For more information please contact:

Programme Director
Agency For Accelerated Regional Development (AFARD)
Plot 3-5 Butiime Road, P.O.BOX 80, Nebbi-Uganda
Tel: +256 772 437 175, **Email:** afard@afard.net,**Website:** www.afard.net

"OUR HEALTH YOUR RESPONSIBILITY"

Community Management of Preventive Health

Community Health Frontline Advisors Toolkit

Prepared by:
Rose Orach, Chonga J.B. Franklyn, Alfred Lakwo
Agency for Accelerated Regional Development (AFARD)

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Acronyms

AFARD	=	Agency for Accelerated Regional Development
AIDS	=	Acquired Immunodeficiency Syndrome
BO	=	Beneficiary Organization
CHFA	=	Community Health Frontline Advisors
CMPH	=	Community management of Preventive Health
FMC	=	Facility Management Committee
HIV	=	Human Immunodeficiency Virus
O+M	=	Operation and Maintenance
UGX	=	Uganda Shillings

Acknowledgement

Times are changing and we ought to change with time. The overreliance on the state, market, and civil society wherein the community becomes a synonym of agenda other than that of the grassroots people continues to baffle (inter)national development goals. For instance, many targets of the Millennium Development Goals (MDG) are not yet met and will not be achieved by 2015. This requires more than the usual call for concerted efforts. It necessitates, in part, 'going back to the basics'; an approach where the subsumed – "the community" – are given adequate space, voice, actions, and support to undertake interventions commensurate with their 'livelihood desires" without damaging the "desires" of others now and in the future.

This toolkit takes that initiative pivoting on the preventive health aspects (MDG – Goal 6 of HIV/AIDS, Malaria and other diseases; and Goal 7 of Environmental sustainability). It strives to empower grassroots community in taking a lead in managing their health.

It is in this regard that AFARD appreciates Gorta funding support towards West Nile Development Initiative (WENDI) (Project # UGA/1906/09) that was used to develop this toolkit. AFARD is also grateful for the relentless efforts provided by Mrs Rose Ngamita Orach during various discussions and elaborations that shaped this toolkit. A similar gratitude is extended to Dr. Sam Orochi Orach for the invaluable reviews he conducted of the contents and clarity of the various draft materials.

Finally, AFARD appreciates the efforts of all the donors – Maria Stroot Fonds, Cordaid, Irish Aid, and the Royal Netherlands Embassy in Kampala - who supported and helped shape this community-led approach to improved community health.

Thank you all!

Dr. Alfred Lakwo
Programme Director

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PART I

Engineering Community Management of Preventive Health

GENERAL INTRODUCTION 1

What is contained in this Part

This part provides a general introduction to the guidelines detailing WENDI focus, why the guidelines, and its users. It also spells out why a community-led approach, who the stakeholders are as well as the roles, skills and qualities of Community Health Frontline Advisors (CHFAs).

1.1 Introduction

According to the 2006 Uganda National Household Survey 2005/06, the people of West Nile (located in northern Uganda) are poorer than other people in Central, Western, and Eastern Uganda not because they lack adequate income alone but also because they are paying an enormous cost for being unhealthy largely from otherwise preventable diseases, which are caused by unsafe water and sanitation conditions. All these are occurring at a time when government has skewed its health focus to facility-based approach (curative medicine). Preventive health service is not a priority in terms of funding and community energies for self-management of their safe health is not given the due attention it deserves.

The notion that government will provide all that the citizens need has for long proved untenable and unsustainable. The people are consequently entrapped in: (i) low life expectancy; and (ii) income poverty. Many people neither have adequate time for productive work nor are they able to save for investment as high medical bills continue to dig deep into their already meager savings.

Such a scenario can change if the community is given a chance to take a lead in managing their health albeit co-existing with government systems. Yes, it can! AFARD has demonstrated that through an active engagement of the marginalized communities (both fishing and farming), pandemic diseases like cholera can be avoided while the high burden of malaria too can be tremendously reduced. The recipe lay in "Community Management of Preventive Health".

1.2 About WENDI

It is evident that for various reasons, the more than 1.9 million people in West Nile are twice as poor as an average Ugandan is. As such, the West Nile Development Initiative (WENDI) was participatorily formulated by various Beneficiary Organizations (BOs) and local leaders to transform the livelihoods of the people in West Nile by focusing on fighting against food and income insecurity; human underdevelopment; and bad governance.

