a day end up opening for 5 hours. In-charges are more often absent from the duty station. Some workers run parallel private clinics and drug shops, some of which are equipped with drugs and facilities which are illegally taken from their workstations, because some of the drugs (such as class C drugs) stocked are even not supposed to be dispensed by such facilities.

The DHO is the coordinating office. Within the office are other officials like the DHI, DDHO, DDI, and the DHE, who head their respective departments. Despite this, policies and regulations regarding maternal health and other tenets of Health service delivery are often disregarded both by officials and patients.

b) The dismal number of women who complete the four visits

Researchers have discovered a reason: Because a woman who turns up to deliver without an antenatal card is 'reprimanded' and 'rebuked' for having not attended ANC, expectant mothers got the trick. Instead of appreciating the value in attending all the four ANCs, most come only for the first visit "to get the card", so that in the event that they come to the centre for delivery, "they are not rebuked". Most still deliver from home assisted by relatives, or at a Traditional Birth Attendants' place. The card therefore is for 'Option B' – good to have just in case one develops complications. Many women triumphantly told the researchers how they 'dupe' health workers just to cover their backs.

Research findings indicate that this behaviour is not just a new phenomenon. Older women interviewed also revealed the same strategy: They would go to Kalungu health centre to get the '*ekiparati*' (card) but would subsequently deliver from home or at a TBAs[15]. She added that she would use local herbs. This preference for home delivery or delivery with the assistance of TBAs, despite all the 'benefits' that accrue, at the public health centre such as antenatal care package including immunization against tetanus, intermittent treatment of malaria, giving women information on feeding, family planning, and also medical examination to check on the status of the pregnancy, is an indicator of something fundamental. From the

[15] Bernard Sabiti interview with 65 year old woman, Ms. Namuddu.August 10, 2010 in Lwemiwafu who revealed that she had given birth to all her 8 children from home, all by herself, without any complications.

sentiments expressed by the women interviewed there a cultural aspect of a woman's pride being delivering a baby unassisted and preference for TBAs because of their stature in a community.

c) The absence of men at ANCs and during delivery

During antenatal care visits also, both the woman and her husband are supposed to be tested for HIV, which is the reason women are encouraged to come with their husbands. The purpose is that once the HIV status of the couple is ascertained, appropriate action can be taken. If both of them are HIV positive, they are enrolled on the PMTCT program to prevent the mother from passing the virus to the baby. If they are found to be discordant couples, they are also given appropriate advice.

However, most women go alone, saying that their husbands refuse to come along, promising to get tested alone at a later date or claiming that the results of the woman will apply to both of them and that therefore there is no need for both of them to be tested. Some HIV positive women have reported that even after relaying the bad news to their husbands, they live in denial and accuse the women instead, of bringing the virus into the home. At all the health centres studied, there doesn't seem to be a mechanism effective enough to encourage men to come with their wives for couple testing. To some women, asking them whether their husbands escorted them seemed too much a thing to ask. They didn't seem to think that a man was obliged to do so anyway[16].

The problem is acknowledged even by the Masaka Diocesan health unit, which in its 2005 report puts it clearer,

> "The entire health system in the area continues to suffer serious challenges from economic to organizational ones. Enormous challenges still abound in the area of reproductive health and rights. ANC coverage is very high at 90% for first visit but with a drastic reduction for subsequent visits. Supervised deliveries have continued to be very low, between 30-40%, access to obstetric care is even a worse challenge"[17].

The overall lack of interest in completing the four mandatory ANC visits therefore may derive from the fact that there hasn't been a deeper understanding of what keeps women away from delivering at health centres, why other preferences such as home and TBA assisted births are chosen over the HC, even when these are risky options and what hybrid would bridge this gap.

Clearly TBAs still play a crucial role in providing maternal health services in the two districts. They for example also provideANC, deliveries, Family planning and PNC. Commonly known here as *okunywa eddagala (taking herbs)*, the ANC TBAs administer is in the form of herbs and other local medicines they give to expectant mothers before the time of giving birth. Some TBAs claimed that they turn away women who just come to deliver if they never went for earlier visits in which they are supposed to have been given local herbs. The reason they

[16] Bernard Sabiti interview with one Namatovu, a 22 year old mother of 3 in Kasambya village, Kyamuliibwasubcounty, July 12, 2011. 'Asked whether he escorts her when she is pregnant, she seemed surprised by the question and quipped; "Amperekerekoki" (Luganda slang for, 'what for?') … (He doesn't care about me or look after me). Even when she is pregnant, Namatovu says the man never gives her any support, moral or financial, yet, she claims, she lives with his 15 year old daughter from a previous marriage. On further probing, I discovered hers had been an arranged marriage'.

[17] Masaka Diocesan health report, 2005.

gave was that they have to know a detailed history of a woman's pregnancy and possible complications, before undertaking the 'risk' of helping her to deliver.

However, health workers rarely turn away a woman who can pay for the service. Payments to the TBAs by women depends on the length of time one takes to deliver, the relationship that exists between the woman and the TBA and whether the woman has gone with the requirements for delivery like gloves and a polythene sheet, among other reasons. Most of the TBAs reported that even if there is an amount that they do charge, at times they simply accept a token of appreciation. From the researchers' observations, payments to TBAs are neither standardized nor formalized across the board. Payment does not proffer sufficient explanation to this phenomenon.

Perhaps the way TBAs handle the expectant mother may hold the key. TBAs administer several types of local medicine to pregnant women, "to prepare them for delivery". The medicines include "eddagala elyokumenya" (a drug to widen the pelvic area, mainly given to first-time mothers), "eddagala ely'olubutokuzannya" (One that enhances the movement of the embryo in the uterus) and several other medicines that 'cure' several pregnancy-related complications and other conditions that may affect the growing of the baby in the uterus. This personal care and attention, compared to the 'treatment' they get at the Health Centre, from "young and inexperienced staff" may call for incorporation of TBAs into the health care system.

Post-natal care

At all the health centres studied, there was no special day for postnatal care services. The mothers are examined on a case by case basis as they come in. Attendance, however, is very poor, and most women never show up again after giving birth, unless they get serious problems with their health. At Nakasojjo Grail health centre, PNC service is always incorporated in the young child clinic day. This is the day where all the under fives are brought here for several checkups and interventions, yet at Kyamulibya, Kasambya and Buwunga health centres postnatal care is given on any day because they tend to provide postnatal care on different days.

In Rakai, the situation is no different. At Kabira HCIII, nurses admitted that very few women show up again after giving birth even though this is something that they are encouraged to do. Some women we interviewed seemed not to even know that it is mandatory for them to go back to the health centre six weeks after they have given birth. Those who know give reasons such as long distances and seeing no need to go for postnatal because they had never developed any complication. Similarly, health authorities have not put in place any measures to enforce postnatal care attendance, except to 'encourage' the mothers to always come for it.

Family planning

The researchers sought to get their perceptions on the practice in its entirety. Most of the women respondents had high fertility rates and their views about family planning ranged from mildly enthusiastic to utterly dismissive. While this is one of the topics taught to the women during their antenatal and postnatal care visits, many women seem to harbour suspicions about family planning, some of them genuine, others plain misconceptions[18].

[18] Annet Nannungi interview with woman, 2nd March 2011: Grace said she has never used any family planning method administered in the health units for the fear of complications, which fear was spread by her friends: "My friends have been telling me of the complications like over bleeding and not having menstrual periods, which leads to women getting strong abdominal pains and painful cramps, as well as

a) Reasons for the low usage of family planning

The most common reason women here have against modern family planning is that most of the methods cause a wide range of illnesses which affect the health of a woman. "*zifamile"* as they locally refer to family planning methods causes drowsiness, fatigue, headache, fibroids and most serious of all, infertility. There is a danger that one may never conceive again, they say.

Some of them balked at the very idea that they should restrict the number of children they are to have, out of cultural idea that a woman's pride is in giving birth to children – enough children. Those who have never used or do not intend to use modern family planning methods say that as long as the man can look after them, they are duty bound to have children.

Some, especially older women stopped giving birth when they clocked menopause. It was not unusual to find women in their late forties doing household chores with babies on their backs. The very old ones even despise the practice of family planning as a foreign thing, which young women should shun. One of them suggested to us that women using family planning are weak or not up to the task of motherhood: *Bagamba kampumuremu: oba orima?* (They say, "let me take a break";it is as if they are digging), the woman said of those who space children. (The idea behind the statement is that having children does not amount to manual labour, thus the reason why she does not understand it when women say they want to take a break.)

Other women however take family planning with genuine caution especially when the complaints concern the impact some of the methods have on their general health. This could be due to inadequate sensitization by those concerned, about the side effects of different methods. This has led to the bad news taking precedence over the good news of family planning. Most of those who had experience with family planning were therefore quick to point out the negative side effects than the benefits they had found in planning their families. It's the story their counterparts who have not yet experienced it hear more often, which in the end discourages them from using family planning.[19]

These could be the reasons for the high unmet need for family planning. While district-specific data are not available for Rakai and Masaka, the 2006 UDHS and other recent studies show that Uganda has the third highest unmet need for family planning at 41% and the highest in the east African region. The TFR of 6.69, the second highest in the world, therefore is not surprising.

b) Formal education as a factor

There are, however, a small number of women who are using family planning. Most of them were likely to be young and also having had formal education, however little. Most of the

development of fibroids. Ever since I heard of such side effects I do not see any good in using it. I was listening to a radio and heard a woman giving a testimony about how she took injectables and spent 2 years without having her periods and by then she had developed a big clot of blood in her uterus". Another women had pills stark in her uterus", she claimed.

[19] Annet Nanungi interview with woman: She reported that when her husband heard of that he told her never to use family planning. He advised her that they use the natural method by not having unprotected sex in the fertile days. She also said that women have a challenge of taking these family planning services when their husbands are not aware. When they develop complications they are insulted and ignored by their husbands.

mothers we interviewed who had any formal education background were primary seven dropouts, with a few having had a few years of secondary school.

The most common reason these gave for using family planning was economic. “Njagala kuzaala benaasobola” (I want to have children I can look after), most would tell us. They cited the need to educate, feed and clothe them as the reasons they wanted to have a reasonable number.

It was very clear that health centres considered family planning as important. Posters displaying family planning were visibly pinned at walls of health centres. In one instance, researchers observed opposite posters with one showing a small family, happy and well-fed, while the other one showed a pregnant woman in tattered clothes with several other small kids all over her. This definitely is a powerful picture in terms of visual education. The ministry, however, does this largely by persuasion. This persuasion is also mainly through posters, with little if any attempt to **take the messages to villages**. A few radio spots are aired but this also has limitation as few own radios and where they own them, money to buy batteries to power them isn’t always available to everyone.

c) Limited options

The government provides only two free family planning services at its health centres; these are pills and injectables, and all a woman has to do is to come for advice and then select her preferred method among these two. Some methods like implants, however, are not available at the health centers we studied, because they were not equipped with facilities to administer them.

An NGO, Marie Stopes International sends its staff once every three months to do the job at one of the government health centres at which time many women gather there. These family planning methods provided by the NGO include Norplants, IUDs and the permanent family planning methods. Like vasectomy, tubal ligation or sterilization. The PNFP we studied, courtesy of their being affiliated to the Catholic Church were only providing natural family planning.

The most preferred method turned out to be the injection which is also available on the open market where it is administered by some retired medical workers. In Lwemiwafu village, for example, researchers were told that a certain man passes through the village giving the three month injection at sh2000. The injection and pills are readily available at Kasambya and Buwunga health centre IIIs in Masaka, and Kabira in Rakai. In situations where they are out of stock women reported buying them from drug shops. Procedures which require surgery like vasectomy and tubal ligation are carried out in hospitals. This method was found to be common among some older women who were done with children. (Abaana) *Baalibaweddemu*”(There were no more children in the womb), they preferred to say.
Lack of Male involvement also complicates matters even if women were more willing to undertake family planning. In *Kiganda* culture, the man exercises a lot of authority over his wife.

3.6 Challenges faced by Government health centres

Public HCs face daunting challenges in their quest to provide health care to citizens. Almost all of them were found to be lacking the basic equipment to provide maternal health services effectively. These include lack of weighing machines, a ‘delivery set’. In one HC, there was one baby receiver, no suction machine or even baby sucker, no catheter which empties the bladder during delivery, no stove for boiling the one pair of scissors available. The nurse had

to improvise by using ordinary bleach (JIK) as a disinfectant. The health units also don't have aprons for the midwives to wear when delivering mothers. They have no gumboots, buckets, or even laboratories and reagents for testing HIV at HCIIIs.

Given that they are located in remote areas, the public health units we visited did not have electricity. This meant that preservation of vaccines is a problem because they had to use solar power or gas-powered freezers. Where they used gas-fired freezers, once the gas got used up, immunization for tetanus and children would stop. Re-stocking these necessities can take long in which time there won't be any maternal health services being offered.

Furthermore, lack of electricity discourages midwives from assisting mothers who come at night unless they can come earlier so that nurses can organize themselves before it gets dark. Health units use lamps which government never fuels. So it's always the mother in question to pay some money to buy paraffin/kerosene for the lamps.

There are no ambulances at the health centres studied. As a result there is no ready transport means whenever there is need to transfer a mother quickly. In situations of emergency where a mother has to be referred to another health unit it is always the mother and her kin to find transportation to the next health unit. This oftentimes leads to delay delivery since the commonest means of transport is a motorcycle taxi (*boda boda*) which may not be readily available. District health officials blamed this on resource constraints. While that may be true, there are also glaring example of sheer negligence and carelessness, perhaps even incompetence on the side of health units' administrators. The few ambulances available were often cited ferrying private goods. Others have become sources of conflict between [politicians and health officials over control as was the case of the ambulance at Kyamuliibwa HC which had ended up being grounded at the local police station.

Cleanliness at the health units was very poor. The compounds were unkempt, there were no incinerators and it was a usual sight to see blood on floors and walls. Lack of water is one of the major problems faced by some of the health units especially during the dry season. This has been so because there is no any other source of water at the units besides harvested rain. One midwife at Kasambya HCIII reported that when there is no water at the health unit the patients have to bring their own water. In such circumstances, they don't even have water for a mother who has just given birth to bathe. The problem is compounded by lack of soap, disinfectant and other detergents used in cleaning. Some health workers blamed scrapping of the user fees in government health workers for the lack of the basics which they claim the user fees used to cater for. Cleanliness ought to be second nature to health staff. Modern facilities were meant to set an example of high hygienic standards within the community they serve, applying the adage: Cleanliness is next to godliness. The inability of health staff to maintain healthy standards epitomises a serious underlying problem.

Compensation for health workers in Uganda has for long been a contentious issue and nowhere is the implication of the problem more visible than in rural health centres. Medical workers claim that they are not motivated to work because of the low pay compared to the work load. Researchers' findings, however, reveal that medical workers in the private-not-for-profit health units are paid even less compared to the medical workers in the public health units. According to the 2010/11 salary scales, an enrolled midwife at Nakasojjo PNFP, for example, is paid Sh200,000 per month, while the one at Kasambya HCIII, a government facility earns Sh334,784 (U7). However, unlike their counterparts in urban settings, rural government health workers do not threaten to strike over poor salaries. Instead they make up for the deficit by being absent, running their own businesses and setting up clinics which

some stock with the very medicines that are supplied to government health centres, by diverting them.

Sometimes the drugs allocated to health centres are not enough. However, there was an observation that even the medicines sent are not properly used. The diagnosis technique here is poor as there are no labs to test people before determining whether they need a certain drug. Most complaints here are about malaria and the most sought out for drug is Coartem. Health workers treat everyone who comes even with the vaguest complaints of malaria and within three days of supply, drugs normally have run out.

It was discovered that since locals also know that drugs are seldom in the units, once they see the district vehicle delivering the drugs, they come en-masse. For example a family sends all children who present themselves as sick in order to pick the drugs which are kept for when they actually fall sick, an extremely dangerous as the practice denies the genuinely sick the medication they need but also puts their lives at risk since the drugs will most likely expire in hoarding or could be 'wrongly' used and yet community members are not educated on this fact.

There are tales of drug theft by health workers in Uganda society to the point of the accusation being folklore but medics we interviewed vehemently denied that they steal drugs. The fact that most local private clinics are owned by them, however, and that some category 3 (sensitive) drugs can be found in those clinics when they shouldn't be stocked is evidence enough.

3.7 Private providers

Private Not-For-Profit Health Centres (PNFPs)

These are categorized into two different forms; PNFP and private for profit. Researchers focused on the PNFPs, four of which were studied in great detail. These charge some money but because they are subsidized by the government and also get support from some donors, the amount charged is small compared to the for-profit providers.

The Facility-Based PNFPs (FB-PNFPs) provide both curative and preventive services while the non-facility based PNFPs (NFB-PNFPs) mainly provide promotive, preventive, palliative and rehabilitative services. The FB-PNFPs account for 41% of the hospitals and 22% of the lower level facilities and are more present in rural areas, thereby complimenting government facilities.

In the PNFPs, there seemed to be general satisfaction with the service among the women we talked to, but the general complaint was the amount of money charged which most said they could not afford. This issue was raised at the catholic diocese diocesan health assembly which two of the researchers attended. The money the units charge, however, is much less than what is charged in the purely private settings. For example while a C-section delivery goes for Sh80,000 at Villa Maria hospital, at Byansi Private clinic it goes for anything to the tune of Sh500,000. Nakasojjo also registered complaints from the community regarding the behaviour of some of its staff, who women said were too young and not serious enough for the all "important business of accessing our most sensitive areas of our bodies".

There are several reasons why PNFPs seem to be doing better than government owned health units in providing services. Firstly, PNFPs provide some semblance of ethical practice, sanity and empathy to the rural people. Empathy in health care provision is very important and

gives the patient a sense of love which contributes to the healing process. While they charge money, most clients see it as necessary to maintain good standards. Many people told our researchers that they would rather part with something and get a good service than go to the supposedly free health centres only to be treated badly and go back without the services. They say that, unlike in the public health centres, whenever they go to PNFPs, drugs are available.

This was visible in many of the PNFPs we visited. A case in point is Sister Maxencia Namasinga, the bare-knuckles in-charge of Nakasojjo PNFP in Buwunga sub-county, Masaka. She takes care of the health facility like her personal estate, punctuating caring for health workers with tending to the garden around the facility, cleaning and personally cuddling babies as she talks too their mothers.