In the next 7 years, WENDI aims at 'empowering rural marginalized communities in West Nile to transform their energies for the attainment of secure and self-sustaining livelihoods'. In rural marginalized communities, it will target all households in a village and look at their empowerment as an inclusive process of enabling them gain voice and choice to identify, prioritize, commit to, access critical resources and work for the well-being of their households and village. Their livelihoods will be considered secure and self-sustaining when they will become able to withstand current stresses and shocks without falling back into desperations and when systems are in place (organizational, environmental, socio-economic) to ensure long-term derivation of benefits.

WENDI Focus – Healthy, Productive, and Wealthy Home Model

WENDI among other things focuses on building a healthy, productive, and wealthy home. What makes a home worthwhile is how productive household members are. Yet, the ability of the home to produce adequate food, amass wealth, and live a happy life inheres in how healthy the people are. This explains in part why WENDI aims at a safe and healthy home where every member of the household and the community are functioning optimally to ensure their day-to-day needs are adequately met with minimal susceptibility to preventable morbidity and mortality.

1.3 AFARD's experiences

Given the above importance of health in the functioning of a society, the cardinal principles of AFARD's health education are based on the (i) realization that the high prevalence of otherwise preventable diseases is largely due

to ignorance and avoidable unsafe health practice; and (ii) the philosophy that healthy living is a human right. Herefrom, AFARD has in the last 9 years also learnt that:

Table 1: AFARDs experiences and lessons learnt

In Water and sanitation:	In HIV/AIDS prevention and mitigation:
• Increasing effective and safe water and sanitation chain management is better emphasized beyond personal and home hygiene by integrating institutions like the LCs and other existing community structures like the Beach management committees. • Improving community sanitation status requires the provision of both health enhancing facilities like safe water points and toilet facilities in public places together with education for people to know the importance of such facilities. • Community sanitation education is better internalized and adopted when built on existing local conditions using local change agents and a multi-channel communication approach. • Effective bye-laws are those formed by the community. After knowing their sanitation status and abilities a community can ably set its own standards and enforce it locally. • To enforce any community bye-law, start by enforcing community exemplary leadership standards so that leaders have the moral authority to guide others.	• HIV/AIDS is not only a health issue. It is closely linked to the economic (dis)empowerment of the people and can better be approached from a multi-pronged approach that integrates prevention and mitigation measures. • Behavior change communication can impact better when a multi-channel approach that is built on local area sensitive practices are used. • To leave a sustainable impact, building local capacity of selected change agents who are acceptable to their community is important. These agents need both skills and tools with which to put the skills to use. • It takes time for people to openly declare their HIV sero-status. Testing services alone are not enough. Regular rapport building with the community increases the chance of trust upon which individual-to-individual counseling starts hence public and self confidence to declare one's sero-status and support initiatives to prevent further spread. • Economic empowerment catalyses community care and support systems for PLWA and OVCs.

As such, AFARD anchors it community health education on:

a) Learning from the existing social dynamics concerning health Knowledge, Attitude, and Practice (KAP) research.
b) Localizing behavior change messages with respect to local KAP.
c) Adapting regularly behaviour change messages through participatory review.
d) Working with local change agents drawn from the various social categories.
e) Diversifying communication channels and developing new products for effective outreach.
f) Networking with local leaders and institutions to broaden outreach and share strengths.

1.4 Why the Community Health Frontline Advisors (CHFAs)

AFARD is currently implementing WENDI in 51 BOs in West Nile districts of Nebbi, Arua, and Yumbe (but will upscale to Moyo district in 2009). One cardinal aspect of WENDI is to improve the health status of its beneficiaries in a sustainable manner. And the process must be owned by the BO members with minimal reliance on other institutions outside their control (like the Village Health Team currently promoted by government). The focus here is on the reduction of otherwise preventable diseases largely from unsafe sanitation and water chain management, poor sanitation and HIV/AIDS through Behavior Change Communication and Education (BCCE). For a sustainable approach to be embedded in each BO, a touristic approach is counterproductive. A touristic approach is where Development Agency staff simply drive into a BO, accomplish a given task and leave the BOs with only the

knowledge, without a contact person who live among them for further contact when the need arises.

Thus, having CHFAs who are part and parcel of the BO is critical. CHFAs are teams of people identified by their BOs, trained by AFARD, and given room to work and upgrade their basic health skills for the benefit of their BO members (and the wider community). CHFAs provide opportunity for continuity of a sustainable health improvement component of WENDI.

Primarily, the CHFAs will focus on safe sanitation and water chain management as well as HIV/AIDS behavior change communication and education. To do so, working with CHFA will entail:

- BO identification of trainable representatives (5 each comprising of 2 women and 2 men and 1 LC1 representative). These people must be English language literate and coming from those known as exemplary (homes or character). They need not be the BO members themselves but can come from the BO member households given that WENDI targets primarily the household.

- Training of the identified CHFAs on basic knowledge and skills for community health promotion as well as their roles. This training will be conducted in incremental manner starting with basic issues through an intermediate and finally advance skills training. This will enable the timely provision of technical skills at the time when they are needed as well as delivering such skills to those who deserve them (excluding the dropout cases).

- CHFA's undertaking of routine roles and responsibilities assigned to them in their various areas. In so doing, they will be deepening their knowledge and skills. Together with AFARD's provision of periodic technical backstopping support this should enable them to deliver better services to their BOs and set a pace for the next capacity building initiatives.

1.5 Why this Guidelines

The funding of WENDI by Gorta is based in its effectiveness in producing Visibility, Impact and Sustainability. Achieving on these 3-pillars entails a strategic intervention approach among which is the setting-up and strengthening of CHFAs. By living in their communities the CHFAs will better understand and intervene in a sustainable and responsive way to the local needs. All the CHFAs need are the skills, backstopping and an operational framework. This guideline is therefore developed to enhance this process. It is to act as a facilitator's guide in rekindling correct and relevant but timely community response and demand for safe practices that will engender the BO members' health.

1.6 Users of the Guidelines

The primary users of this guideline are the CHFAs in undertaking their roles and responsibilities. Second is AFARD for facilitating, mentoring, and accounting for WENDI implementation. Finally, both Gorta and local government officials may use this manual in facilitating community-driven development initiatives.

1.7 How to use this Guidelines

This guideline provides a quick reference point for CHFAs with regards to their prescribed roles and the basic information that the community members of their BOs needs to know in order to adopt positive behaviors requisite for a healthy living. The guidelines should therefore be used as such.

COMMUNITY HEALTH IN WEST NILE 2

What is contained in this Part

After looking at the basis for this guidelines in Part 1, in this Part attention is paid to the relevance of such an approach in West Nile. WENDI focus on West Nile is not just because of the big poverty disparity the region has with the rest of Uganda. Rather, the simple logo on Ministry of Health bus 'Health is Wealth' provides a great challenge for the people in West Nile to catch up with the rest of the country. This part therefore presents the health status of the region and attempts to explain why there is limited access to and utilization of modern health services.

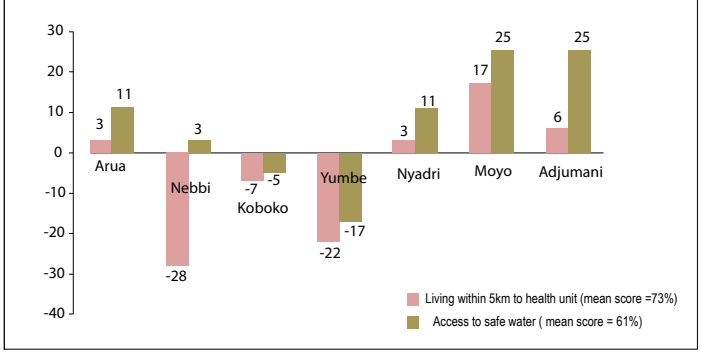
2.1 The health status of West Nile region

According to the 2008 report on West Nile profiling conducted by AFARD, West Nile region is characterized by underachievement in health sector given that:

- With the limited number of health units many people are still living outside the 5Km radius to a health facility particularly in Nebbi, Yumbe, and Koboko districts.
- The few health facilities are poorly staffed with a minimum of 27, 000 people per doctor.
- Persistence of otherwise preventable diseases like malaria that is noted as the number one cause of both morbidity and mortality.
- There is inadequate access to safe water sources.

The 2002 Census further depicts that under-5 mortality and maternal mortality rates are exceptionally high meanwhile, life expectancy in the region is 40 years, yet an average Ugandan lives for at least 48 years. In such a scenario, it is saddening to note that many people die young; at the prime of their ages. It also means that the general population in the region are young, largely having children with high dependency ratio and unable to consolidate the economic gains, if any, that they have made.