PNFPs espouse a hard work ethic among their staffers. They are run like business corporations where complacency, mediocrity and absenteeism are not tolerated. This is partly the reason there is very high staff attrition in these health centres. The staff who work there complain that they work harder than their counterparts in public health centres, yet earn less than them.

PNFPs are beloved because most of them are located in hard to reach areas, and are in some cases the only viable health centres in the areas. All the PNFPs this research focused on were in the very deep rural areas. Some of them are well equipped with amenities that make services that would otherwise be impossible in such settings possible, like surgeries and caesarean operations. For example in Nakasojjo, 20 km from Masaka town, the unit is furnished with the several water tanks, where villagers come to draw water free of charge. The solar electricity at the health centre is also widely used by the people to charge their mobile phones free of charge. The PNFP staff is comfortable working in these rural settings because some of them see their service as more of a calling than simply a vocation. Government, despite enormous effort to set up a health centre at least in every sub-county, still is unable to establish a presence in some hard to reach, insecure areas and for these, PNFPs are always a welcome, if not miraculous relief.

The user-fees that the PNFPs levy on clients is also important in helping them deliver comparatively better services. While it is always not enough to meet all their needs, this money is a huge help towards ensuring steady, quality service. For example, a full treatment course for malaria goes for Sh3,000 in most of these health units, far below the amount in for-profit settings. This money is used to top up on the donor funds and the subsidies from government. Many public health centre employees told researchers how scrapping of cost-sharing has impacted negatively on the quality of services provided in the government owned health centres.

PNFPs also perform better because of the ‘Faith’ in the name “faith-based” health centres. Indeed most in-charges of the health centres APPP researchers studied were either nuns, (Kyamuliibwa), sisters (Nakasojjo) and where others were not either of these by calling, they deeply religious people. The religious orientation of these workers started far back to the time of evangelisation of Uganda. Their history is treasured and recorded in the UCMB manuals that are circulated into all catholic PNFPs staff to read.

Strict rules: It was also found that the Health Unit Management Committees of PNFPs were more effective than that those of government health units. These were committed men and woman who took their work seriously. They were also deeply religious and shared the mission of the Catholic Church. “Code of conduct for office bearers” hand-book is circulated to all

health workers, intended to “set standards to which all persons holding a senior position, those administering or governing or simply serving as employees of the catholic health services are invited to choose, pursue and adhere to as a matter of personal choice and commitment”.

The first and second sections of the document constitute the statement of commitment applicable to, respectively, senior staff and members of the management team of catholic health services. The third section is an oath for code of conduct for members of the board of governors of hospitals/health units. The senior staff and members of the management team affirm their allegiance to these rules as regards to; Pursuing the health unit mission and plans, Integrity and openness, Exemplary behaviour, and Professional practice among other attributes.

However, they also have challenges which include but are not limited to the following.

While accessibility and productivity have improved, this however has not been followed by corresponding changes in other variables such as the Primary Health Care conditional grant[20]which does not match the required levels. Government has instead been gradually reducing the amount of primary health care funds it remits to PNFPs.

The unit cost for services provided remains twice as much as the fees paid by the patient. This is putting enormous pressure on the operating capacity of PNFPs. While all PNFPs are not businesses that they require to break-even to stay afloat, they need sufficient income to buy medical equipment and afford maintenance costs.

The expenditure on salaries is shooting up. Medical workers, owing to the demand for them from other markets require repeated salary increments to stay with PNFPs, which more often than not they cannot meet when donor funding is declining.

Consequently, user fees have increased. Since the fee contributes to 63% of PHFP income, it cannot be done without. The increase in fees will ultimately reduce affordability and accessibility, disaffecting PNFPs main goal of providing healthcare to all.

Furthermore, despite the increasing expenditure on salaries to improve retention, the exodus of qualified staff to Government units and NGOs continues. The gaps between the Government salary and the diocesan salary have widened with the new salary increment for government health workers that takes effect in the financial year 2010/2011. Over 60% of the staff who leave join government at various levels (mainly districts) and the main reasons they give include Poor pay compared to government, working “too much” compared to government staff. The lean health workforce experiences heavy pressure to implement an increasing range of services within the national Minimum Health Care package. There is also pressure to force further downtrends in HIV prevalence. Efforts to scale up anti-retroviral therapy (ART) and other HIV services have increased the workload in some PNFP units.

[20] This is money Ministry of Health gives to health centres through districts to help them in paying for medical and nonmedical costs. The different levels of health centres receive different amounts per year. A manager at JMS in Kampala told us thus: “There are different modes in which different districts give out the PHC funds to the PNFPS. Some districts give out the PHC funds straight away whereas others wait for the invoices from the PNFPs to pay back. Since there are no guidelines for giving out these funds to different PNFPs, some miss out yet the Ministry of Health releases the funds”

The uncertainty about the continuation of credit lines for medicines for PNFP has caused anxiety to many recipients[21]. The credit line system is a mechanism worked out by the ministry of health to supply drugs to health centres through the joint medical stores. The arrangement was in such a way that instead of the ministry giving cash to districts or health units to buy these equipments, it deposited it with JMS which procured drugs worth the money that was to be allocated to each health centre and thereafter sent the drugs instead of cash

This money used to be provided through Joint Medical Stores, but now all is given to NMS. The challenge with this is that JMS and NMS are two different statutory bodies with different rules and regulations. PNFPs report that there is difficulty with accessing drugs from NMS and they would prefer the earlier arrangement where JMS was the conduit. They claim that the Interpretation of the NMS statute seems to be wrong, thus denying PNFP access to medicines in NMS. NMS has now embarked on the 'kit format' in which health centres are no longer going to be requesting for drugs. Instead, all health centres of the same level will be receiving a kit containing certain amounts of different types of drugs, an arrangement that assumes that demand is the same everywhere. PNFPs fear that if there is no more credit line, there will be severe shortage of drugs in PNFPs

Clinics and drug shops

These are mainly found in trading centres and small towns in the study areas. They exist to make profit and so they operate under the competition principle. The drug shops are owned by individuals, some of whom are not trained, even though the laws require that owners and operators of these shops be qualified in some medical fields. Those set up by medical people are mostly owned by trained medical personnel working in government or private health units. Most of the private maternity homes studied were owned by retired midwives like the one in Kyamulibwa that is owned by Mrs. Sematiko, and another one in Buwunga- Kyabumba that is owned by Mrs. Margret Kyeyune.

Research findings also reveal that some, but certainly not all of these clinics and drug shops are run by trained nursing assistants. This training however is questioned by district officials, who argue that everyone who learns on job calls him/herself *Musawo* (Health worker) and the clients follow suit in according her the honour of the title. We physically observed this, from the responses we got when we interviewed some of these drug shop attendants. Few of them would mention a school with a reputation of training health workers like Masaka school of nursing or Villa Maria.

[21] The credit line system has since phased out. PNFP officials admit it was the best thing that had ever happened to the PNFP-GoU partnership

A drug shop in Buwunga trading centre, Masaka

Although all drug shops and some of these clinics are not supposed to provide certain services like admitting patients or selling certain kinds of drugs, like antibiotics, those we visited did render such services and sold those drugs, claiming that there can be no meaningful business unless they sell such drugs. Policing this is compounded by the fact that licenses are got by the qualified owners of drug shops, who later employ the unqualified nurses to dispense drugs. This is also attributed to non enforcement of the law which is partly attributed to poor inspection of such shops and clinics because the district drugs inspector is poorly facilitated and in most cases has no money for transport to far-flung rural areas where most of these illegal shops are found.

Traditional birth attendants

In Uganda, TBAs have been involved in maternal health for years and are traditionally supporting women in child birth. TBAs have always been older women without formal training in midwifery but with skills and experience in preparing and delivering mothers which was passed on to them by their mothers, aunts and other relatives through assimilation. In the late 1990's the government of Uganda recognized the role of TBAs in the provision of maternal health services and it took up the initiative to equip them with basic skills in child birthing so that maternal and infant mortality could be minimized.

After a period of over 10 years the Government through the Health Development Partners, stakeholders and District Health Officers terminated TBA trainings (June 2009). This was as a result of focusing on the evidence based interventions to accelerate reduction in maternal and child mortality[22]. The government took up this action because it had widely acknowledged that TBAs couldn't handle complications arising during delivery and could eventually lead to death. In training them, government realized it was sending mixed messages to the communities that it had endorsed their role in the reduction of maternal health, a very genuine fear as shown how the TBAs touted this 'training' and displayed their certificates in their shrines[23].

[22] This is an excerpt from the letter the DHO of Masaka wrote to all NGOs that were still training TBAs, ordering them to stop doing so.

The research findings, however, show that, despite the turn of events, a number of women still deliver under the watch and assistance of TBAs. Others deliver at home with the help of relatives whom they trust. Beyond the statistics in the health units showing that there were bigger numbers of women attending antenatal care with few of those returning for delivery and very few turning up again for Post natal care, more evidence was adduced during individual interviews which showed that if a mother had 6 children at least 4or 5 of these were delivered with the assistance of TBAs. However, on occasions, researchers failed to establish what "TBA" was understood to mean to the responding mothers. It is possible that the TBA and any other women or relatives who help in giving birth could have been used interchangeably. Some of the TBAs who kept records which the research studied revealed that some registered more deliveries in a month than the nearest health centre.

Despite government action, TBAs still play a critical role in provision of maternal health services in Masaka and Rakai districts. Reasons for this include the following:

- They are trusted by the communities and this stems mainly from the birth history of the older women. This trust and belief is strengthened by the presence in the communities of mothers who have been successfully helped by TBAs.

- The caring attitude of TBAs towards mothers has also been another reason highlighted by mothers for delivering from TBAs. Mothers claimed that TBAs care a lot by being there during the labour times, comforting them, giving them food and tea free of charge, and the fact that when one delivers from a TBA she doesn't need to go with a care taker because the TBA does it all.

- The trainings which were given to these TBAs ten years back tend to give mothers confidence that they are also qualified and that they have midwifery skills to deliver them successfully. It was therefore no surprise when we would ask women where they delivered from and they would give responses such as; "*Nazaalira awokumpi; tulinawo omuzalisa omutendeke. (I delivered from nearby; there is a trained TBA).*

- Indeed, during the days when the government legitimated the activities of TBAs, many NGOs took interest in training them. Among these NGOs in Masaka are World Vision which trained a big number of TBAs.

A Certificate of training is shown to the APPP researchers by a TBA in Lwemiwafu village, Masaka District

However TBAs also face challenges in their bid to provide maternal health services. We observed these problems as TBAs would admit to only a few. The claim that they have answers to almost many technical challenges involved in delivery could be dangerous. Not everything can be fixed by a local herb.

Problems faced by Traditional Birth Attendants include:

- ***Lack of equipment (gloves, cotton wool, polythene, apron and many others):*** Some of our respondents reported that TBAs ask for gloves, razor blades, polythene but sometimes don't use them on the patients who would have brought them, preferring instead to reserve them for other clients. There was also evidence that some of the materials used on one mother are not always discarded but are instead re-used on another. One respondent told us of how she saw a pair of scissors which seemed to have just been used on a previous client and she wondered whether it had been sterilized so as to be used on her.

- ***Lack of separate labour rooms:*** We observed that almost all the TBAs deliver mothers from their houses either in the sitting room or in a separate room, none of which are clean-enough places to deliver from. Just a handful had small huts besides the main house which acted as wards in case mothers stayed overnight. Some TBAs also cited this as a challenge. Some had elaborate plans to put up separate houses for this purpose.

- ***Failure of some mothers to pay:*** TBAs also reported that some mothers don't pay them but they bear with it because they are community members who they can't report anywhere. TBAs normally charge between 10000/= and 20000/= depending on how long one has stayed with them, and whether she has reported with the delivery requirements. But women who delivered from the TBAs ten years back reported that

they used not to take anything for delivery. As for payment, they could just give a kilo of sugar and a bar of soap or even be delivered free of charge since TBAs might be blood relatives. Clearly, from our observations, among some traditional birth attendants, attending is now a commercial business.

A TBA washes a newly born baby in local herbs in Buwunga village, Masaka district. These apparently protect the baby against skin rashes

Village Health Teams

The Village Health Teams programme is promoted by the Ministry of Health since 2008. The VHT program was introduced by the government because it didn't have resources to construct health centre at village levels. Originally each sub county in the entire district had one Health assistant to report household health problems in different villages and carry out sensitization in communities which they never did effectively. The need for VHTs was to extend basic health care services to the entire population almost a half of which is living below the poverty line and is concentrated in rural areas. The main concern was to reduce the gap in health service provision between the households and the facility- based health service providers. The main purpose of the VHTs was to collect information from household to household concerning health problems and promote health in villages. The team is answerable to the local council 1 executive on the health status of the households that fall in each one's area of jurisdiction.

VHTs are also supposed to collect and provide a variety of answers to questions which include the following: - population records of the households, birth and death registration, education status of household members, water sources used by households, immunization status of babies and pregnant women, pregnancy monitoring and latrine coverage.

Furthermore, VHTs are supposed to hold periodic meetings in which they identify health problems that are affecting communities. They are then to come up with action points and then mobilize people for community sensitizations. If for example some households are found to lack latrines or using unsafe water for drinking, household visits are to be held, and health education given on spot. More so when information from sub-county Health Assistants reaches the district, the District Health Management Team is expected to sit and draw action points that should be implemented in the different villages.

Some Community members further said that they discuss issues related to sanitation but not maternal health implying the VHTs have not played a thoroughly comprehensive role. The VHTs themselves complain of lacking the necessary equipments to use and complain of working for free, as one of them said at one of their trainings attended by the APPP researchers:

> "We need to be paid for our time. For example, I leave my home and spend the whole day out there, teaching people about hygiene, sanitation, and other health issues. I would be doing work that is profitable for my family but instead I just spend the whole day doing this work"[24]

Other challenges VHTs face include:

- Homes that are far apart. Some members have as many as 20 households under their jurisdiction which are far from one another. This creates a challenge in terms of transport.
- Allowances: one member retorted; "We need to be paid for our time. For example, I leave my home and spend the whole day out there, teaching people about hygiene, sanitation, and other health issues. I would be doing work that is profitable for my family but instead I just spend the whole day doing this work". From our conversations with villagers, however, we learnt that some of these VHTs have never been seen and are not even known by some residents of these villages.
- Some home owners are not welcoming and they see VHT visits as an intrusion. As a result, some said they needed VHT identity cards, to avoid being mistaken for impostors
- The rainy season is challenging. VHTs said they need gumboots, gloves, umbrellas, and overalls. Besides, there is need for stationery like pens, books and paper, and also a megaphone especially when mobilizing people for campaigns like immunization and collection of mosquito nets.
- They further asked for mosquito nets to give to their people back in the villages and Coartem drug to treat Malaria
- Some homes are inaccessible, as they are located in physically difficult areas to reach like hills and forested areas
- Rude health workers- in situations where they have to take critically ill and expectant mothers in the communities to the health units.
- Infrequent supervision of VHTs by the district health authorities; even where it is done, there is no feedback from the supervisors to the VHTs
- Some VHT members claim to know it all, and parade themselves to the rural residents as health workers which led to the resistance from the community since it's aware that they don't have a professional training.

[24] Team observation at VHT training in Gurama Parish, Buwunga sub-county on Sept 1 2010

- People have a challenge with collapsed water sources, bore holes not functioning- this means that as much they sensitize the communities about proper sanitation, the major sanitation facility is not available which renders their efforts useless.

VHTs, however, keep doing the job despite the challenges. This is because some join in anticipation of some goodies such as allowances when there are opportunities for training. VHTs are also given first priority when massive community drives by the government, such as distribution of mosquito nets, are rolled out. They are also given short term jobs NGOs bring that involve community mobilization for things such as distribution of drugs and immunization. The team witnessed for example the giving of bicycles ceremony in Buwunga sub-county, a gesture by Caritas Maddo NGO. But when this doesn't happen, they complain[25].

3.8 Summary, recommendations and conclusions

The 2010 MDG report for Uganda states that the progress for Uganda's achievement of MDG number 5 on maternal health is "slow". This is clearly the case if the situation in the two districts of Masaka and Rakai investigated under this study are anything to go by. Research findings have identified a range of service providers for maternal health as summarised in the table below.

Table of Health providers

PROVIDER	SERVICE	PERCEIVED BENEFIT	PERCEIVED CHALLENGES	COMMENT
• Central Government	• Legal & institutional framework • Effecting decentralized delivery system with each level of local government or administrative unit • Funding and Personnel for government run HCs • Partial funding of PNFPs • Previously trained and provided kits to TBAs	• Free services • Availability to all • In close proximity to communities • Political interventions to solve problems	• Disjuncture between policy intensions and the reality on the ground • Weak management and supervisory execution • Inadequate resources – financing, staffing, supplies etc • Frequent stock-outs • Diversion of resources • Political interference • Health Centre Management Committees whose members are less committed and have limited technical capability • The scrapping of user fees has impacted	• Mixed signals provided by the political elite • Inconsistent dithering on the role of TBAs

[25] Annet Nannungi and John Bosco Mubiru interview with a VHT couple, 11 Feb 2011: Deborah said that the only thing that they were given to help them perform their duties were markers and manila papers. She has sensitized the community 2 times at community gatherings.

			negatively on the quality of services provided • Negative attitudes of staff towards patients	
• Local Governments	• Implement Central Government programs • Enact bye-laws	• Undertake mobilization of resources • Mobilise community participation • Take corrective action	• (Similar to those of central government)	•
• Not-For-Profit-Private facilities run by FBOs and NGOs, with a subsidy from government	• Facility and non-facility (outreach) health based services • Capacity building and training on health education to communities • Provision of supplies and equipments e.g. toilets, water harvesting and water treatment supplies	• Often better managed, better staffed and stocked than their government counterparts • Better work ethic • Quality 'top class' services provided in remote areas • Health Centre Management committees stronger and more informed than government	• Dependence on donor and government subsidy with support declining • User fees which are unaffordable to some community members and seem unregulated • Lower pay for harder work which causes some staff attrition to government facilities	• Pay differential which robs PNFPs of staff
• Private for Profit Providers	• Maternal Health Services • Dispensing of medicines	• Effectively run • Services available if one can afford them	• Concentrated in urbanized settings • Costs are high • They are perceived to be diverting medicines from government health centres • Some use the time they should be at government facilities to run their private clinics	•
• Traditional Birth Attendants – TBAs	• Delivery services • ANC and PNC services • Support and empathy	• While they charge a service fee, its amount and terms of payment are often negotiable • Support and empathy during labour • They are trusted • Considered to	• Some of have inadequate facilities like delivering in living rooms • Limited training depending only on inherited or acquire skills from relatives and or mothers • They reuse of delivery supplies supposed to be disposed of after	• Unlike the health worker, this a permanent residence within the community

		• be very mature and experienced • They have herms for everything	each use	
• Home deliveries	• Family members assist the mother	• Familiar environment • Pride of the woman	• Highly risky for the mother and the child	• Pride is a huge factor
• Village Heath Teams	• Health education and mobilisation • Home visits	• VHTs provide services voluntarily	• Low motivation (complaining that they are not paid) • Not always appreciated	• Byelaws not fully implemented
• Male Spouses	• Indirect	• Support such as provision of transportation in cases of referrals or emergencies • Influence family planning participation • Support for PMTCT	• Little to no support to wives – they do not accompany them to clinics for ANC or/and PNC • Their authorization for family planning and other such not always forthcoming, resulting in women having to lie to their spouses to access services	• The role of the spouse is not deeply explored • Level of education modifies attitudes towards maternal health services positively
• Community	• Both direct and indirect • Care and support	• Social support system & network	• Negative influences as a result of certain culture, norms, practices and beliefs e.g. family planning practices and child spacing	• No clearly spelt out mechanisms to counter negative influences
• Mass Media	• Disseminate very important health messages	• Can reach and far and wide audiences • Can be passed on by word of mouth	• Multiple messaging • Misinformation or distortion of scientific facts especially during phone-in programs	• Generally mass media can give wrong or mixed messages, de-campaigning current health education programs and messages • Media should have obligation to provide verified information
• Cultural Institutions	• Indirect influence	• Influence on location of facilities and the impact on the attitudes towards beliefs towards those facilities and the service	•	•

In terms of the modes of governance for service delivery, the following is what was found to obtain in the districts and areas studied, written in the order that they are strongest:

1) Administrative – Central & Local Government, PNFP
2) Local democracy – Local Government, HC Management Committees and VHTs
3) Traditional/indigenous – TBAs, Family, Spouses and Community
4) Associational – PNFPs/NGOs, Community and Mass Media
5) Chiefly – Buganda cultural institution/Kingdom and its agents at lower levels (they influence cultural beliefs, norms and practices, early, arranged and multiple marriages)

While the administrative mode would appear to provide the bulk of the maternal health public good, the contribution and interaction with the other modes of public good provision is significant. Often the lines between that, the local democracy mode and the traditional/indigenous mode are blurred. Government contributes financially to PNFPs run by institutions whose main motivation is faith; TBAs assist mothers who might otherwise deliver un-attended by the un-initiated; and some medicines from government facilities find their way into private clinics.

While the chiefly mode may not be conspicuous in the delivery of maternal services, the influence it has on the conduct of a good *Muganda* woman, the authority of the man over his wife, the age-difference factor when assessing the role of and the trust to accord the a young health worker; and ultimately, the counterfactual – what could have been if this system was mined more, all point to the need to explore how to make the chiefly role more overt.

Therefore, there is a lot to draw from a more intentional collaboration with PNFP in the way they motivate their teams, inculcate commitment, and manage facilities effectively and a work ethic that serves the poor well. Cleanliness is not only a function of funding but more a way of life. As the saying goes ‘cleanliness is next to godliness’. The feel good factor through empathy and good handling of mothers at a most critical stage should be brought into the public HCs.

The role education plays in family planning and other maternal health aspects is important. It therefore needs to be made more prominent through intentional incorporation into health sector planning as well as the school curriculum.

Media plays an important role in promoting development in general and maternal health in particular. The research has indicated that there were incidences where radio was used to give out information that turned out to be misleading and not factual. It would benefit the MoH more if District Health Information Officers and district officials in general worked more closely with such media to ensure that information provided to the public is factual at all times and promotional of good practices.

In any community, politics plays an important role and communities under this study were no exception. However, numerous cases were cited by the researchers where politically motivated intervention stifled local initiatives, undermining local authorities and bye-laws. In some instances politicians helped to mobilize community action for provision of public goods while in other instances they countered efforts to mobilize resources and community participation under the guise that government is supposed to provide fully for those public goods. In this regard democratic politics was found to be undermining law enforcement and other forms of collective action. An example was the case where a conflict between a politician and a district health official led to the grounding of an ambulance. Government

should devise a strategy for minimizing the negative tendencies and conflicts between the administrative and local democracy mode of delivering public goods.

In answer to the research question, “what works for the poor”, the study finding is that poor expectant mothers ‘vote with their feet’ in a matter that risks their lives when many choose to deliver at the TBA’s. They proudly say that they ‘dupe’ the system to get a card as a backup plan B, with no intention whatsoever to deliver in the modern facility unless circumstances force them to.

This evidence points to people responding positively to *what they know and what they believe* in rather than what they are told as good for them. Therefore, to increase the stagnant uptake of maternal health services, government needs to take the lead in bringing together different players in a way that taps into this finding. For example, instead of discontinuing the support government was giving to TBA, and dithering about incorporating their role into mainstream health services, government should explore bringing TBAs as coaches and mentors for the young health workers as well as strengthening their role as encouragers and educators of women in general and expectant mothers in particular about maternal health. TBAs can also play a role of linking women to health centres. It would appear that ‘trust is passed on’ rather than acquired (at school). Furthermore, an exchange system should be considered between government HC and PNFP at management level and Management Committee levels.

Furthermore, evidence in this study shows that there are four modes that directly deliver maternal health services and these are Administrative; Local democracy; Traditional/indigenous and Associational. A partnership already exists and is planned for between government (administrative/local democracy) and PNFPs (Administrative and Associational). Presently the partnership with TBAs, while it has existed in the past, does not exist anymore. Because of the extent to which the expectant mothers choose TBAs over government health centres, this traditional/indigenous mode of delivery needs to be more intentionally integrated into the mainstream health system as had earlier been envisaged. This is due to the fact that they have a lot to offer in terms of the handling of expectant mothers and engendering trust, confidence and respect, which are low in the government health centres.

Another important category of providers, though indirect are the cultural institutions and media. To break the stagnation in maternal healthy delivery, the hearts, minds, attitudes and beliefs of mothers and youth women is critical. Therefore government must devise a strategy that effectively brings the influence of these players to bear.

Our conclusion is that local governance systems are better able to produce public or collective goods when they build on other existing forms of legitimacy, authority and accountability and/or ‘work with the grain’ of local de facto institutional arrangements. Without intentionally bringing other modes of service delivery, administrative decentralization alone, is not able to take maternal health to another level necessary to meet the MDG targets.

4 Delivery of public goods, 2: water

4.1 Introduction

Water is a key strategic resource, vital for sustaining life and promotion of development. “Water is life” and everyone has a right to clean drinkable water as well as a clean and healthy environment.

The first piped water systems were completed during the 1930s while water-borne sewerage was introduced after 1937. The construction of new facilities increased from 1950 to 1965 under the framework of large national development programmes (Nilsson, 2006). During the period of political instability (1970s and 80s), water infrastructural development suffered a set-back. However, access to water resource has improved from 18 percent (1990), to 47 percent (1999) and 66 percent (2006). In rural areas, access to clean water (within an average distance of 1 km) was 65 percent for rural and 67 percent for semi-urban communities in 2009-10. Available information states that 70 percent of water sources in rural areas were protected and safe for domestic use and consumption.

In Masaka (before being carved into 3 other districts) 81 percent of 833,700 people were served with water but only 66 percent of the sources were functional[26]. According to Rakai water source progressive report of 2009, of the population of 434,559 (2008), only 54 percent were served with water. But even then only 32.6 percent of these sources were functional.

Different administrative units i.e. sub-counties, parishes, villages, perform differently when looked at on a one on one basis. In Rakai for example, safe water coverage in FY2009/10 was only 12 percent for Dwaniro sub-county, while it was 50 percent for Kabira. This understandably attracted different handling by the district leaders while allocating moneys to the two areas, reflecting the unique needs of each of the sub-counties. Hence while the Former received the IPF figure of Sh38million in the FY, the latter got only Sh21 million[27].

Concerning distance to the nearest safe water source, 14 % of Rakai residents still have to walk over 3km to fetch water. Only 30 percent find the source within half a kilometre away, 35 percent walk a further half to find the water source a kilometre from their homes, while 8 percent fetch water within a radius of 1-1.5km.[28]

The type of water Sources range from boreholes, shallow wells, ditches/dams or ponds, spring wells, taps (in semi-urban areas) and rain water (where water tanks such as Ferro-cemented, plastic rain water and tarpaulin underground tanks) are used. Like elsewhere in the country, concerns over the quality of water are still echoed among the population. In rural communities of Rakai, open and unprotected ditches or dams prone to animal and human waste pollution are still used where safe water sources barely exist. Water from some of these sources is also brown or chalklike in colour, meaning it is mineralized and not safe for consumption. Information from community members also revealed that unlike ponds which collect water during the rainy season, water from boreholes and shallow wells is hard and salty (not suitable for domestic use).

[26] Masaka District Water Office: Water source situational analysis, 2009

[27] Water and Sanitation Sector, Rakai District Local Government, Sub-county Indicative Planning Figures for FY2009/10

[28] Rakai District ‘MDG Localisation report’, 2010

Table 6: Percentage Distribution of safe water coverage for Rakai

County	Sub-County	Census Popn 2002	Projected Popn 2008	Popn Served all sources	%Coverage Constructed	Popn Served Functional sources	%Coverage Final Source
	Kakuuto	26426	29371	27106	85	16806	57
	Kasasa	15345	17070	19204	85	6900	41
Kakuuto	Kibanda	15506	17248	13622	72	8822	47
	Kifamba	12305	13687	9355	69	5547	41
	Kyebe	16020	17729	6990	40	3690	21
	Byakabanda	13792	15342	11288	74	7880	52
	Ddwaniro	21197	30253	3165	11	2065	7
	Kacheera	17754	19750	5505	28	3705	19
Kooki	Kagamba	27523	30620	2748	9	2322	8
	Kyalulangira	27778	30893	2749	9	2107	7
	Lwamaggwa	33162	36890	10719	29	6519	18
	Lwanda	24964	27768	16731	60	10131	37
	Kabira	26097	29028	14318	50	10118	35
	Kalisizo	27847	30981	18620	85	13226	62
	Kasaali	22793	25353	19918	79	12018	33
Kyotera	Kirumba	23716	26383	16258	62	8758	48
	Lwankoni	13988	15560	16216	85	8516	55
	Nabigasa	18549	20633	13234	64	9525	45
Total		**390762**	**434559**	**227746**	**54**	**138655**	**32.6**

Source: Water Department Rakai April 2009

Fetching Water is mainly done by women and children, especially girls. In both districts, most of the men that were seen at the water sources fetching water were water vendors with bicycles and motor cycles collecting water to sell it in trading centres.

Water from communal water sources such as boreholes, shallow wells, lakes and ditches is free of charge. In some cases however, especially in trading centres where water is accessed from taps or individual rain water harvesting tanks, payments are levied. Some of the trading centres the research team took keen interest in were Buyamba, Kabira, and Kifuuta in Rakai, and Miwuula, Gurama and Kyamuliibwa in Masaka.

Most communal water sources the research team visited were 'dirty'. The water sources were characterised by surrounded overgrown bushes, floating polythene materials, sugar cane peels, banana leaves, among other wastes. In some sources, people have to share water with cattle from the same sources, in the process disposing their excreta in the wells and ponds. Some fetchers step in the water while drawing it. This is sometimes deliberately done, but other times the well is poorly constructed with no steps which leaves the fetcher with no option. The drainage trenches at unprotected spring wells, shallow wells, boreholes and ditches were clogged with dirt and lack of periodic maintenance. There were many non-functioning boreholes and shallow wells.

4.2 Key actors in the provision of water

The Government

Delivery of water in Uganda is a responsibility of the government under the mandate of ministry of water and environment. Major investments in water resource are undertaken through the Directorate for Water Development (DWD) under the ministry of water and environment and conditional grants are channelled directly to the district local governments which are responsible for service delivery to lower levels under the decentralized system.

Actual implementation of water delivery is done through public institutions specifically the NWSC (National Water and Sewerage Corporation) for large towns and DWD for the rest of the country. DWD is a government statutory body set up in the year 2000 to provide the technical and managerial support to district administrations. The directorate also ensures quality assurance of the private contractors' work.

The role played by the Local Governments

The main source of funding to Masaka and Rakai districts water departments is the central government and international donors such as the European Union and previously DANIDA. The central government provides a range of conditional, unconditional and equalization grants disbursed by Ministry of Finance, Planning and Economic Development through the Ministry of Water and Environment. The water and sanitation sectors within the districts are responsible for allocation of financial resources depending on the safe and unsafe water coverage percentages. Normally places with higher percentages of unsafe water are allocated more financial resources than their counter parts using a formula (***%unsafe coverage)/Total unsafe coverage)*Total financial allocations***[29].

The district administration is responsible for planning and budgeting for water activities in the district. Planning for water activities starts right from the lower levels of local council. The community is supposed to express their need for water facilities through writing to the sub-counties, in what is known as the '**Demand Driven Approach**'.

Every financial year, the Ministry of Water and Environment sends Indicative Planning Figures (IPFs), work plan formats and budget estimates in which the sub-counties are supposed to budget/ work within. The water and sanitation department then communicates to the different sub-counties by sending them the IPFs to plan for water activities. After the sub-counties have received the IPFs, the sub-county technical planning committees (including the sub-county chief, parish chiefs, Health Assistants, NAADs coordinators and Community Development Officers), sit and plan for the water activities according to the IPFs. When the sub-county technical planning committees finish the selection of beneficiaries and the types of water facilities to construct, they send their work plans to the water and sanitation sector for approval, integration and compiling of the mandatory District Work plan, an annual ritual every district must perform if it is to get funding from the central government.

Through the district water and sanitation committees Local governments plan, supervise, monitor and coordinate the process of water delivery in the district of jurisdiction. The health assistant stationed at the sub-county level monitors and supervises the maintenance of hygiene at the water sources. Districts periodically report progress of the water situation to the Ministry of Water and Environment. The local government further invests in construction of water sources.

District administration also builds the capacity of stakeholders in the water sector such as the water-user committees, hand-pump mechanics who repairs water sources (boreholes and shallow wells).Enforcement of maintenance and collection of water user fees is the work of the sub-county level administration. It is at this level where direct supervision of the water source construction sites and overseeing of the planning process takes place.

[29] Water and Sanitation Sector, Rakai District Local Government, Sub-county IPFs for FY 2010/2011

The district administration through the water and sanitation sector is also mandated to coordinate all the water and sanitation activities in the district. The water and sanitation department is supposed to communicate polices and guidelines from the Ministry of Water and Environment to all the stakeholders in the district including NGOs and private providers. Furthermore the department is supposed to be receiving reports from them concerning their work plans and activities they have implemented in the district after which it is to compile progressive reports concerning those activities and send them to the Ministry of Water and Environment.

It is at this point that it is evident that some districts can be more creative than others. In Rakai district, for example, every quarter of a financial year, there is district water and sanitation coordination committee meeting (DWSCC) organized by the water and sanitation sector actors. The DWSCC is a multi-stakeholder committee that brings together District, Non-Governmental organizations and Private sector organizations involved in water and sanitation related activities on quarterly basis. The purpose of the committee is to discuss sector plans, priorities, review progress made by the stakeholders and agree on common approaches. While the DWSCC has problems of its own, like lack of quorum in some meetings, non adherence by some members to binding resolutions passed, the initiative is a step in the right direction.

The research team attended one of those meetings and here is what they found:

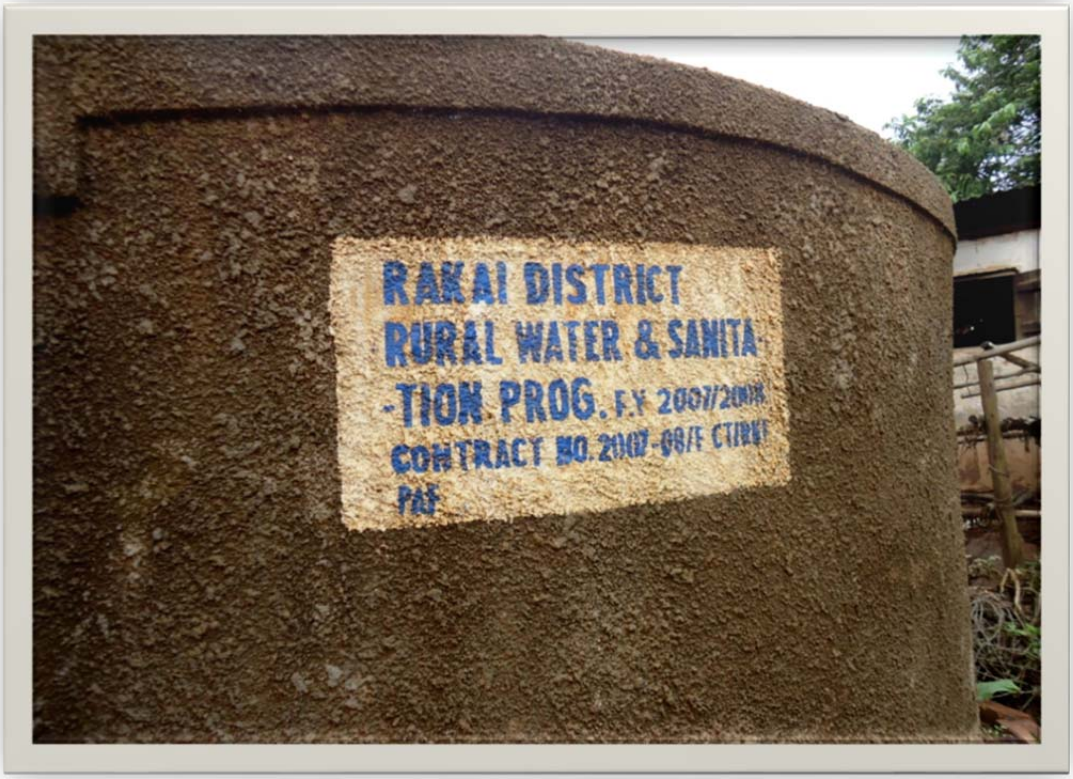
> The meeting was chaired by the Assistant CAO of Rakai District and attended by different stakeholders who included; District civil servants (Water engineer, District Health Inspector, Productions Officer, Health Assistants, County Health Inspectors, Deputy CAO, Town Council water officers, District statistician, Physical Planner, among others); NGOs (ACORD, Red Cross, COWESAR, Rakai NGO Forum, among others) and Technical Support Unit (TSU) staff. The discussions in the meeting were around the activities that had been implemented in the previous quarter, those yet to be implemented, operation and maintenance challenges faced by different stakeholders and the way forward. It was jovial and as each member shared what they were doing and emphasized unity. The district water engineer however later told us in a private interview that there is still a problem with coordination of water and sanitation activities in the district because some NGOs are still hesitant to share their work plans and budgets approved by their donors with the district water department. This he said had led to fragmented interventions, duplication of efforts and ineffective use of resources by the different stakeholders". **A DWSCC meeting held on 16th December 2010 at Rakai district headquarters** [30].