Figure 1: Access to health facilities in West Nile districts versus Uganda (%)



Source: AFARD West Nile Profiling Report, 2008

2.2 Why limited access and utilization

The above scenario of limited access especially to safe water and sanitation can be attributed to:

a) Weak political support exhibited by:

- Poor priority setting in favor of curative health and not preventive health.
- 'Politicians give development approach' that neglects community involvement.
- Focus on infrastructure minus changing the mindset of the people who are the users of such facilities.

b) Limited community responses because of:

- Inadequate awareness of the importance of safe sanitation.
- High cost of accessing services.
- Some social categories are unable to provide safe facilities on their own (e.g., the aged, widows, and persons with disabilities).
- Inadequate community sensitization and mobilization for heath care management and utilization

UPHOLDING COMMUNITY HEALTH MANAGEMENT

3

What is contained in this Part

In the preceding part, a wide gap in a purely government-led approach is shown to be counterproductive to community health. Both government and communities, with firm grounds in their varied domains, need to work in a complementary way. That means while government continues to provide mainly curative services, the community should undertake to as much as possible prevent diseases thus reducing the strain on government ability to provide services. Community Management of Preventive Health (CMPH) bridges this gap. In this part, therefore, CMPH as a concept and approach is explained.

3.1 Why a community management approach?

A number of reasons stand out in support of community management approach, namely:

1. Health issues are human rights issues
The participation of individuals and communities in making decisions for and provision of services is a democratic right. Community management promotes this right and creates ownership, acceptability of programs, adaptability, and replicability of the programs.

The following rights inherent in a number of United Nations conventions warrant mentioning.

- The December 1948 Universal Declaration of Human Rights Article 25(1):
  'Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control'.

- The December 1966 International Covenant on Economic, Social and Cultural Rights, Article 11(1):
  'The States Parties to the present Covenant recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing, housing, and the continuous improvement of living conditions. The States Parties will take appropriate steps to ensure the realization of this right, recognizing to this effect the essential importance of international co-operation based on free consent'.

- The December 1966 International Covenant on Economic, Social and Cultural Rights, Articles 12(2):
  'The steps to be taken by the States Parties to the present Covenant to achieve full realization of this right shall include those necessary for:

(b) The improvement of all aspects of environmental and industrial hygiene;

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases.'

- The December 1979 Convention on the Elimination of all Forms of Discrimination Against Women Article 14 (2):
  'State Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right:

(h) To enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications.'

- The November 1989 Convention on the Rights of the Child, Article 24 (1,2):
  1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

2. States Parties shall pursue full implementation of this right and in particular, shall take appropriate measures:

a) To diminish infant and child mortality;

b) To combat disease and malnutrition, including within the framework of primary health care, through among other things, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking water, taking into consideration the dangers and risks of environmental pollution;

c) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breastfeeding, hygiene and environmental sanitation and the prevention of accidents.

2. Water and sanitation and HIV/AIDS are development issues

The cumulative effects of poor health resulting from inaccessibility to safe water, poor sanitation and hygiene, and HIV/AIDS have enormous effects right from the individual through the households and their communities to the macro-economic levels. Such effects are behavioural, psychosocial, economic, and even political. For instance, due to frequent sicknesses, many people are unproductive meaning they simply drain their households of the limited saved assets; something that cumulatively affects the economic dynamics of the household and society at large. Further, the high infection rate of HIV/AIDS is noted to lead to food insecurity, stress on health facilities, and reduction in child education participation, among others.

Giving community a hand to self-avert the pace at which poor health affects them could sustainably promote economic growth and development.

3.2 Framework for Community Management of Preventive Health Services

Curative health service is an ex-post intervention as opposed to prevention. Besides, ill-health affects not just the individual who harbors it but the household, and the entire society. Thus in AFARD the starting point of health is in a home. That is why WENDI programme prioritizes a safe and healthy home; a home is a residence where individuals live in harmony with each other both in their homestead and in their community. This definition brings to the fore 3 core actors in building a safe and healthy home, namely:

1. The individual:	Refers to a person who is expected to practice what keeps him/her safe as an entity but also for the safety of his/her household and the community.
2. Homestead/ Household members:	Refers to a collective of individuals who live in the same homestead. Besides observing the required individual safe practices, collectively they are required to adopt safe practices that keep their home safe for them as members and for the safety of their community.
3. Community members	Actors at this level are members of (1) & (2) above who are required by collective responsibility to avoid collateral damage that can affect all of them should any one individual or homestead adopt a contrary safe health practice.

The above mean that:

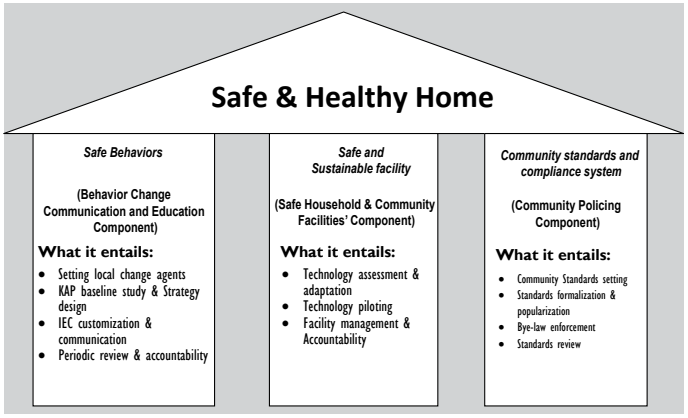
i) CMPH is not a single person affair. It needs to cut across a single individual into a collective responsibility involving all actors in a given community (which in WENDI's case is the BO).

ii) Safe health of an individual alone is less productive to the entire community. Rather, it is the safety of the homestead (a collective of individuals) that benefits both the individuals therein and the community that has a broader comparative advantage.

Seen in this light, community health especially with regard to safe water chain and sanitation management and HIV/AIDS prevention require tackling the root causes of negative attitudes and practices as are shown in Figure 2 with emphasis on:

1. Safe behaviors exhibited by individuals in the community especially with regard to sanitation (like personal hygiene) and HIV/AIDS (like ABC).
2. Safe facilities that act as barriers to exposure to disease infections. This can be a health facility for testing and treating HIV or a pit latrine as a vector control mechanisms.
3. Community standards (and enforcement) that reduce the predisposition of the community to disease spreading agents like the sanitation bye-law.

Figure 2: Community Management of Preventive Health



3.3 The Approach

Table 2 below shows a step-by-step approach in building a sustainable community-driven solution to preventive health. It entails engaging the 3 core actors noted above within the 3-pillars (see Figure 2) in a participatory manner. Worth pointing out is that as a multi-stakeholder process, CMPH is a gradual process that should not be hurried but set-up and strengthened at the pace of a given community (for it to own the process vis-à-vis their envisaged goals).

Table 2: Step-by-step approach in designing CMPH

Approaches	Key activities	Process management issues
1. Behavior change communication and education	a) Setting local change agents	• Sensitize the community about the intervention • Develop clear roles of change agents • Develop clear qualities of change agents • Develop clear skills the change agents should have • Together with the community identify change agents • Train change agents on roles and skills • Leverage building with local government
	b) Baseline study & strategy design	• Develop study instrument with change agents and LLG personnel • Train change agents in data collection • Analyze draft findings • Provide feedback to the community & explore action points together with strategies and change monitoring indicators
	c) IEC customization & communication	• Develop critical messages for behavior changes basing on bad practices, effects, and desired practices • Disseminate messages through various complementary channels
	d) Periodic review & accountability	• Assess participatorily what has changed, how & why • Explore who and what has not changed and why • Identify new strategies to deepen change among adopters, laggards and deviants • Document changes and challenges

2. Household and Community Facility Management	a) Technology assessment & adaptation	• Explore best basic but safe technology option based on relevance, costs, and skills • Adapt technology to local situation is none existed
	b) Technology piloting	• Jointly choose technology with the community • Use public place to demonstrate technology
	c) Facility management	• Develop clear roles of Facility Management Committee (FMC) • Form FMC with the community • Train FMC • Operationalize FMC • Promote regular facility O+M & accountability
3. Community Policing	a) Community Standards setting	• Using the periodic review in 1 above conduct a change constraint analysis • Develop relevant and basic safe home standards • Develop appropriate penalties to ensure standards are in place
	b) Standards formalization & popularization	• Synchronize standards with existing laws into a Community Bye-law • Secure local government approval of the Bye-law • Launch the Bye-law • Educate the population on the Bye-law
	c) Bye-law enforcement and review	• Establish a Village Register • Conduct home inspection with LC 1 • Aggregate a list of Bye-law defaulters • Prosecute defaulters in formal LC Courts • Recommend for termination habitual defaulters • Review Bye-law success using agreed upon standards in an incremental manner