It is the role of local governments too, to train all staff and individuals in the water sector. The district water department and sub-county extension workers are supposed to train the hand pump mechanics31, county water officers, locally- based contacts and water user committees, the latter before the construction of the water sources. The water user committees are responsible for maintaining the operation of water sources and this is done through mobilizing water user fees, carrying out minor repairs, servicing the hand pump, making by-laws on

[30] John BoscoMubiru's field notes, December 19, 2010.

[31] In an interview with Wamala, a hand pump mechanic, in Kabira sub-county, he said that in July 2010 the water and sanitation department recommended over 42 hand pump mechanics (both old and new hand pump mechanics) for a training that took place in Masaka district. He added that they were trained in repairing shallow wells, boreholes and other water sources and that the training took 2 weeks and it involved both theory and practical's of repairing non functional water sources.(JB Mubiru's field notes).

water facilities and mobilizing the community to promote sanitation and hygiene around water sources.



A community water tank built by the Rakai District local government

The district administrations through the procurement process are also responsible for construction and rehabilitation of water sources in the districts. The central government provides the district's water and sanitation departments with conditional grants every financial year and 8% of these grants is supposed to be allocated for rehabilitation of water sources especially the boreholes that are beyond the community's financial capacity. Sub-counties through the Health Assistants should locate boreholes that need to be rehabilitated and inform the district water department. However due to inadequate funds, it was reported that there are boreholes which take even 2 years and beyond without being rehabilitated[32]. Basing on the observations in the field and interactions with the Water officers, 8% of the total budget allocation to the water department is not enough for rehabilitation of boreholes in the entire district. There are very many boreholes that are broken down in the district and this is mainly because there are no funds to rehabilitate them. For example 2010/2011 the Rakai district water department was allocated 267,307,927 shillings and 8% of this money is 21,384,634 shillings. The guidelines from the ministry say that a single borehole to be rehabilitated costs about 4.5 million shillings and basing on 2010/2011 budget allocations, 8% can only rehabilitate only 5 boreholes in the entire district, yet 65 % of all the boreholes are broken down.

[32] Denis Bataringaya Interview with a group of men in Buyamba trading centre, Rakai 7th March, 2010 where a borehole took over 5 years without being rehabilitated as result of inadequate funds in the district water department.

Local government (monitoring)

The local government is supposed to supervise and monitor all the water activities in the district. Monitoring and supervision should be done by local authorities at all levels of the district administration. The local council is supposed to monitor the construction, maintenance and performance of the water user committees including accountability for community contributions; the sub-county through the extension workers is supposed to engage in the supervision of private contractors, monitoring and following up of the construction of water facilities. The district administration is supposed to monitor and supervise the construction of all water facilities and their maintenance in the district[33]. This however is contested by some of the officials on the ground.[34]

Water quality testing: even though it is written in official policy documents that the district water department is responsible for providing safe water to the community and this is done through carrying out water quality testing, this is rarely done. The testing of the water is supposed to be done on all newly constructed water sources, those rehabilitated and the old ones that are in use by the community. Water quality testing is supposed to be done by both the district health inspector and all the health assistants in different sub-counties. During the quality water testing activity, turbidity, PH and presence of E-Coli are assessed. As a matter of fact, the Rakai district health inspector told us that where water sources are found to be contaminated after carrying out water quality testing, the community is mobilized and sensitized on what they are supposed to do such as boiling drinking water and encouraged always to construct pit latrines and dispose rubbish far away from the water sources[35].
Interviews with the health assistants both in Kabira and Ddwaniro sub-counties revealed that most of the water sources are never tested. The health assistant of Kabira sub-county added that he has never seen the district health inspector in the sub-county taking samples of water from the water sources for testing them. He added that he is trained in carrying out water quality testing but he has never done it because he lacks facilities used for testing. He said that the district has got only one piece of equipment used for carrying out water quality testing.[36]

The challenges faced by the local government in providing water include:

- **Inadequate funding for water activities;** Inadequate funding was reported to be a major challenge facing the implementation of water activities in both Masaka and Rakai districts. It is said to be caused by cuts in Local Government budgets by the central government. Inadequate funding has affected water activities in different ways. For example, there are many water sources (especially boreholes) that are not functioning due to lack of money to buy spare parts to rehabilitate them; sub-counties receive very many applications for water sources from the communities which are never responded to; there are **water user committees** that were formed in communities but have not yet been trained. Less monitoring of water sources and water user committees is also attributed to financial inadequacies.

---

33 Community Resource Book, Directorate of Water and Development, 2007

34 Bernard Sabiti and JB Mubiru Interview with The health assistant of Kabira sub-county on November 6, 2010: "He said that monitoring and supervision of the water sources is rarely done because of lack of transport facilities and sometimes is not aware of where water sources are being constructed. He said that sometimes the district sends private contractors to the sub-county to construct water sources without informing the sub-county leaders. He added that the district water officers only visit the sub-county during the certification of work done by the private contractors and they never follow up to monitor the operation of water sources".

35 Team interview with Rakai DHI, October 21, 2010.

36 JB Mubiru field notes.

The water department has trained hand pump mechanics in different sub-counties of the district but they are not equipped with tool box kits. The district water engineer reported that lack of tool kits for hand pump mechanics is as a result of inadequate funding for the department. A tool box kit costs between 2 to 3 million shillings according to the district water engineer. Of a great paradox however is the fact that both districts have a challenge of spending money remitted to them from the central government. This issue came up in the IDM meeting the research team attended in Masaka:

> "After the presentation of the Masaka DWO, Participants questioned the absorption capacity of his office, given the fact that he hasn't used even half of the money remitted to his office yet the financial year is ending and just a mere 20 days were remaining to use a huge chuck of money. With many undone projects in his district, he was asked how he was unable to use the money. He blamed the problems of the under-absorption on many factors, from complicated procurement process to late release of funds from the centre".[37]

- **Operation and maintenance challenges;** Poor operation and maintenance of water sources was another challenge affecting water provision. The district water officials put the blame on both the local government and water users themselves. They say that no spare parts are made available to the communities by the water department to rehabilitate non functional boreholes and shallow wells. there is no private firm that has come up to put up an out let to sell spare parts for boreholes and shallow wells because it's not profitable and it's an expensive venture. The districts procure the spare parts Kampala which may be another burden for the community to travel and buy spare parts to rehabilitate their water sources. Because spare parts are far away from communities, it has caused many boreholes and shallow wells to remain non-functional. This explanation however is unacceptable to some of the high ranking officials from the central government. One of these was recorded by the researchers as he attended the above mentioned IDM meeting:

> "The commissioner for water (who was present today) argued that since the community clean when they know officials are going to visit, there is need for more visits for the sources to always be clean. The commissioner was angry that in Masaka reports, non-functionality seem to be constant over the years, as if nothing is changing or being done. "The minister is disappointed. We are spending sh47bn each year, sh480m per district to improve water coverage". He further argued that post construction activities are very important and wondered why they are not done yet they are budgeted for. In post-construction guidelines, officials are supposed to follow-up on a newly constructed Well, by checking whether WUC is still functioning by checking their minutes of meetings, state of the facility, etc. these should be done. The commissioner further said that 5% of the money sent to districts is for monitoring and it should be used. He warned the officials to be careful since next year is a 'tough year'[38]. Funds are now going to be decentralized to sub counties because there is a feeling that the districts are not using them effectively. Our jobs are on the line. The voters want results and the politicians are flocking the ministry asking for results. Guys step up, and perform"[39].

---

37 Bernard Sabiti field notes June 23, 2010.

38 By this he was alluding to the 2011 presidential and parliamentary elections where politicians are always put on the spot over poor public services.

39 Bernard Sabiti field notes of the said IDM meeting in Masaka.

A non- functioning borehole in Masaka District: non-functionality of water sources is one of the greatest challenges facing local governments

However, water users are in some instances also responsible for poor operation and maintenance of water sources. This is so because the community has largely not played its role. Officials lamented apathy in taking responsibility of maintaining communal water sources (boreholes, shallow wells and rain water harvesting tanks). Some communities have failed to contribute water user fees to buy spare parts and repair water sources that are not functioning. When water user fees are not paid, many water sources remain unrepaired. Officials blamed this apathy on high levels of dependence where the community thinks that everything should be provided by the government.

> Vincent, a Hand Pump Mechanic on Non-functionality: He reported that the community was told that after the construction of the water sources, they are supposed to elect the water user committee and it's the role of the committee to mobilize water user fees and bank it on an account at least every month. He added that this money was to be used to buy spare parts and even pay the hand pump mechanic who has repaired the borehole. He reported that in communities people do not want to contribute towards the water user fees and when the boreholes become non functional, there is no money to buy the spare parts and even to pay the hand pump mechanic. Rampant theft of spare parts from the bore holes and shallow wells by unknown people is a headache. Boreholes are very expensive to construct so the government and other development partners have invested in construction of shallow wells which are always constructed in swamps which are far away from homesteads and this makes the thieves easily uninstall spare parts and go away with them. He added that lack of monitoring these water sources by both the district water engineers and the hand pump mechanics causes the non functionality of water sources because if water sources are monitored, there is easy identification of what kind of spare parts are needed to be reinstalled. Vincent reported that he is facing lack of transport means to assist him in moving the heavy tool box while going to repair the boreholes in different villages. After the training in 1996 all the hand pump

> mechanics were given bicycles and tool boxes but the bicycles are currently spoilt and unable to carry the tool boxes which are really very heavy. He also that after repairing the boreholes, sometimes the community is not willing to pay him for the services offered because they fail to contribute user fees from whence he would be paid by the WUC": John Bosco Mubiru Field Notes, 23 September 2010.

This tendency was also reflected in a very subtle way; the way locals named water sources: Most of the water sources (ditches, shallow wells, protected and unprotected springs) visited were named after the owner of the land where a water source was constructed, caretaker or the individual who dug it. The presumed meaning of this was that the responsibility over these sources lay with those individuals, even though they benefitted all of them. Examples included; ekyowa Kakembo (The well at the Kakembos), oluzi lwa Ssonko (Ssonko's well), Clement, Mutuma, Lwambazira, Lwanakakawa ([well] of Nakakawa in Rakai, Ekyewamucyala Kalyango (The pond of Mrs. Kalyango)[40] in Masaka, among others. When it came to ferro-cemented community tanks for example, an official told the research team of an incident where the whole village lacked water because the tank lacked a simple tap which costs less than UGX 10,000 but they could not raise it. The concept of 'community ownership' though theoretically touted by the officials and communities is, in reality, very difficult to sustain.

- **Influence of politics:** This was also highlighted as a cause of poor maintenance attitude where politicians tell [falsely] community members that it's the role of the government to provide social services and that the community should not contribute water user fees.

> "Another problem that was cited was the interference by local politicians who promise users of a broken water source for example, that they are going to bring 'their mechanic' to repair it. They do not tell the people the whole truth, the possibility of the community contributing something but just make promises and this makes people to just sit and wait instead of doing something, so they degenerate into an apathetic relationship with their own water source. It eventually becomes a case of 'to whom it may concern'. The water officials are resultantly blamed, even when they had no idea about the condition of such a far-flung water source. The Water officer Kalangala gave what perhaps was the best illustration of political impact on water service delivery when he narrated how President Museveni recently summoned him to a rally to explain why a certain water stand tap was not functioning. Apparently residents had complained to him that they do not have water. The problem was the community's refusal to pay user fees, as articulated in the law but the president could hear none of that and he tasked the officer to explain."[41]

At the time of this research was also raging parliamentary campaigns and researchers witnessed some incidences where candidates repaired broken boreholes to endear themselves to the voters. In Kasambya village, a borehole that had been dead for three years was repaired by Vincent Sempijja, the LCV chairman of Masaka district who was locked in a bitter NRM primary for Kalungu East with the incumbent MP Hon. Lule Umar Mawiya[42]. Politician's therefore misled the people just to win their votes.

---

[40] Full description of these found in Denis Bataringaya's draft write-up on sanitation in Rakai

[41] Bernard Sabiti Field notes, from the IDM meeting of June 5, 2010

[42] Though Sempijja lost the primary to Mawiya, he trounced him in the General when he still ran against him as an independent, like many of his compatriots across the country, citing a flawed Primary process

For local leaders, some of them deflected blame and defended users on non-payment of fees (possibly because these were culprits themselves) and tended to tell us the ideal rather than what was on the ground. In an interview, a village chairman had this to say on non-functionality:

> "Nakabuye says the frequent breakdown of the only borehole in the village can be attributed to the many people who use it. Three villages share this lone, fragile machine and these are Kasambya, Kalama and Kyambulala. The water user committee of five people has tried but people are adamant and they refuse to pay money for repair. Nakabuye says the users are requested to pay between sh1000-3000 to repair the borehole but admits that it's too much money for some people. Constructed in 1995, the borehole is prone to non-functionality yet it serves a key area, the health centre. (Note that Nakabuye claims that there is a functional WUC, yet most people we talked to, notably the Kalindaluzzi said the committee disbanded a long time ago)"[43].

- **Theft of parts;** This was a problem of both districts. Vandalism of parts of the boreholes and shallow wells was widespread The district water officers and the communities reported theft of parts from the water points which they claimed was stolen by private contractors and part dealers. In Rakai, the district devised a mechanism of engraving the parts of both shallow wells and boreholes but still the theft continued. Theft of parts from boreholes and shallow wells was very evident in Kabira sub-county where we observed many hand pumps with missing parts.

- **Coordination with other stakeholders;** Poor coordination between the stakeholders providing water services in the districts was reported to be a challenge. In both districts are many organizations that provide water services but many choose not to collaborate with the water department or work together themselves. Regulations that govern NGO operations stipulate that non-state actors operating in the district are supposed to share their work plans and budgets with the district authorities but few do. As a result, there are many cases of duplication and waste. An NGO haphazardly builds a borehole a few meters from another one that government earlier put in place. Or instead of repairing a broken one, a new one is put in place, which also breaks down shortly. As a result, it was common site to find a number of broken down water sources in the same locality. In Rakai, a district official complained that some organizations never turn up during the district water and sanitation coordination committee (DSCCC) meetings to share their progress and lessons. Hence the district leadership barely knows their target areas and services they provide to the community[44].

[43] Bernard Sabiti Field notes, July 2, 2010

[44] Team interview with a Rakai district water official, Dec 05, 2010: "He said that they are not involved in their [NGOs'] planning processes which may help to identify areas for them that should be targeted. He added that some organizations arrive in the district and start implementing their work without reporting their existence to the water department. He gave an example of what happened sometime back when a program manager of a certain NGO approached his office requesting him to certify his work because the donor was coming to monitor and evaluate the work and he was sacred he would ask for this".

Children draw water in a pond, in Rakai district

Collaboration between the local government and other stakeholders (NGOs and private firms) is very limited because there are water sources in areas studied which the local authorities (local council and sub-county authorities) and villagers claimed they could not attribute to any organization, saying they did not know who had constructed them. (We do not think that they meant this in the literal sense but as a way to dramatise the lack of coordinated action).

Role of the community in the provision of water

The users are supposed to play a critical role in the water provision chain. First and foremost, they are responsible for applying to their local governments for water sources, expressing need. Communities participate in Village Planning Meetings in a process popularly known as "**Bottom-up Planning**". This process is guided by Community Development Officers (CDOs), who are stationed in sub county headquarters. Some villagers however denied ever seeing local government officials coming to ask them their priorities in a planning cycle. It is in this process however that they demand for water sources as part of their priorities. It is done by expressing their needs in writing through their Local councils via sub-counties, demands which end in district water department. During the course of the study though, researchers physically saw loads of files containing applications from community members both for new water sources and rehabilitation of old ones. These applications are later integrated into the work plans and budgets.

Contribution towards construction of water sources

The community participates in the provision of water by contributing towards construction of water sources. Cost sharing is an approach used by both the local government and Non-governmental organizations while constructing water sources, to create a sense of ownership in the community. For most of water sources studied especially boreholes and shallow wells constructed by local government in both districts, communities had donated pieces of land on which they were constructed, provided hard core stones, sand and provision of causal labour

during construction. Other water sources constructed such as Ferro-cemented tanks, beneficiaries told our researchers that they were contributing local materials like fine and coarse stones, bricks, hard core, poles, water used while constructing, and casual labour, feeding masons, and accommodating them during construction period. In cases where the department of water was providing communal plastic water tanks, the community was supposed to provide materials for construction of the bases on which the tanks were placed. Beneficiaries are further expected to protect the building materials during the construction period. These materials include; bags of cement, gunny bags, binding wires, rolls of wire mesh, chicken wire mesh, gutters, pipes and other accessories. When it comes to contributing cash however, many do not pay up. Communities claim the money charged is too high and they can't afford it. (Payments are as follows: for a Borehole – Sh180,000 is supposed to be contributed, Shallow well- Sh100,000 Protected spring – Sh45,000 Gravity flow scheme Sh45,000, while for a Borehole rehabilitation – Sh90,000)[45].

An underground water harvesting tank in Dwaniro sub-county, Rakai district

Formation of water user committees

It is the role of the community to elect among themselves, a water user committee (WUC). The process takes place before the construction of a water source, to avoid any leadership gap once it is completed. This process is often times facilitated by the provider of the water source; which might be the government or an NGO. The purpose of forming the committee is mainly to mobilize water users to ensure that a water facility is used and maintained properly, with contributions in the form of cash or in kind.