3.4 Principles of community management system

As noted from AFARD's experiences and lessons learnt, a successful CMPH system is dependent on:

- A balance between supply-driven and demand-driven approaches. Education by demonstration entails the supply of say safe facilities and using it as a bait for creating demand for increased utilization.
- Effective participation of the community right from planning to review in order for them to appreciate what is good for them, set realistic targets and revise their goals incrementally in the direction that they can manage.
- Building leverage with local government that is constitutionally mandated to deliver services as well as to punish those who act contrary to agreed upon standards. Besides, such an alliance helps in providing indirect political and policy support.
- Providing a life-skills behaviour change communication and education using a multi-channel approach. This should be anchored on what the people know and practice in order to trigger positive changes.

STAKEHOLDERS IN COMMUNITY MANAGEMENT OF PREVENTIVE HEALTH SERVICES

4

What is contained in this Part

This part highlights how the different actors in a community like government, community leaders, NGOs, and the private sector can play a vital role in promoting CMPH approach.

4.1 The different stakeholders

It is already hinted that CMPH is an approach aimed at complementing the strain curative medicine is facing in the wake of resource (people, funds and logistics) scarcity. By implications, CMPH needs to coexist with curative services and should therefore operate within the bigger framework of community health.

Table 3 below summarized the various stakeholders and their areas of value-addition. CHFAs can therefore use these different stakeholders to build leverages that can make their work effective.

Table 3: CMPH stakeholders

Stakeholder	Area of interest
Central government	• Provision of policy framework for delivery and regulation of health services • Quality assurance through monitoring and issuing of guidelines • Provision of financial and technical back-up support to districts • Capacity building for the district health sector
Local government	• Construction of community facilities • Budget and technical support to local health services delivery • Provide technical support to communities: community mobilisation for new water sources, training, monitoring, community hygiene promotion, planning for O&M • Performance monitoring and mentoring • Enactment and enforcement of ordinance
NGO's and CBO's	• Direct planning and budgeting with communities and services delivery • Mobilization of communities for health related activities • Community capacity building
Private sector	• Supply of manufactured products • Undertake contracts on behalf of government • Manage some facilities especially water
Local council I	• Mobilization of the community for health related meetings • Ensuring user fees for community facilities are paid • Enforcement of bye-laws • Arbitration in conflict situation
Village Health Committees/PDC	• Community mobilization and education • Liaising with health facilities
Community	• Planning and budgeting for health improvements • Contributing towards O&M by among others providing labour and cash • [S]electing representative to manage the facility • Making relevant byelaws

4.2 Lead actor in Community Management of Preventive Health Services

In order to build synergy between BO members and the existing health system from a preventive health perspective, Community Health Frontline Advisors (CHFAs) provide the lead persons to bridge the gaps. These are teams of people identified by their BOs, trained by AFARD, and given room to work and upgrade their basic health skills for the benefit of their BO members (and the wider community). They act as Advisors because their role is to catalyze their BO membership into adopting positive attitudes and practices the reduces predisposition to infections from poor sanitation and HIV related diseases.

4.3 Roles of Community Health Frontline Advisors

Working for, with and on-behalf of their Beneficiary Organizations especially in areas of safe water and sanitation chain management and HIV/AIDS prevention and mitigation, CHFA are required to conduct:

1. Assessment of health needs

With the skills that they have, CHFA are required to carry out community health assessments of individual and BO health needs in respect to safe water and sanitation in their area. (For details see part 5). The assessment should indicate the core issues identified for redress and how doing so will help in making the health situation better.

2. Planning health education programmes

Arising from the assessment, the CHFAs as a team are required to conduct a diagnisos of the situation and plan for an appropriate health education approach requisite in creating a desired behavior change in the BO members. This plan should indicate the issue to be addressed, the method to be used and when it should be done (see part 6).

3. Community sensitization and mobilization for health actions

With a clear intervention plan in place, CHFA need to mobilize the community for an engagement in addressing the water, sanitation, and HIV/AIDS issue to be addressed (see part 7). However, this mobilization should be done in close consultation with the BO leadership while taking into consideration the appropriate timing and venue for the other BO members.

4. Community education on relevant preventive health

Health education, if well done, is a very powerful tool for creating change in community attitude and behaviours. Using various methods (see part 8 & 9) CHFA are required to create awareness among their BO members on the required positive health behaviors. This education is largely a behavior change communication and education required to establish the knowledge lacking in many cases to drive a better health attitude and practice.