[45] Community Resource Book (2007), Water and Sanitation Sector, Directorate of Water Development

The election of water user committees is done during village meetings. After the election of the committee, the district water department and sub-county extension workers (Health Assistant and Community Development Officers) are supposed to train the water user committees in their roles and responsibilities. The water user committee comprises seven members; a Chairman, vice chairman, treasurer, secretary, a caretaker and 2 committee members. The WUC is responsible for; mobilization of water user fees; ensuring sanitation and hygiene around water sources; contracting and hiring hand pump mechanics; making bye-laws governing water sources; Fencing and clearing bushes around the water sources; carrying out minor repairs and servicing of the hand pumps for shallow wells and boreholes, among other functions. Even for rudimentary water sources such as improvised hand dug ponds and natural springs, WUCs are (at least initially) always put in place.

While reports at the districts showed that the district water departments had trained some water user committees, a vast majority on the ground told our researchers that they had not yet been trained. In both districts, there was not a single complete WUC. In many cases only about two or three members were still active46. We sought out reasons why these stayed put. Many said they cared deeply about their community. However, the fact that the kalindaluzzi (caretakers) constructed a majority of those who didn't give shows that still a personal connection (ownership) of the facility or water source or the land on which it is built was the main reason why these stayed active. In other cases, we found that a member was likely to stay active if that would individually benefit him or her. This is validated by the fact that the other members who escaped the malaise were mostly those who occupied the post of "Treasurer". In one telling quote, a certain treasurer when asked why she lost interest said;

"There is no treasure to keep"[47].

There are various reasons why WUCs are not functioning properly

- **Inadequate support from the local councils** especially in the enforcement of bye-laws regarding utilization of water sources such as contribution of water user fees to rehabilitate water sources. Often local councils do not participate because of politics. They never punish people in the communities who do not obey bye-laws because they are potential voters who may support their political rivals. This has led to reluctance to work or withdrawal by some members from the committee. Some are fed up with this life. A member of the LC executive told one of the researchers that it's pathetic she can't crack a whip. She has as a result decided not to seek re-election[48].

Those few committee members who were still active cited the need to have access to clean water, the alternative water sources being far away from their homesteads and water sources being constructed in their own land as reasons as to why they continue operating.

- **Lack of continuous follow up** by both the district water officers and sub-county extension workers on water user committees to effectively tackle and address

[46] The water user committee members who were still active mainly participated in mobilizing the neighboring users to clean around the water sources. These were mainly caretakers (Kalindaluzzi).

[47] Bernard Sabiti discussions with a woman in Lwemiwafu:

[48] Bernard Sabiti discussion with LC official: "…*"Ebintubigenzebicyankalana"* (Things are running out of hand), she said and added that there is perhaps a need for new leadership of the village to inject fresh blood into the LC system here. That's the reason, she says, that is inhibiting her from running for office again. She says she is giving a chance to others to come and try their best at governing. Namatovu says she has no positive things she has benefitted from serving on the committee and can't wait for her tenure to end. "People are stubborn, they don't want to listen**".** Lwemiwafu village, August 12, 2010.

continuously emerging challenges they face while implementing their roles and responsibilities. Many WUC members and former members told the researchers that they had never received a visit from the district water officer. The distract officials attribute lack of monitoring and supervision visits to inadequate resources

- **Lack of motivation**: water user committee members serve on a voluntary basis and because of this many of the members have withdrawn due to lack of motivation in the form of rewards or payments. A number of water user committee members that were interviewed said that they invest a lot of their time in serving the community but that they are never rewarded and because of this, they have to withdraw. The fate that has befallen their commitment is similar to that one of the LCs. Many LCs complain that they are tired of "working for free". The popular colloquial term "Nfunira wa" Luganda for "What's in it for me?" is used to explain their frustrations.

- **There is a great mistrust** between many water user committees and the village public which ironically selects them. This could stem from the fact that while emphasis is put on informing WUCs of their roles, nobody tells users that they have a responsibility too. Hence they will resist bylaws, directions and anything the WUC tells them, the most critical of which is payment of user-fees. But this also stems from a contradiction of political decentralization which subjects officials to 'the will of the people' to the extent that the officials become incapacitated to execute certain duties. Members of communities think that the committee members embezzle their money which they rarely pay

- **Many WUCs have served Long tenures**. Without being replaced mainly because there are no community members that are willing to take their places and this also leads to loss of morale by those serving because there is an apparent lack of end in sight for their terms, which are not clearly stipulated in the government policies. Again, this is the same thing with LCs who have had elections since 2001. Government claims this is because there is no money to conduct the elections but others say the infusion of multiparty politics, if applied to village levels where the LC 1 chairpersons still know they are in "the Movement System", would mean confusion in the ruling party's solid base of support. Hence many chairpersons are tired of governing, which is similar to the fate that has befallen the WUCs.

Self-supply of water.

It is noteworthy that there are local level or private initiatives by individuals, households and communities to improve their own water supplies without the involvement of either the government or non-governmental organizations. These individual, households or groups pay for their own investment in water sources either in cash or in kind. An important aspect of this finding is the fact that wealth or being rich didn't fully explain the scenario.

In both districts, community members dug ditches where they collected water. The ditches were dug in valleys water collects from hill tops whenever it rains. Those dug by the community become communal ditches whereas those that are dug by individual homesteads are owned individually although the rest of the community members have access to them, but on the owners' terms. In Bigando C and Lwenkologo villages it was reported that in the digging of ditches the community is mobilized by the local council chairpersons. This is mainly done in water stressed areas where other alternatives are hard to come by. Both in Masaka and Rakai districts, there are homesteads that have invested their own money to buy plastic rain water harvesting tanks of different capacities. Others have constructed Ferro-cemented, water jars and tarpaulin underground water tanks in their homesteads without contribution

from local government or Non-governmental organizations. This latter case however was most prevalent in what one would call affluent homesteads. The houses were likely to be *grander and permanent*.

In this picture taken in Kabira subcounty, Rakai district,
men draw water from a trench alongside a broken down borehole

It is also important to note that these individually dug ditches or privately owned springs or shallow wells were at least better maintained than the rest. They were more likely to be found clean and better maintained. There was "somebody" in charge.

There are also community members whose job is to vend water. These community members own bicycles, motor cycles (*boda boda*) and wheel barrows. They collect water from different water sources (ditches, boreholes, shallow wells and dam) and sell it to community members at different prices depending on the distance to the water sources. This happens mostly in trading centres. A 20 litres jerrycan of water in Bikiira trading centre costs Sh300 whereas in Kabira trading centre it was sold at 400 shillings only. In Buyamba trading centre there is a lady who owns a 10,000 litres plastic water tank but she sells 20 litre jerrycans of water at Sh500 only.

Challenges faced by the community

a) Poverty

In communities studied, the problem of poverty was evident, which is not surprising given that this was rural Uganda. Poverty limits people's access to safe and clean water. Most of the stakeholders in the provision of water use a cost sharing approach even with its challenges, meaning that the user will have to bear a cost of some sort nevertheless. Even with goodwill towards the most vulnerable, some of them still do not access the service. For example when the local government is providing the Ferro-cemented water tanks in Rakai, the first priority are the widows, old people and persons with disabilities. However these are people who

cannot raise raw materials that are required while constructing the Ferro-cemented water tanks. Community members are supposed to contribute raw materials such as sand, bricks and aggregate stones. However most of the people find themselves unable to raise the money to contribute to the procuring of raw materials. Other community members have poor housing structures that cannot harvest rain water. Consequently, they have continued collecting water from unprotected water sources.

b) Unsafe water

Limited access to clean and safe water is a big concern. The water in ditches dug by the community members has this brownish colour and it is not treated. It runs from the hills and with the runoff comes along different substances which include plastic items, animal waste, soil, among others. Furthermore water in these ditches is shared with animals such as cows. In some areas where there are water sources that are not functioning as a result of the community failing to contribute user fees to repair broken boreholes and shallow wells, users have been forced to revert to the natural but old and dirty unprotected sources.

c) Long distances

In Rakai especially, communities have to travel long distances to collect water. In Kabira sub-county shallow wells are only constructed in swamps where the water table is high. These swamps are far away from homesteads.

d) Frequent breakdown of water sources

Breakdown of water sources was very frequent in both districts. Hand pumps for both shallow wells and boreholes have been stolen by unknown people, shallow wells are constructed in areas with low water table which makes them irrelevant especially in dry seasons, lack of access to spare parts to repair the shallow wells and boreholes that need rehabilitation, and inactiveness of water user committees and the unwillingness of the water users to contribute water user fees are all responsible for high rates of non functionality.

Public Private Partnership in the delivery of water sources

Government recognizes the private sector as an important partner in the delivery of water. This partnership is reflected in the number of joint meetings participated in and the actual delivery. The National Water and Sanitation Sector Working Group (WSSWG) formally established in November 2003 is chaired by the sector donor group (World Bank) with Environment Health Division (MOH) as its secretariat is one of such partnership meetings. This working group has a broad membership, including representatives of government, donors and NGOs. The group is a policy and strategy advisory group; coordinates water and sanitation sector and implement activities such as sanitation week.

In Masaka and Rakai, private water providers include water vendors, stand pipes operators in semi-urban areas, private contractors and NGOs play a vital role in the delivery of water. Water vendors fetch water from streams, private stand pipes and hawk it around homes at a cost of UGX 200= to 500= per jerry-can. Such providers are unregulated and there is free entry and exit from this enterprise. The research team observed hygiene issues around the jerry-cans used by the vendors and some collected water from unprotected sources. Private run stand pipes are contracted under the DWD's small towns water supply scheme. These operators are responsible for standpipes through hired collectors. Private contractors are hired by district to construct boreholes and shallow wells. Water activities are tendered by the district and drilling companies supply bids for consideration.

The dominant non-state water delivery actors are the NGOs (Non-governmental organizations). These construct water sources (using their foreign mobilized funds or as contractors for local government), maintain, treat and manage water sources. In Masaka and Rakai, Caritas organizations like Maddo, Lwabenge community development programme, World vision, International care and relief, Agency for cooperation and research in development, Dwaniro integrated farmers association, Community integrated development initiative and Community welfare services all play a role in the delivery of clean and safe water. NGOs construct rainwater harvest tanks, boreholes, shallow wells, train and facilitate water user committees and hand pump mechanics and sensitize communities on safe water and hygiene practices. Some NGOs jointly fund sanitation and hygiene events such as the annual sanitation week. During such events prizes are given to cleanest homes.

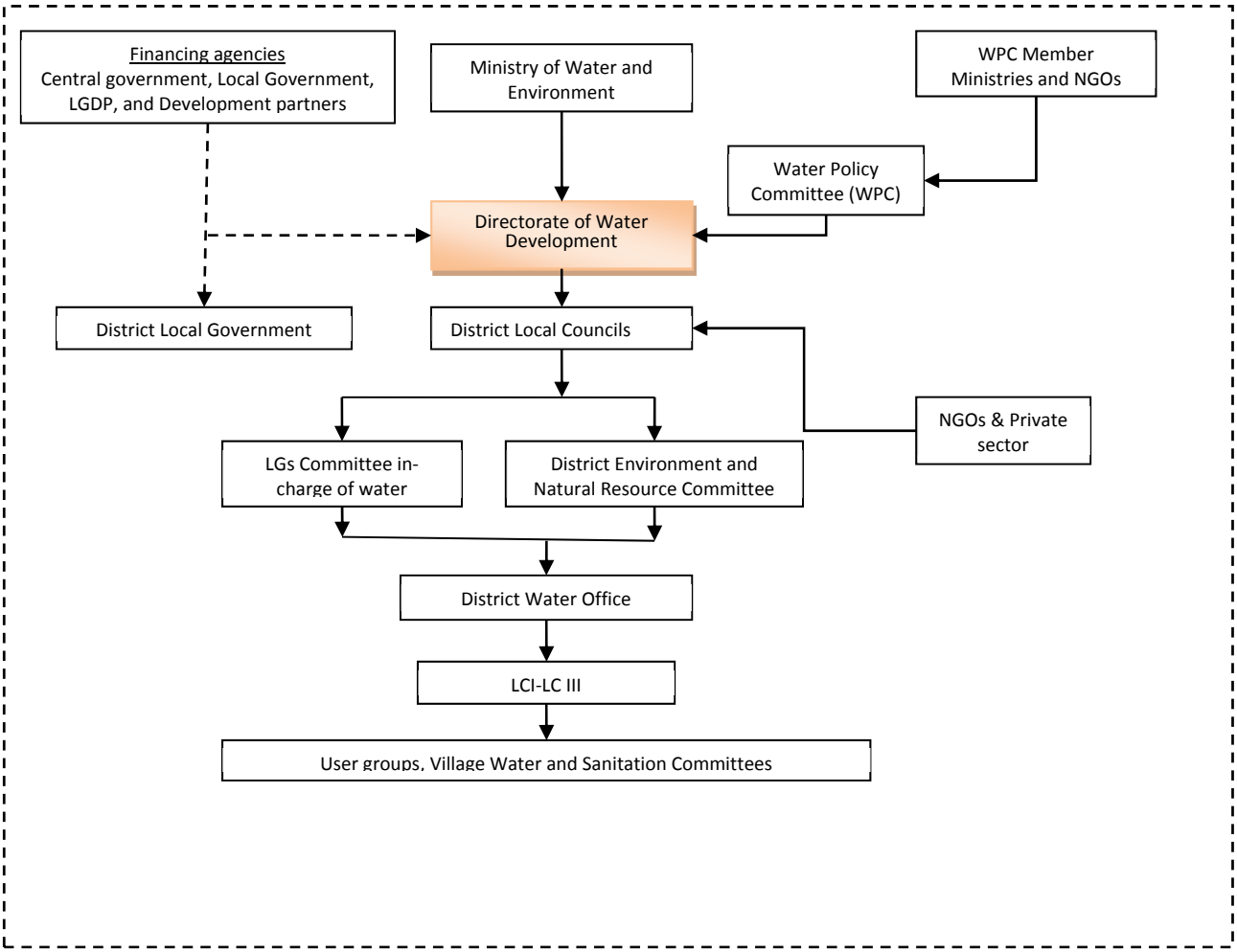
A ferro-cemented tank built by an NGO in Dwaniro sub-county, Rakai district: maintenance becomes a problem when communities take over such facilities

I@MAK (a Makerere University water and sanitation project) has constructed water purifier units in Rakai district. The project has also rewarded NsumbaTwezimbeSalaama women's club[49] with money which has been used to construct Ferro-cemented water tanks for the group members.

Private sector water providers are supposedly supervised by the district water office for quality assurance but also all their work is supposed to be done in consultation with the communities. However, local governments are often short of this function as we shall see later in this paper.

[49] This is a women's group that has promoted sanitation and hygiene in Rakai district.

Figure 1: Water delivery structure incorporating all actors



Source: Wokadala et al (2010).

4.3 Coordination and enforcement of water delivery

Local governments are required to coordinate the delivery of water sources in the district. Some NGOs and the private sector are claimed to construct water sources without the notice of the local governments. This compromise the quality of water sources constructed. From all rural communities, there are reports of private persons using second hand parts or are claimed to steal parts from the already constructed sources and use them for the new ones at a pay. This could explain the multiple water sources (boreholes and shallow wells) found non-functional.

Local governments have failed to enforce water laws. Failure to enforce health and hygiene laws has meant that community members do not comply to set rules and regulations. User fees meant to facilitate maintenance of water sources are in most cases not paid by the community members and there is no enforcement mechanisms put in place. In addition, maintenance of water sources is not enforced for fear of losing votes in the next elections. This scenario was compared to 40 years ago, when the king's appointed leaders effectively enforced health and hygiene laws without fear of losing their positions.

Enforcement of by-laws is also becoming very difficult. Elected local leaders for fear to lose votes in the next elections, they do not participate in hygiene and sanitation enforcement.

Where things work (proper water source maintenance happen), it is because the caretaker or 'Kalinda Luzi' is active and willing to offer time to the source.

4.4 Public-private partnerships

In search for better systems of public goods delivery, governments has on one hand attempted to commercialize public goods provision and built partnerships with the private sector on the other hand. The involvement of the private sector is one way of addressing the potential political pitfalls of full privatization. In addition, this is one way of utilizing new technology and expertise, share risks and gain access to increased capital to improve operating efficiency and ultimately make the sector more responsive to the consumer needs. Progressively the three tripartite arrangement of government, the private sector and civil society organization (CSO) have become clear and popular in the public-private partnership (PPP) schemes. PPP aims at improving efficiency, effectiveness, responsiveness and adequacy of public goods.

From the areas of study, NGOs have trained community members specifically VHTs (on hygiene awareness creation), hand pump mechanics (to manage and maintain water sources) and sensitized the population (on issues of hygiene and better sanitation). NGOs sometimes hire and facilitate the water technicians from the district to carry out their activities.

Researchers were told by the district water officers of the coordination processes of the water service providers which include the District water and sanitation coordination committee which meets quarterly and that this is represented by all stakeholders in the district, the regional Inter-district meeting on water convened by the Technical Support Unit (TSU)[50] also takes place annually bringing together all water and sanitation actors.

Children ferry water home from a well (Rakai District):
ordinarily most bicycle-carried water is for sale in trading centres

[50] TSUs are regional offices constituted by the ministry to advise the district Water and Sanitation offices on staff capacity issues, reporting and management. There are 8 TSUs in the country based at regions. TSU7 oversees Rakai, Masaka, Ssembabule, Lyantonde and Kalangala districts.

Researchers however learnt that such meetings do not resolve participants' concerns and that often the same issues are raised which frustrated the participants as one participant commented:

> "Why is it that similar issues keep cropping up in these meetings? I have attended several meetings as the RDC but keep hearing the same challenges. Are we meeting for the sake? Today I am expecting success stories". This opening statement seemed to make some participants uncomfortable. (Remarked the RDC of Masaka during the opening remarks of the regional water sector meeting)

4.5 Corruption in the water sector

The water sector suffers the 'plague' of corruption which manifests itself mostly in the tendering processes. Malinga (2011) estimates that between $5 and 10 USD meant to improve water for drinking in Uganda is lost to corruption every year. The World Bank (2010) revealed that 10 percentto20 percent of money given to contractors is spent on kickbacks, which significantly reduce the extent to which the contract can deliver on improving access to safe water. 54 percent of the water operators said that they paid 10 percent of the value of the contracts to winning them. The other form of corruption is viewed in influencing peddling by politicians during the decision making of resource allocation with a hope of winning people's favours in the next elections.

4.6 Summary

In terms of water provision, the actors are summarised in the table below.

PROVIDER	SERVICE	PERCEIVED BENEFIT	PERCEIVED CHALLENGES	COMMENT
Central Government	Overall responsibility under Ministry of Water & Environment provides funding through conditional grants to Districts Local Governments for onward delivery to lower local governments. Technical and managerial support provided through DWD to district administrations Solicits for funding from donors Under DWD provides quality assurance	Has the responsibility to provide water and water in "free" Supposed to be clean (routinely tested)	Inadequate funding for water activities Corruption (kickbacks) at tendering stages Influence paddling by politicians	The issues of user fees needs re-articulation for the community to take greater responsibility and for resources for greater maintenance "Broken sources not good for nobody"
Local Governments	Collate water needs, under the Demand Driven Approach, device a formula for prioritizing allocation of resources District Water and Sanitation Department		Receive inadequate support from local government especially in the enforcement of bye-laws Poor coordination between stakeholders providing water	

	communicates policies and guidelines from the ministry to all stakeholders in the district including NGOs and private providers District Water & sanitation Coordinating committee DWSCC which is supposed to bring together all stakeholders on a quarterly basis to discuss sector plans, priorities, harmonize approaches and review progress Sub County Technical Planning Committee which plan for the water activities in the sub county or LC 3 Health Assistants who monitor and supervise hygiene at water sources		services a challenge Lack of quorums for meetings and non-adherence to binding resolutions	
Local Community	Communities contributes locally available and affordable materials, form user committees supposed to enforce collection of water user fees and supervise hand pump mechanics Apply to the local government expressing need for water sources	Some people construct water sources and under certain terms allow communities to use the water Individually constructed sources tend to be better maintained		Apathy Dependency syndrome Misleading information from Politicians which discourage community effort/contribution
NGOs	Construct water sources Mobilize community participation Promote hygiene	Boost water coverage (compliments the meagre government resources) Focuses on health centres and schools and other vulnerable communities	Accused of not revealing their budgets Lack of coordination with the district authorities regarding water sites Not there permanently (they are 'projectized' and when the project ends they leave of when the donor funding ends) Water sources not maintained after they leave	The issue of budgets and coordination need to be addressed
Private Providers	Take contracts	Increase coverage – 'what you pay for is what you get' Batter maintenance	Prone to giving kickbacks which takes away resources for actual provision of water	

Water Vendors	Vend water		Unit price quite high and inconsistent	
Health Assistants at Sub County Level	Identify water sources to be rehabilitated Check the status of the water source	Help keep the relevant authorities informed of broken water sources	Lack of funding which leaves water boreholes un-rehabilitated Rampant theft of spare parts for borehole maintenance Water quality testing rarely done Not all reports acted upon And they don't visit water sources regularly	
Politicians	Candidates repair broken water sources Provide their own mechanics	Support such as provision of transportation in cases of referrals or emergencies Influence family planning participation Support for PMTCT	Little to no support to wives – they do not accompany them to clinics for ANC or/and PNC Their authorization for family planning and other such resulting in women lying to access services	Not sustained because once they get the vote, that's is the end

In terms of the modes of governance and leadership for service delivery, the following is what was found to obtain in the districts and areas studied, written in the order that they are strongest:

1) Administrative – Central & Local Government
2) Local democracy – Local Governments
3) Traditional/indigenous – Natural water sources
4) Associational – NGOs, Community, Private and Local Vendors
5) Chiefly – None although in the past the Mutongole used to play the role of WUCs and Kalinda Luzi seemingly more effectively. For example, Mukudde Spring which is located in Buwunga village was protected by a Mutongole who was the village chief responsile for mobilizing community members to clean the water source monthly. Whenever a drum was sounded every able bodied person in the community turned up. This practice was discontinued during the political/administrative process starting in 1986.

The role played by the Private sector in the provision of public services in Rakai remains critically important. The reason is that without the private sector, some public goods' provision would be severely affected and the extent of the masses' benefit from them would be significantly curtailed.

The main providers are the government and NGOs in collaboration with the community. This partnership needs to be maximized in light of inadequacy of resources with government and NGOs.

A number of inconsistencies have been identified including:

- Instances where politicians seeking elections do both the good and the bad

- NGOs which also do well by additional providing water sources but do so without adequate coordination and transparency
- The fact that communities need water and sometimes take the initiative to get the water while other times they are apathetic and are easily swayed by false claims that government is supposed to provide free water to everybody
- And the use of big names in political circle to scare the effective implementation of bye-laws need to be address

If these are addressed, better public goods delivery systems can be achieved where hybrid provision is established. However, to fully achieve this, certain conditions must be met. Proper participatory planning, good communication, strong commitment of all partners, effective monitoring, coordination, regulation and enforcement by the government must all be put in place. Where any of this has lacked, delivery of the public good has not achieved the desired results. The challenge ahead of the hybrid system might lie in reconciliation of the competing aspirations of the different actors. Governments for instance needs to fulfil its socioeconomic responsibilities on one hand and at the same time preserve the interests of the private sector (which is profit oriented). In the same way, the private sector needs to be convinced that investing in a public good such as water, will offer more attractive returns than other available investment opportunities.

Government should formulate clear legislation and regulatory systems that will give guidance and confidence to all partners, especially to private operators working in the sector, to determine their own policies and plans and to protect their financial interests and property rights.

5 Delivery of public goods, 3: sanitation and hygiene

5.1 Definition of key concepts

According to the National Environmental Health Policy (2005), Environmental Sanitation is a subset of Environmental Health and refers to the safe management of human excreta and associated personal hygiene including hand washing with soap; the safe collection, storage and use of drinking water (safe water chain); solid waste management; drainage and protection against vermin and other disease vectors.

5.2 Sanitation and hygiene status in the country

Access to sanitation and hygiene facilities

Latrine coverage in rural areas in Uganda was 90% in the 1960s but in the 80s, it had steadily declined to almost 30% as a result of political and socio-economic decline the country went through (EHD, MoH July 2001).[51] Currently, there is confusion about rural data with considerable variation by source. The Health Inspectors' Annual Sanitation Survey stated that national latrine coverage stood at 55.7% in 2002, up from 50.1% reported in 2000. In contrast, the Uganda National Household Survey (UBOS 2005) suggested that household pit latrine coverage in rural areas has risen from 85% in 1999 to 87% in 2003. The 2004 National Service Delivery Survey (NSDS) indicates that 82% of rural households and 83% of urban households had access to a pit latrine. However, according to the annual Health Sector Performance Report for 2003/04, national latrine coverage stood at 57% in June 2004.

In the FY 2009/2010 the National sanitation coverage rose from 67.5% to 67.75%. One of the challenges faced by communities, government says, is lack of sustainability of the toilet facilities constructed. Most facilities last for only 2-3 years either after getting filled up or collapse due to poor maintenance. This makes it expensive for the households to replace. The National average[52] of access to hand washing facilities at toilets is at 21%. Sanitation coverage for the urban areas stands at 77%, up slightly from 74% in 2007. The coverage for sewerage services is about 6.4%. Customers are reluctant to connect to sewerage system because most of them already have on site sanitation facilities and do not want to pay high installation charges.

Funding sanitation and hygiene services

Investment in Sanitation and hygiene services is done by different stakeholders. These include; Government, NGOs, Private sector and Community. Government funding responsibilities fall under the Ministry of Health, Ministry of Water and Environment and Ministry of Education and Sports. The main sources of on-budget financing are:

- **The District Water and Sanitation Conditional Grant;** Under the DWSCG, funds for sanitation improvement are imbedded in resources set aside for pre-construction mobilization activities (the training of water source committees has a string sanitation component). This makes it difficult to keep track of funds that are directed to sanitation improvement under the DWSCG. Details of 2010/11 DWSCG indicate that 8% of the grant was allocated for sanitation.

[51] EHD, MoH (July 2001). Strategy on Household Sanitation and Hygiene promotion.
[52] Ministry of Water and Environment Sector Performance Report (2010).

- Part of the Primary Health Care (PHC) Grants allocated to the District Health Departments is usually used to facilitate sanitation and hygiene services. 10% of PHC grants at every Health Centre3 are used to facilitate Health Assistants in every sub-county
- **The School Facility Grant;** The School Facilitation Grant program was set up by the Ministry of Education and Sports under the UPE program in 1998. The grant provides primary school classrooms, teachers' houses, class room furniture and pit latrines. The School Facility Grant is often used for classroom construction and hardly for improved sanitation and hygiene.
- Other sources of financing (off-budget support) for sanitation and hygiene services are; Household investment in sanitation facilities; User charges/ tariffs; NGO and donor projects (grants and loans); Investments by the private sector with the aim of securing a return on the investments and Community contributions to sanitation and hygiene projects.

Policies, legal framework and strategies

The main legal document governing sanitation is the public Health Act, enacted in 1968, and updated in 2000. This is the primary legal basis for measures for the preservation of public health and prevention of a range of diseases in Uganda. Under the 1995 Constitution of Uganda every Ugandan has the right to a clean and healthy environment and it's the duty of every citizen of Uganda to create and protect a clean healthy environment[53]. There is also Kampala Declaration on Sanitation (KDS) (1997)that was endorsed by district political heads, and is considered as indicator of political will. The KDS defined ten areas of action to improve sanitation both at district and lower local government level. The ministry of Health published the National Environmental Health Policy in 2006, spelling out the roles and responsibilities of different stakeholders in sanitation and hygiene service delivery, in line with the Memorandum of Understanding signed in 2001 between Ministry of Water and Environment, Ministry of Health and Ministry of Education and Sports; but also recognizing the contribution of NGOs, CBOs and Private Sector. Under the policy, collaborative development should be carried out at the district level, coordinated by the District Water and Sanitation Coordination Committee. Even subsidy for construction of household facilities was to be considered for the marginalized sectors of the society and in difficult areas where low-cost innovative technologies are pioneered. MWE's related objective is to achieve sustainable provision of safe water and hygienic sanitation facilities for 77% of the rural population by 2015.

The 10 year Improved Sanitation and Hygiene Promotion Financing Strategy (MWE 2006) serves as a roadmap for the attainment of the sanitation targets. It is based on three pronged approach of (i) increasing demand for improved services, (ii) improving the supply of services to facilitate households to acquire improved sanitation and hygiene, and (iii) addressing the enabling environment. Creation of demand for improved sanitation includes ISH promotion and social marketing; as well as enforcement of the public Health Act.

Several District Local Governments have developed bye-laws and ordinances as a back up to the Public Health Act. In order to improve the supply of services, the ISHPFS recommends development of pro-poor technologies as well as improving private sector supply chain. Strategies for improving the enabling environment include creating a rewarding and competitive environment for the private sector; improving multi-sectoral coordination of the ISHPFS at all levels and enhancing Government efforts to improve civil service performance.

[53] Constitution of the Republic of Uganda, Article 245 (a), (b), and (c)

Most officials we talked to agree with other analysts that if these laws were enforced even mildly, there could be a world of difference in sanitation standards in Uganda's rural areas[54]. This however is not adequately done

5.3 Actors in sanitation and hygiene service provision

Government

In 2001, through a Memorandum of Understanding (MOU), The Ministry of Health (MoH) took responsibility for household sanitation, Ministry of Water and Environment (MoWE) became responsible for sanitation in urban areas and rural growth centres, and MoES responsible for school sanitation and hygiene. The ministries are co-ordinated by Water and Sanitation Sector Working Group that comprises of representatives from MoWE, NWSC, MoH, MoES, Ministry of Finance, Planning and Economic Development (MoFPED), development partners and NGOs represented by UWASNET.

Again at central government level is the National Sanitation Working Group (NSWG) that brings together key institutions and actors in the sanitation sub-sector established in December 2003. It has actively engaged with all the major sanitation stakeholders including the three sector ministries of Health, Water and Education; Ministry of Local Government and Gender; development partners, and NGOs. Much work however remains in translating the existing policy statements and strategies into action.

The NSWG also established a Technical Task Team sub-committee that sits more frequently in order to address pressing issues, such as promotion of Eco-san, establishing better coordination, following up on budgetary support, and determining performance measurement indicators. Given the decentralization policy, the centre however is not in position to enforce sector policies and guidelines as developed by the centre. The implementation and enforcement is left to the district local governments.

District level

Local Governments at district and the lower Sub-county levels are responsible for the provision and management of sanitation services, in liaison with the ministries responsible for Health, water, rural sanitation services and community mobilization.

A number of departments/directorates are involved with sanitation at district level:

- Reporting to the District Health Office, the District Health Inspector (DHI) takes responsibility for environmental sanitation. The DHI is assisted by Health Inspectors (HIs) at county level and Health Assistants (HAs) at sub-county level.
- The Directorate of Education (headed by a District Education Officer – DEO) is in charge of education activities at the district level and the District Education Inspectorate co-ordinates sanitation and hygiene promotion activities in schools.
- The Department of Gender and Community Development with the key staff of Community Development Officers and Community Development Assistants at sub county levels who work closely with staff from the Health Inspectorate.

[54] See for example, Dr Myles Lugemwa: "Invoke the Public Health Act to eliminate cholera". New Vision 28 October, 2009

- The office of the District Water Officer to which most of the District Water and Sanitation Conditional Grant is directed.

Also involved in service delivery at the district level are NGOs who have played an important role in the promotion of sanitation and hygiene education as well as private sector organizations and individuals involved in the design, construction, and operation and maintenance of sanitation facilities.

A drying rack in Rakai that is not built according to standards laid out in the district sanitation ordinance (see Annex)

District Water & Sanitation Coordination Committee

Within the district water office, efforts made to recruit assistants to the District Water Officers to be responsible for planning, community mobilization, hygiene and sanitation did not seem to work well and resulted in more distancing and lack of coordination and exchange of information between the key sector departments. This problem is observed in the National Environmental Health Policy (EHD-MoH July 2005).[55]

Given the various departments involved in sanitation, the need for coordination at the district level is even paramount. Within the sector, only the environmental health and community services departments have staff working at lower sub-county levels. District water offices have no extension workers at sub-county level and rely on other staff from health and community services (or NGOs) to carry out community-based interventions, while the district education offices draw on technical support from other departments when installing school sanitation facilities or designing hygiene education.

To address coordination, sector guidelines provide for the formation of **District Water and Sanitation Committee (DWSC)** that brings together key sector actors at district level including NGOs to improve the co-ordination and management of water and sanitation

[55] EHD-MoH (July 2005) National Environmental Health Policy

programs at the local government level. This concept (of the DWSC) however has not been embraced by all districts while others have shown outright resistance to the formation of the committee. The centre (DWD, EHD, NSWG) says it is directing its efforts to ensure that DWSC are formed and active in all districts. While the DWSC was actively present in Rakai, it was curiously absent in Masaka.

Sub-county/town (lower) level

At the Sub-county/town council level, the Sub-county or Town Council is the decision-making body, acting on information and action plans from the Lower Local Councils (parish and village). The HAs under the office of the District/Town Health Inspector are the front runners involved in sanitation improvement. Much of the district data on sanitation coverage is based on field reports from Health Assistants.

All sub-counties have Health Assistants and all counties are headed by Health Inspectors who provides support supervision and technical guidance to the Health Assistants.

5.4 Cases of sanitation in different areas

- **Sanitation in Kyamulibwa, Miwuula and Gulama trading centres:** there are normally Private garbage collectors who are mainly found in towns, big and small. In trading centres such as Kyamuliibwa, Miwuula and Gulama, we found that there were informal arrangements albeit poorly enforced and adhered to, to have clean environments. There appears to be unwritten understanding between most residents who ply their trades in trading centres where everyone has to clean in front of his or her shop, stall or kiosk. This work is normally policed by an individual who is elected as the chairperson of the trading centre. Most trading centres however were found to be dirty, without any proper drainage patterns, toilets and urinals. The exception when it came to toilet facilities was Miwuula trading centre in Lwabenge, where an ECOSAN toilet, supervised by the area LC one chairman was saving the day in terms of providing toilet facilities. Users were supposed to pay a fee but as is the case with complacency in other sectors, even in this case most were not paying.

- **Sanitation around health centres and clinics, water sources:** PNFPs were found to have better sanitary conditions in terms of environment sanitation, even inside the health centres themselves. PNFPs had better medical refuse disposal facilities whereby St Cecilia, Bikira, Kyamuliibwa and Nakasajjo PNFPs had incinerators. All public health centres studied had no incinerators but improvised rubbish pits which are not safe for medical refuse disposal that MoH policy says should burn at over 600 degrees centigrade[56]

- This therefore goes back to the issue of management and overall performance capacities where private providers do better. However, some clinics and drug shops, especially those in rural areas also had bad if not worse sanitary conditions than those in public health centres.

- Sanitation around water sources was in a bad condition in most cases. Part of this duty is for the water user committees yet in most of the instances we observed, these committees were in large part non-functional with only one or two of the committee

[56] The team went along as the Masaka DHO visited Birongo Health centre 111 on Aug 12 2010 and listened as he examined the centre's incinerator.

members working. There are several reasons for this which includes apathy, lack of incentives, etc.

5.5 Strategies and initiatives to improve sanitation and hygiene

Campaigns, legislation and enforcement

Districts local governments have tried to enforce policies and laws by the government of Uganda's sanitation sector but with little results. The key document that has stood the test of time is the Public Health Act of 1968 on whose basis even the district ordinances and bye-laws are enacted. When developing these ordinances and bye-laws, districts try to set realistic penalties so as to enforce sanitation and hygiene promotion in the communities. During the enforcement of the district ordinances and bye-laws, households without sanitation facilities especially the pit latrines are supposed to be taken to courts of law, pay certain amounts of fines or arrested and detained for a certain period of time. However the enforcement of these ordinances and bye-laws is affected by a number of factors such as influence of the politicians, limited participation of the local council authorities, and inadequate awareness of them by locals as well as inadequate facilitation of the Health Assistants[57]. This activity also needs collective action from different offices such as police, health workers, parish chiefs and local council authorities for the enforcement to be successful. Where they have been enforced in the communities, there is a bit of success but the enforcement takes once in awhile which leads to deterioration of the sanitation and hygiene facilities in place.

Politics thwart sanitation promotion

At the local council level there are bye-laws that govern sanitation and hygiene in small rural towns and those governing hygiene and sanitation around the water sources. These bye-laws are not enforced as a result of what local council authorities claim is fear of annoying their voters who could ultimately punish them at the next election. For those who have attempted to play their roles, their seniors at sub-county and district levels have even threatened them if they touch "the president's voters'. When the enforcement is done by the non-political VHTs but who have to be escorted by the authoritative LCs to make their work credible, results are not better. VHTs complained in a meeting with their district leader that LCs fear to move the villages with them for fear of political retributions[58] Politics has been one of the factors that have led to limited enforcement of the bye-laws and the ordinance hence leading to poor sanitation and hygiene.

[57] Each sub-county has got one Health Assistant who cannot effectively enforce the laws across a big geographical area that is always a sub-county. HAs we interviewed further decried inadequate resources for transport

[58] Bernard Sabiti field notes from a VHT meeting the team attended, July 12, 2010: "Some members also told the DHI that some LC1 chairpersons are nowadays refusing to travel with them as guides as they visit and inspect homes because since 2011 is near, they fear to be seen with people that are seen by some as 'harassing' them on sanitation issues, especially those who have struggled to meet basic sanitation standards, yet their votes are needed"

Inside a pit latrine in Lwabenge sub-county, Masaka district: the green leaves on top are used as 'toilet paper'

Perhaps a more poignant case is this:

> The Health Assistant of Lwabenge sub-county said of a period when he and the LC1 authorities started arresting all the household heads without pit latrines in their homesteads. However one of the sub-county residents phoned the sub-county LC3 chairman who was away for training in Kyankwanzi in Kiboga district[59]. The LC3 chairman called back the Health Assistant and the LC1 authorities to release all of them claiming they had neither 'sensitized' them enough nor given them enough time to construct the pit latrines.[60]

Sanitation week

Every year, the district water departments celebrate sanitation weeks in the country. During this week, there are different activities that take place in order to promote sanitation and hygiene in communities. The week normally ends on the World Water Day[61] with celebrations. During this week, the district authorities (District water departments and the District health department) meet and decide on which sub-county and parish to conduct the sanitation week. During this week, the health assistants and the Community development officers of the chosen sub-county are assigned duties of aggressively sensitizing communities on promotion of sanitation and hygiene in their individual homesteads. Specific tasks are set and assigned to the individuals and communities such as construction of tippy taps, drying racks, bathrooms, among other sanitation and hygiene facilities. Home visits are done by health assistants and community development officers where they give necessary advice and educate the household members on hygiene practices and provision, use of the sanitation

[59] A political training school where civil servants and politicians across the country mainly from the ruling party occasionally go for lectures or as some critics call them "indoctrination classes".

[60] John Bosco Mubiru field notes, July 26, 2010.

[61] A global annual event that takes place on 22 March of every year.

facilities and their maintenance. Usually emphasis is put on provision, proper use, maintenance of latrines, hand washing facilities, kitchens and the main houses. There is also monitoring of water sources to promote sanitation and hygiene around them. During this inspection exercise, the homes of community leaders are especially spotlighted.

The weeklong event, which ultimately ends on the WWD, is capped with the selection of the best improved homesteads. It's like a beauty pageant where the judges (who constitute a sub-county team normally comprising of Health Assistants, Local Council Chairpersons and the community development officers) crown the cleanest home and shower its owners with gifts. The selection of the winner is usually based on provision, use and maintenance of various facilities required in a homestead. These include; latrines, hand washing facilities, kitchen, main house, bath rooms and their drainage, drying racks, cleanliness of the environment and general knowledge on health issues such as immunizable diseases, water borne related disease and effects of poor sanitation and hygiene in homesteads and communities.
The sanitation week is one of the few bright spots of a remarkable effort by officials the research team witnessed, which leaves one wondering why more of this is not happening. Documents from the district water office show that the Sanitation week is always a meticulously planned affair. Minutes from planning meetings show commitment and even inclusion of the district top administrator, the CAO.

We were lucky to have been part of at least one sanitation week, and consequently attending the WWD in Kirumba sub-county, Rakai district in March 2011. One of our research team members captures the event's aura:

> "There were different officials that attended and among them were the Minister for Water and Environment, Hon Maria Mutagamba[62], the District Health Officer, District Health Inspector, Sub-County Chiefs, Councillors, Community Development Officers, the RDC, Health workers and members of the community. There were different activities on this day such as Music Dance and Drama on sanitation and hygiene related issues, presentation of the outcomes of the sanitation week such as the latrine coverage figures and award of prizes to the best homesteads. The prizes awarded included certificates of recognition, hand washing facilities, garden tools, among others"[63]

This is definitely a good strategy in promotion of sanitation and hygiene. Surveys normally done in the host sub-county always show very high percentages of latrine coverage of up to 100% and 90s for drying racks, hand washing facilities, etc. After the Kilumba event, it was the same thing. The place was exceptionally clean. However, we observed, and by reading sanitation week reports from the DHO that normally a few weeks after the event, the standards go back to where they were before, and in some cases to worse states. This shows that people put on a show but the effort is not systematic and indulged in out of genuine intent.

The lure of the prizes given therefore may be partly responsible for the unusual community enthusiasm. While this is not out rightly wrong, we think it is unfortunate that people have to take personal charge of their own hygiene because they expect to be rewarded for it, not by the rewards of living in a clean environment but by gifts from someone else. This shouldn't be encouraged. Furthermore emphasis is put in one sub-county leaving others out.

---

[62] It should be noted that the Hon. Mutagamba is a native of Rakai districts and has been the district's Woman MP since 2001. Whether this could have added to the reasons of her presence is anyone's guess.

[63] John Bosco Mubiru field notes, March 20, 2011.

5.6 Funding and provision of sanitation and hygiene facilities

The government and NGOs have played a role in provision of sanitation and hygiene facilities in order to promote sanitation and hygiene in the communities.
However, because Sanitation is only mentioned alongside Water, always the allocation of funds to the former is meagre. Most of the funding for sanitation at the district level comes from the Ministry of Water and Environment through the Water department. While the allocation is curiously known as the District Water and Sanitation Development Conditional Grant, the reality is that water takes the lion's share of the money.

Box 1: DWSCG Financial Year (2009/2010) - National[64]

Water supply – 70%
Soft ware actives (sensitizations and Trainings) – 11%
Rehabilitation – 8%
Sanitation (hardware) – 6%
Office operations – 5%

When the money gets to the local governments, the share of sanitation and hygiene reduces further when it comes to actual expenditure:

Table 7: Actual share of Sanitation in the DWSCG

Services	Water supply	Software	Rehabilitation	Office operations & supervision	Sanitation
Guidelines	70	11	8	5	6
Actual expenditures	72	19	6	10	2

Source: Uganda Water and Environmental Performance Report 2010.

Facilities that have been funded include construction of latrines both in homesteads and public places such as health centres, schools and markets. Other facilities include hand washing facilities, slabs, water tanks for drinking water, etc. During the construction the community participates too through contributions either in form of cash or local materials. However communities usually contribute local materials such as donation of land where latrines are constructed, bricks, sand, stones and causal labour. NGOs normally construct latrines in individual homesteads especially those with vulnerable and marginalized categories of people such as elderly, widows, orphans and persons with disabilities.

Latrines that are constructed in public places such as markets, schools and health centres their management. There are always user committees put in place to manage the latrines but because of the reasons not different from what has already been discussed in the Maternal Health and water chapters, the committees are barely functional. Poor community attitudes, non-payment of maintenance fees affect the running of these toilet facilities. In some public places such as markets, the users are supposed to contribute user fees so as to pay the caretaker/toilet attendant, buy facilities such as water and toilet papers but because the community does not contribute, the committees feel useless and hence their withdrawal, just like the village WUC. Furthermore there is influence of the politicians who normally tell the users not to contribute the user fees 'since government facilities are supposed to be free'.

[64] Uganda Water and Environmental Performance report 2010.

There are also public latrines that are constructed in individual homes and it's usually the responsibility of the family members of such a home to manage it. A case in point was Miwuula trading centre in Lwabenge sub-county, Masaka district where a public eco-san latrine was constructed in the local council chairperson's home. This latrine was well maintained because there was usually a certain amount of money contributed by users and this money was used to buy the water to fill the hand washing container, pay community members who collect ash to use in the latrine and even paying the family members who were cleaning it. This eco-san latrine was also utilized by the family of the local council chairperson. The latrine had bye-laws including one that said the toilet closes at 8pm. No user bothered the family beyond that time and it was understandable to all.

5.7 Sanitation and hygiene competitions

In an effort similar to the sanitation week, Non-governmental Organizations convene sanitation and hygiene competitions. During these competitions, the local council authorities mobilise the community members for meetings while the Health Assistants do the sensitizations and trainings on putting up different sanitation and hygiene facilities like construction of drying racks and hand washing facilities like a tipy-tap. After the sensitizations and trainings, the community becomes very active in implementation of sanitation and hygiene facilities in their households in anticipation of incentives/prizes. A certain period of time is given to the community to maintain, improve or construct the facilities and later assessments take place through home visits. World Vision and Ddwaniro Integrated Farmers Association (DIFA) both in Rakai carry out such competitions. The best homesteads are always awarded different prizes such as certificates of recognition, garden tools and water containers.

During these activities, the Health Assistants and the local council authorities are also very active because they are facilitated by the Non-governmental Organizations that initiate the process. They are given allowances (Transport, Lunch and day allowances) since they are the mobilizers and coordinators in the communities. These competitions are always carried out in a small geographical area because of limited funding to the Non-governmental organizations which leaves the other areas discriminated against. These competitions also do not occur regularly. At the end of the competitions, the community tends to become reluctant to continue improving on their sanitation and hygiene facilities since there are no prizes to be given out to them. Even as a result of limited facilitation with in local governments, the health assistants and local council authorities tend to relax in mobilizing the community to improve the sanitation and hygiene in their homesteads afterwards. Verdict for the NGO-initiated competitions: Ditto Sanitation week/WWD initiative. In other words; well intentioned effort, but hardly any genuine, long-lasting results

5.8 Sensitizations and trainings

Districts and Non-governmental Organizations have carried out sensitizations and trainings on sanitation and hygiene. Sensitizations on promotion of hygiene and sanitation are carried out in different ways; through Music, Dance and Drama and Videos shows. The main purpose of sensitization is to create an understanding by the community of their roles and responsibilities in the promotion and maintenance of sanitation and hygiene in their communities. This work is predominately done by NGOs yet according to the government policies, this is work that is supposed to be done by the government, the DHI and DHE offices. The officials we interviewed however blame lack of resource for governments relinquishing this responsibility

to NGOs[65]. There is no routine programme for sensitizations by the district health inspector or health assistants but they hitch rides on the NGO or other district programmes' vehicles as they go to do sensitization where they also get a chance to give a pep talk to communities on hygiene and sanitation. Health Assistants admitted to us of carrying out sensitizations only when better funded departments go out to do their work and they exploit the opportunity to go along, for example when the NAADs (A hugely funded government program, that bagged sh640bn budget in 2009) extension workers are going to the field or when the health workers are going for immunization outreaches. The irony of a health educator riding with an agriculture official would be amusing if it wasn't for the fact that government has clearly got her priorities very wrong. Because of lack of funds, on the few occasions where sensitization activities are done, the HAs or other concerned authorities never follow up to assess the impact of the sensitizations they carried out[66].

Has also conduct trainings on a number of issues such as construction of the different sanitation and hygiene facilities like tippy taps, squatting slabs and Eco-san toilets (there are demonstrational eco-san toilets that have been built in many areas by both the government and NGOs). However the challenge is that government and NGOs have invested a lot of money for the communities to undergo such training but to larger extent there has not been any impact. Community people especially in the rural areas lack the resources to replicate demonstrations in their homesteads.

The government introduced the programme of Village Health Teams to participate in most of the village health activities. VHTs are also supposed to sensitize communities about hygiene and sanitation promotion through health education. They are further supposed to monitor the sanitation and hygiene around the community, households and water sources. In the studied areas[67] most of the work such as training and facilitating the VHTs has been done by the NGOs. The government has done very little work yet it's the one that introduced the VHT programme.

In some cases even where VHTs were trained, they were not active, for reasons not different from those given under the Maternal Health section. i.e. lack of motivation from the government (in terms of payments), limited facilitation such as transport means, negative attitudes of the community which claims that VHTs are not health workers but mere persons just like them, limited support from the local authorities who are supposed to enforce what VHTs are promoting, lack of follow up on the VHTs' work by the Health Assistants, among others.

5.9 Creation of model village specifically in Rakai District

Rakai District introduced sanitation model village concept in 2004 starting with Nsumba village in Kalisizo Sub-County. In a review meeting after one year, this model village had done very well in sanitation[68]. The district Health Department decided to scale up the concept in all Sub-Counties by establishing 2 model villages per Sub-County.

---

65 Interview with the DHE

66 John Bosco Mubiru's field notes, January 15, 2011

67 In Buwunga sub-county VHTs were trained by NGOs MADDO and Stop Malaria whereas in Ddwaniro sub-county (Rakai district) VHTs were trained by World Vision.

68 In our visit to Nsumba, the LC 1 chairperson, while thanking the initiators of the village model concept admitted (as we could also see ourselves) that standards have now gone down: "However he reported that the situation currently has changed and sanitary facilities within different homesteads in Nsumba village have collapsed because many homesteads have not gone ahead to improve on them. He said that this is evident in the community where sanitary facilities such as drying racks have collapsed, Hand washing

The Process of creating model village involves a number of activities[69] starting with inviting stakeholders for a village meeting and sensitizing them on hygiene, sanitation and community development. However special attention is put on existing groups with common interests of development in different communities. The HAs work together with Community Development Officers, Sub-County Chiefs, Non Governmental Organizations, Local Councils, and Religious leaders to strengthen their development interests together with hygiene and sanitation; The Health Assistants as usual, ride on vehicles for richer programs (as was the case in Mitondo village, Dwaniro sub-county where HAs went along a tree planting expedition)[70], Water Tank Projects, Heifer Project for Religious Leaders, LC meetings etc. Further a sanitation checklist highlighting hygiene facilities to be in every homestead is given to all members in the selected villages. Non Governmental Organizations are asked to invite health workers to give integrated health education in all their gatherings involving model villages. Staffs from different departments are invited to some of these meetings/gatherings to give the community multiple skills e.g. roof water catchment, modern farming, micro finance & saving etc.

The selected model villages are visited regularly by Health Assistants e.g. monthly. Every quarter the selected model villages are supervised by teams from the district to assess the progress using the sanitation checklist that has been scored. The best model village in a given year is recognized by bringing a prize giving ceremony to the village, during a sanitation week or an international day aligned with any of the development indicators the Model village promotes like World Health Day, or WWD.

Model villages are motivated in different ways. They receive visitors curious of learning from what they do and in the process make the neighbouring villages enthusiastic to replicate the model in their own villages. Assessment is routinely done and feedback sent to them; something that is supposed to encourage them to carry out one in their village. The annual prize giving ceremony pits the model villages against each other, creating a frenzy of competition whose winner gets more donations from the district and NGOs in the area.

Although the district has adopted the model village concept, there are challenges that the process faces in achieving the desired results. Some health assistants are irregular at work while those that are committed to work lack the facilitation especially transport. Due to lack of transport means, monitoring and supervision of sanitation and hygiene activities becomes difficult leaving their sustainability difficult. The process relies heavily on motivating people to carryout hygiene/sanitation activities hence it may take long to cover all villages of the district. It still faces the challenge of rewarding people to be clean, which while attractive conceptually, is not naturally right.

We spent some time in the very first Model Village that acted as a pioneer for the rest, Nsumba in Kalisizo. The multimillion shilling community centre is currently surrounded by over grown grass, solar panels and computers are dead. This is a village that made headlines like, “Uganda’s cleanest village,” “Africa’s best village”, etc. the issue of ownership therefore is still important in making development outcomes sustainable. With the many millions poured into Nsumba village, the glory was short-lived. Residents told us it has slipped back to its former self, with the large community centre now redundant.

---

facilities exist but never used whereas in other homesteads never exist or were destroyed by anti-hills”. JB Mubiru field notes from Team visit to Nsumba, 16 November 2010.

69 Establishment of sanitation model villages in Rakai district (2008). Report by Dr. Mayanja Robert (DHO), Rakai District.

70 John Bosco Mubiru field notes.

5.10 Conditioning rewards

Government and NGOs have used the programmes meant to benefit residents to promote sanitation and hygiene in the households and communities. In order for a person to be given a Ferro- cemented water tank by the district water department for example, the household should be having most of the sanitation and Hygiene facilities in place. The Community Demand Driven (CDD) initiative where citizens demand for water facilities also puts such conditions. Before replying positively to a community's demands, it must fulfil certain sanitation standards. However, since these projects normally have limited funding, they cover a limited number of communities.

5.11 Summary

The table of players in sanitation is as follows.

PROVIDER	**SERVICE**	**PERCEIVED BENEFIT**	**PERCEIVED CHALLENGES**	**COMMENT**
Central Government	Legal& Institutional framework (the public Health Act), used to measures and for the preservation of public health and prevention of a range of diseases in Uganda Funding Ministries co-ordinated by Water and Sanitation Sector Working Group that comprises of representatives from MoWE, NWSC, MoH, MoES, (MoFPED), development partners and NGOs represented by UWASNET.	Bringing stakeholders together - MoU between Ministry of Water and Environment, Ministry of Health and Ministry of Education and Sports; but also NGOs, CBOs and Private Sector.	Inadequate funding Non implementation of policies as a result of the handicap placed on the central ministry due to decentralization Difficult to execute policies fully because responsibility lie with different ministries Sanitation remains a junior cousin of water and therefore does not receive adequate attention	Can a policy framework be better than the implementation of the policy?
Local Government	Grants allocated to District Health Departments is used to facilitate sanitation and hygiene services District Local Governments developed by-laws and ordinances as a back up to the Public Health Act National Sanitation Working Group (NSWG) brings together key institutions and actors in the sanitation sub-sector District Health Inspector (DHI) takes responsibility for environmental sanitation. District Education	Collaborative development carried out at the district level by stakeholders, coordinated by the District Water and Sanitation Coordination Committee Technical Task Team sub-committee established by NSWG sits frequently to address pressing issues, such as promotion of Eco-san, establishing better coordination, following up on budgetary support, and determining performance measurement	Bye-laws not adequately enforced due to influence from politicians, limited participation of local council authorities, inadequate awareness of bye-laws by locals and inadequate facilitation of the Health Assistants Much work remains to be done in translating policy documents into action Efforts to recruit assistants to the District Water Officers to be responsible for planning, community mobilization, hygiene and sanitation did not work well and resulted in more distancing	Efforts should be sought to maintain the high standards generated during sanitation week There seems to be lack of the use of mass media especially local radio for the promotion of sanitation and local hygiene

	Inspectorate co-ordinates sanitation and hygiene promotion activities in schools Community Development Assistants & the District Health Teams	indicators Sanitation week with different activities that promote sanitation and hygiene in communities	and lack of coordination and exchange of information between the key sector departments	
NGOs	Promotion of sanitation and hygiene and education	NGOs convene sanitation and hygiene competitions and sponsor the Model Village competition Health Assistants and Local Councillors are the mobilizers and coordinators in the communities for the competitions Focus on vulnerable and marginalised categories/groups	The issue of ownership is important in making development outcomes sustainable	The Model Village idea seems to have been super-imposed on the communities hence the lack of sustainability
Private for Profit Providers	Promotion of sanitation and hygiene, education and the design, construction, and operation and maintenance of sanitation facilities	Increase stock of facilities Build facilities of good standard		
Community	Some individuals involved in the design, construction, and operation and maintenance of sanitation facilities	They contribute materials including land for the building of public toilets	Poor community attitudes, non-payment of maintenance fees affect the running of public toilet facilities Culture of poor hygiene They manipulate and blackmail politicians and by threatening to withhold their votes at the next election if they make them perform duties they do not want to perform and they allow themselves to be manipulated by the politicians	The culture of neglect of sanitation facilities and the blackmailing of those who attempt to enforce by-laws is perhaps the most important constrain to improving sanitation
PNFP	Provide sanitation around the health centers – Environmental sanitation; inside the health centre they put medical refuse disposal facilities such as incinerators and rubbish pits	They set higher standards and do a better job		

In terms of the modes of governance for service delivery, the following is what was found to obtain in the districts and areas studied:

1) Administrative – Central & Local Government
2) Local democracy – Local Government
3) Traditional/indigenous – Community
4) Associational – PNFPs/NGOs, Private for Profit Providers
5) Chiefly – None but in the past, the *Mutongole* played a key role in environmental health.

Uganda has been acclaimed to have good sanitation policy framework. However, effective implementation and enforcement remains weak. Implementation of the policies, guidelines and Acts is found primarily at the local government level, where sanitation rarely receives a priority because of the competing political, financial and other resources issues. Sanitation and hygiene are not considered as a separate program area either in funding or implementation but are always paired with water projects which leave the sub-sector with less funding and overall consideration.

Evidence from the study shows that where there are incentives such as prizes, communities respond positively to sanitation and hygiene promotion but this approach is not sustainable given that such incentives come in a while and cover a small geographical area. Also when done regularly other than once in a while, enforcement of the district bye-laws and ordinances could promote better sanitation and hygiene practices.

Furthermore where there is individual or household management of public sanitation and hygiene facilities, there is always proper running and maintenance rather than when management is put under a committee of community members. In such cases where there are individuals or households are managing public sanitation facilities they put in a lot of effort because rewards from user fees and the fact that they also utilize the facility free of charge motivate them. This holds the key to the intractable issue of trust of the Water User and other Committees.

MDG number 7 is to "ensure Environmental Sustainability" and Target 7 C of this MDG for Uganda is to; "Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation". While Uganda does well in urban areas, achievements there are distorted by results in rural areas such as the ones we studied where water and sanitation issues remain far from acceptable standards

Table 8: Target 7 C progresses for Uganda for MDG 7

Year	**1999/2000**	**2002/2003**	**2005/2006**	**2014/2015**
Proportion of population using an improved drinking water source (urban/rural)	57% (87%/51%)	63% (87%/58%)	68% (87%/64%)	89% (100%/70%)
Proportion of population using an improved sanitation facility (urban/rural)	n/a	n/a	(74%/62%) year is 2007/8	(100%/77%)

Source: MDG progress report for Uganda, 2010

While the 2010 MDG report for Uganda rates the progress on the Water and Sanitation indicators for MDG 7 as "on track", the figures in the table clearly show the imbalances in

achievement between rural and urban areas, vindicating the findings from the study sites which show a poor sanitation and water sector.

6 Overall summary, conclusions and recommendations

The main focus of this research was to assess the relationship between the variety of local governance systems and their performance, as gauged by their provision of public goods that are normally underprovided. Furthermore, it was to identify the relationship between the ways local
Leaderships are constituted and the ways they perform; how formal rules and de facto norms compete with, supplement or complement one another to create functional hybrid orders and positive outcomes. The intention was to select cases of local leadership that are endowed with different kinds and degrees of power, legitimacy and accountability to answer the question,
Under what circumstances does local leadership act in ways that are less predatory?

In this regard, critical public or club goods that are significantly under-provided under current forms of local leadership or governance, and whose proper provision would constitute an important positive outcome, were identified as: Maternal Health (safe motherhood); Water and Sanitation. While each of these goods contributes to the attainment of beneficial public outcomes of a higher order, the research project aimed at focusing on intermediate outcomes that enable conditions for positive shifts in final outcomes. The research was interested in outcomes that are sustainable and can be scaled up.

6.1 Summary of the formal & informal systems & structures of governance

Formal governance structures

Formal governance structures the researchers interacted with are central government systems and how they are implemented through the decentralized systems. In the main, central government systems provide policy frameworks within which local governments operate; they provide the resources/funding and recruit and deploy key staff that operate at the district level. Alongside the technical structure (at the local government system) is the political structure. The political structure is the locally elected whilst the technical structure is a combination of centrally deployed staff and those recruited by the local governments. For some staff their allegiance is to the parent ministry at central level and for other staff the allegiance is to the district authorities, both technical and political. This dual system, although it has existed since the 1919 African Native Authority Ordinance, providing for powers and duties of African chiefs under the colonial administration (Tumushabe, et al 2010), was intensified under the current administration.

At the district level, while the Chief Administrative Officer (CAO), who is the accounting officer, reports to the central government, the political head of the district is the elected chairperson and is the ‘final man’. This is only answerable to his electorate and sometimes to the center. This structure replicates itself at lower levels of decentralized local councils. This leads to technical staff with dual reporting roles: to the elected councilor as well as to the technical head and the technical departments. At LC 3 for example, technical officers report to the sub county chief and through him to the LC3 council. They also report to the district line officials who report to the CAO and through them to the district council. Reporting lines needed to be clarified and well aligned.

Informal structures

The research found religious based institutions which are the implementing arms of the religious institutions providing essential public goods, especially maternal health. The reporting lines are to their religious superiors/heads. These too can have their structures extending to the lower levels but they have no responsibility to report to either the elected leaders or the sub-county chief or the CAO. Although when they sit on committee or receive government funding, there is some form of accountability to government.

NGOs, which report to their headquarters at the national or local level and carry out the mandates of their donors usually in the form of time-bound projects, were also found to be active in the provision of the three public goods selected for this study. This research has established some form of links and relationships between Non-Governmental institutions and PNFP and local government institutions in provision of specific public goods particularly maternal health and water.

Then there are the private for-profit providers who are there to win contracts, reporting to whoever has awarded the contracts, be it the local government council or the NGOs.

There was also another informal structure in the form of Traditional Birth Attendants (TBAs), Sengas and others who are an indigenous maternal health provision agent. They do not report to anyone, although they are accorded high respect in the community they serve.

We also have the community members playing different roles at different times.

6.2 System interaction

Maternal health

The formal government structures are constitutionally mandated with the local council and local governments in their current form incorporated since the 1996 Constitution. The political arm of this structure is elected every 5 years and therefore it is sensitive to its electorates. The central government formulates policies and funds programmes through the local government structures as well as Private Not-For-Profit or PNFPs. And then this is complemented by the contributions of NGOs together with community contributions. Between these various players, the following are being achieved:

- Services have been brought closer to the people;
- A range of service providers (government health centers, FBO/NGO facilities) are delivering much needed services to the communities.

Some of the challenges with delivering maternal health services through these structures have been:

- The fact that the ministries formulate policies but do not have a direct mechanism to implement and enforce them, leaving them totally dependent on local governments and PNFPs whose legitimacy comes from elsewhere.
- Often time there is tension between the political arm and the technical arms of government, with the political arm preferring the populist approach of resource allocation whereas the technical arm prefers the bureaucratic approach. Sometimes the political arm is biased by their electorate who provide the votes and so makes enforcement of laws and by-laws quite very difficult.

- The issue of diversion of resources either to advance the political ambitious or for self aggrandizement of some officials is also common.

Water

The same applies as in maternal health. However, there are even more government ministries and departments involved in the delivery of water than there are in maternal health. This requires greater coordination and becomes potentially greater source of conflict. While the system has registered very good coverage and the most recent MDG report indicates that Uganda is on track, the following non-financial challenges were identified in the study, which if addressed would enable the coverage to increase considerably:

- Corruption (kickbacks) at tendering stages
- Influence paddling by politicians
- Receive inadequate support from local government especially in the enforcement of bye-laws
- Poor coordination between stakeholders providing water services a challenge
- Lack of quorums for meetings and non-adherence to binding resolutions
- Lack of coordination with the district authorities regarding water sites
- Unit price quite high and inconsistent
- Rampant theft of spare parts for borehole maintenance
- Water quality testing is rarely done
- Not all reports are acted upon
- And maintenance, supervision and enforcement of water sources are irregularly done.

Sanitation

There is a range of players in the sanitation sub sector including central and local governments, NGOs, PNFPs, communities, private sector operators and like water, this call for a lot of coordination. Sanitation has been one of the public goods whose level of provision is contested but whose coverage seems to have declined since the 1960's. The main challenges include:

- Non implementation of policies as a result of the handicap placed on the central ministry due to decentralization
- Difficult to execute policies fully because responsibility lies with different ministries
- Sanitation remains a junior cousin of water and therefore does not receive adequate attention
- The culture of neglect of sanitation facilities and the blackmailing of those who attempt to enforce bye-laws is perhaps the most important constraint to improving sanitation.

Of particular concern is the fact that local councils put in place by-laws to govern sanitation and hygiene in small rural towns an around public water sources however these bye-laws are rarely enforced because local council claim that it is unwise for them to antagonize their voters who will ultimately punish them at the next election. It is as if politicians have opted for unhygienic votes.

6.3 Conclusion and recommendations

From the above, it is clear that local governance systems are better able to produce public or collective goods if:

a) They build on other existing forms of legitimacy, authority and accountability and/or 'work with the grain' of local de facto institutional arrangements; and the policy-driven components of the institutional framework of public goods' provision reflect ***a coherent vision;,*** so that resources are allocated and incentives are structured in ways that are mutually reinforcing, not mutually undermining. There are institutions enabling local collective action which are ***locally anchored***, in a double sense – the rules they incorporate are geared to local problem solving, and they make use of institutional elements drawing on local cultural repertoires which motivate, enable and guide individuals to take particular actions. For example, maternal health is the most illustrative public good of how people stick with what they know and believe in.

b) The human-resource components of provision are subject to ***corporate performance disciplines,*** even if in other respects the organisational context is severely lacking in the attributes of a well resourced and well regulated bureaucracy. Clearly the government investments in increasing considerably the number of health facilities particularly from Health Centre I to Health Centre III could be better matched by the utilization of those facilities by expectant mothers if there was adequate allocation of resources, good work ethic and adequate staff.

c) They realized that the challenges that have been highlighted by this study, none of which are new, suggest that the challenges are becoming more entrenched leading to stagnation in the delivery services. There is therefore need for a radical and fundamental shift in the strategy to register a break through. One such action is for government to recognize and take on board the roles and benefits that accrue from other governance systems, especially culturally accepted, trusted and believed in community leaderships and norms.

d) They recognize that the arrangement currently in place is flawed, has distorted the motives and the incentives leaving both politicians and 'voters' to manipulate each other. This makes the service subservient to other interests and perceived gains. For example, there are many cases where political influence is used to undermine authority and communities blackmail politicians and also try to dupe the system. Water and sanitation are perhaps the most illustrative of mixed outcomes of political intervention and of taking 'power belongs to the people' too far.

   There is need to return to the sources of real legitimacy and real authority which in the past would make a community respond to the sounding of the drum.

e) Accept that without intentionally bringing other modes of service delivery, administrative decentralization alone, is not able to take the public good focused in this report on maternal health, water, sanitation and hygiene to another level necessary to meet the MDG targets. It is a fallacy for the country to claim to have 'good policies' which it persistently fails to implement.

References

Booth, D (2008): A Research Design Fit for Purpose. Discussion Paper 3: Africa Power and Politics Programme

Carlson C (2004): Review of Health Service Delivery in Uganda – General country experience: DFID Health Systems Resource Centre

Chambers, R (1983): Rural Development: Putting the last first. Longman, London

Chambers, V and Golooba-Mutebi, F (2012): Is the bride too beautiful? Safe Motherhood in rural Rwanda

Golooba – Mutebi F (1999): When Popular Participation won't improve service delivery. Development Review, London

Golooba – Mutebi, F (2008): Politics and Local government in Uganda

GOU: Ministry of Water and environment (2010) Water and environment sector performance report (2010)

GOU: Ministry of water and environment 2007. Water and sanitation sector. District implementation manual Vol. 1

GOU: Ministry of water and environment 2010. Water and environmental sector performance report.

GOU: The National Development Plan (NDP)

GOU: The National Health Policy 2010

GOU: The resource book for the Water and Sanitation sector (2007)

GOU: The Uganda water and sanitation dialogues (2008) Financing Water supply and sanitation in Uganda: Opportunities for private sector participation

GOU: Water Act (1999), National water Policy (1999)

GOU: Water and Sanitation Pro-poor strategy (2006)

Gyimah Boadi, E. (2004): Democratic reforms in Africa: The quality of progress. Boulder: Lynne Rienner.

Jane Wokadala, NyendeMagidu, MadinaGuloba (2010). Strengthening institutions to improve public expenditure accountability project. Public spending in water sub-sector in Uganda: evidence from programme budget analysis

Jones, B (2000): Beyond the state in Rural Uganda: Oxford university press

Kelsall, Tim (2008a) Going with the Grain in African Development?.Discussion Paper 1. Africa Power and Politics Programme.

Malinga Doya (2009). Uganda's water sector clogged by corruption. Seen at http://www.cepgl.blogspot.com/2009/09/Uganda-water-sector-clogged-by-html

Nuwaha, F. and Amooti-Kaguna, B. (2004): "Factors influencing choice of delivery sites in Rakai district of Uganda" [

Nilsson, David (2006). "A heritage of unsustainability?Reviewing the origin of the large-scale water and sanitation system in Kampala, Uganda".*Environment and Urbanization* (International Institute for Environment and Development) **18** (2): 369–385.

Okello, L. (2012): The political economy of poverty and development in Uganda (unpublished)

Olivier de Sardan, Jean-Pierre (2008) 'A la recherche des normespratiques de la gouvernance
réelle en Afrique'. Draft APPP Discussion Paper, version 2, Sept.

Sabiti, B (2008): *Factors determining choice of place of childbirth among women in Uganda:* A research Proposal submitted to Makerere University Institute of Statistics and Applied Economics for an award of Master of Science in Population and Reproductive Health

Shalita E M (2010): From Goatskin to Woolen Suits: Leadership from humble beginnings. Annesha Publishers, Kampala

Shantayanandevarajen, Ingrid Widlund (2007). The Politics of service delivery in democracies: Better access for the poor. GGDI Secretariat Ministry of Foreign Affairs S-103 39 Stockholm

The Uganda water and sanitation dialogues (2008). Financing water supply and sanitation in Uganda.Opportunities for private sector partnership.

Tumushabe G. et al (2010). Monitoring and Assessing the Performance of Local Government Councils in Uganda. ACODE Policy Research Series No 31, 2010

Uganda Water and Sanitation NGO Network (UWASNET) 2011. A summary of key legislations and policies on water and sanitation in Uganda.

World Bank (2010): Baseline survey on integrity in the Uganda water supply and sanitation sector

Annex: Rakai District ordinance (No. 2, 2009) on sanitation and hygiene

The district passed an ordinance that targeted sanitation improvement. The ordinance spells out sanitation requirement and associated penalties on conviction.

Part one – latrine

1. The owner or a chief person living on each plot of land shall have the duty of making sure that a pit-latrine is made for the people living on that plot of land. It also states that latrines shall be made in a manner approved by the district council and the following rules shall be followed:

i) The depth of the pit shall not be less than 15 feet, except in special areas.

ii) The wall of the building over the pit shall not be less than five feet high.

iii) The building should be roofed well using grass thatch, iron sheets or any other materials approved by the authorized officer

iv) The floor shall be six inches above the level of the surrounding ground.

v) All pit latrines shall not be less than thirty feet from the neighbouring building.

vi) No pit latrine shall be less than one hundred feet from any water supply, spring, pool, lake or stream, except HDPE (high-density polythene) water tanks, and no latrine shall be built in a swamp unless it is approved by the authorized officer.

vii) The squat hole into the pit of the latrine shall be six inches wide and not less than twelve inches, but not more than fifteen inches long.

viii) All latrines shall be kept clean and in good repair. A close fitting cover for keeping out flies shall be made for the hole and shall always be used correctly.

ix) When the contents of any pit latrine reaches within three feet from the ground surface it shall be closed and the pit shall be filled with ash and the building demolished or the pit emptied.

x) No person shall defecate or urinate within one hundred feet of a dwelling house or other building or the edge of a lake, river or other water supply source except in a latrine and a parent or guardian shall be liable if children under their care break this rule.

xi) A hand washing facility with soap and water must be placed by owner of land for washing hands by whoever uses the latrine.

Part II – Other Sanitary Requirements

i) Each household shall have a kitchen, drying rack, a rubbish pit, bath shelter and a clean compound.

ii) Every able-bodied adult shall be required once in a while to participate in communal work in the village spring/well/borehole or any other water source and bulungi bwansi roads.

Part III – Penalties

i) Any person who contravenes or fails to comply with any provisions of this ordinance shall be guilty of an offence and shall be liable on conviction for a first offence to a fine of shillings twenty five thousand or to imprisonment for a term not exceeding one month.

ii) A person convicted of an offence may be ordered to comply with the provisions of this ordinance within two months and if he fails to obey the order within the two months, he shall, unless he/she satisfies the authorized officer that he/she used all the diligence to carry out such order, be guilty of an offence and shall be liable on conviction to a fine not exceeding fifty thousand shillings or for imprisonment for a term not exceeding four months or to both, fine and imprisonment.