5. Participation in community action to prevent disease outbreaks

Not all solutions will require community education. Some will require community actions like in cleaning of dirty community places (such as landing sites, community drainage systems, water points, etc) and mobilization for Voluntary Counseling and Testing (VCT). CHFA are therefore keep leaders in championing this process and are expected to directly participate side by their BO membership in seeing to it that the desired actions are implemented.

6. Reporting and accounting to BO leadership

In order to ensure that CHFA are effectively working to the benefit of their BO members, CHFA are required to report quarterly (on activities and funds if any) as and when the BO executives and other committees are reporting on the various activities they have implemented in their BO. This reporting should be done in a formal BO meeting in the presence of all the group members. The report is performance accountability to both the BO and AFARD. A report form is contained in part 17. It MUST be submitted to and signed by the BO Chairperson. A copy of the report form MUST be attached as part of the BO quarterly report and submitted to AFARD on quarterly basis.

7. Leading exemplary leadership

Change in attitude and practice is not only a consequence of knowledge but also of what we experience and appreciate in our surroundings. CHFA are required to be role models in facilitating positive behavior change in community health. They should lead by examples and simply not let BO members 'do as said'. As such, they shall be required to have the basic safe home facilities (see part

13) and demonstrate Abstinence & Being faithful as well as empathy for Orphans and Vulnerable Children (OVCs) and Persons Living with HIV/AIDS (PLWA) in their fight against HIV/AIDS.

8. Advocacy for a healthy community

That community health involves a multitude of stakeholders who are not all directly under WENDI requires that different stakeholders are engaged differently in order to secure their value-addition to the BO aspiration for a healthy community (see part 10). Thus, CHFA are required from time to time to advocate to other stakeholders like government, other NGOs in their area, and religious institutions among others to support their initiative but particularly in helping to address issues that are beyond their means.

9. Enforcing community bye-law

One of the core concept of WENDI for deepening a safe sanitation is community policing; an approach where individuals acts in unison against any collateral damage by setting up a local standards with penalties for deviation and enforcing such standards using local change agents (see part 16). In this effort, CHFA are required to team lead their BO in developing acceptable standards following the realization (from their various education initiatives) that a healthy community is achievable if all acted safely. They will then enforce their BO bye laws by regular home inspections, subjecting of deviants to local "courts", and recommending persistent deviants for expulsion from the BO.

10. Innovations of new ideas

The community we live in is dynamic and therefore requires an innovative approach to changing their community health. WENDI does not advocate for a one-size-fit all approach. Rather, it is flexible in that it encourages innovations. CHFA who are in direct interface between WENDI and the BO are required to bring forth any creativities they have as individuals or as BOs in handling the emerging changes and challenges in a successful safe water chain and sanitation management and HIV/AIDS prevention and mitigation in their communities.

11. Leverage building

CHFA are also required to work with other stakeholders in their communities. These can be local government officials, other NGO actors or even the private sector. Such a leverage approach is envisaged can improve and deepen BO external relations that is critical for organizational and programme sustainability building.

4.4 Key skills needed by Community Health Frontline Advisors

Table below summarizes the basic skills CHFAs need in order to perform their roles effectively and efficiently.

Table 4: The different knowledge and skills CHFAs needs

Roles	Required knowledge and skills
Assessment of health needs	• Basic research skills (data collection & analysis) • Knowledge of preventive health issues • Training needs assessment skills
Planning health education programmes	• Basic action planning skills • Training design and evaluation skills
Community mobilization for health actions	• Mobilization skills
Community education on relevant preventive health	• Facilitation skills • Communication skills • Training material design skills
Participation in community action to prevent disease out-breaks	• Leadership skills • Mobilization skills • Counseling skills • Advocacy skills

Reporting and accounting to BO leadership	• Report writing skills • Documentation skills • Management of meetings
Leading exemplary leadership	• Knowledge of leadership roles • Role modeling skills
Advocacy for a healthy community	• Advocacy skills • Mobilization skills • Alliance building skills
Enforcing community bye-law	• Local court management skills
Innovations of new ideas	• Decision making skills • Assertiveness
Leverage building	• Alliance building skills • Mobilization skills

4.5 Qualities of Community Health Frontline Advisors

A CHFAs needs to have the following qualities:

- Catalyzer (ability to stimulate action with members being mobilized)
- Organizer (ability to form new organizations and working on organizational issues of growth and development)
- Liasoner (ability to create and sustain linkages with others of similar interest)
- Advisor (ability to provide advisory services on properly grounded knowledge)
- Advocate (willing to help and support community initiatives to obtain resources and change policies)
- Role model (able to inspire others based on his/her qualities and attitudes)
- Communicator (ability to effectively relay messages and receive feedback)
- Negotiator (willing to bargain for the concerns and needs of its community)
- Mediator (ability to link the community with other actors)
- Representative (Ability to stand for a BO without hesitation and lack of clarity)

PART II

Basic Skills a Community Health Frontline Advisor MUST Have

ASSESSING COMMUNITY HEALTH NEEDS 5

What is contained in this Part

This part provides two basic research skills: data collection and feedback meetings. This is a key skill need to inform planning that should be responsive to the existing needs (in order of gravity of the issues)

5.1 Community health needs assessment

The promotion of preventive health is dependent on what issues needs to be addressed. However, the identification of these issues requires that basic data and information are in place to inform a relevant decision-making. Failure to do so may lead to the provision of irrelevant services thereby wasting time, effort, and other resources.

5.2 Why the assessment

Health needs assessment is conducted in order to:

- Know the existing practices and what the community would prefer as solutions.
- Develop relevant intervention strategies that can speed up change processes.
- Monitor progress and changes over time.

5.3 How it is done

Although there are many ways health needs assessment are conducted, for CHFA, the following methodologies and methods shown in Table 5 are preferred.

Table 5: Key data collection guidelines

	Water and sanitation	HIV/AIDS
Qualitative data collection methods	Group discussions, individual interviews, key informant interviews, observation, and pictures	
Key questions to ask	1. What traditional beliefs and practices govern (in homes and public places): a. Water collection, storage and use? b. Waste (solid & liquid) management? c. Vector controls? 2. What challenges do you face in safe water and sanitation practices? 3. What are the current prevalent ailments in the community? What are their causes? What preventive measures are used to control them? How successful are these measures? Why are people resistant to change? 4. What should be done to cause change?	1. What norms govern sex and sexuality? 2. How is sex education conducted in the community? What challenges does this approach have? 3. How does the community perceive HIV/AIDS? 4. How is HIV/AIDS mainly perceived to be spread in the community? 5. What are being done to prevent its further spread? 6. What are being done to mitigate it? 7. How effective are these prevention and mitigation approaches? 8. What are people resistant to change? 9. What should be done to cause change?
Quantitative data collection methods	Individual and household survey (see annex 3 for the instrument that captures information on personal hygiene, safe home facilities, and vector control practices)	Individual survey (see annex 4 for the instrument that captures basic information on comprehensive knowledge about HIV/AIDS and attitude and practices that can support mitigation)

5.4 Methods of data analysis

The two different data collection methodologies yield different data. Transforming these data into valuable information takes different formats as is shown below:

Qualitative data analysis	Quantitative data analysis
• Excerpts from people's expressions • Case stories • Experiences	• Number of cases • Percent (%) of cases

At a more advanced level, the following can be done:

- A Sanitation Index can be developed by analyzing and aggregating the number (and percent) of households and individuals with safe chain management practices.
- A HIV/AIDS comprehensive knowledge index can be developed using the above approach.
- For the health status (the impact level), data relating to sickness (types, duration, services used) and medical care (cost incurred) can be analyzed to show how (un) healthy the community as well as the stress they are going through.

REPORTING AND PLANNING COMMUNITY HEALTH INTERVENTIONS

6

What is contained in this Part

Once data collection and analysis has been completed, it is time for CHFAs to ensure that their findings are put to use for the benefits of the BO. This will entail two things: first, providing a feedback to the BO members, and second, planning with the BO members on the next course of action as are explained below. This part provides the basic participatory planning techniques. It provides a simplified table for presenting health needs identified by the baseline studies as well as planning actions.

6.1 Reporting on study findings

The best option for CHFAs to report to their BO membership is by convening a Feedback meeting. This will involve:

- Holding a pre-members' meeting with BO leaders. During this meeting, strategies are designed on how to make the best of the feedback meeting. Tasks will also be shared among the leaders to ensure that all participate in the process. Finally, a schedule and venue for the community meeting will be agreed upon.

- Mobilizing all the BO members for the meeting on the date and venue as was agreed upon.

- During the BO members' meeting, CHFAs will have to present the reason for the meeting which should be related to 'community responsibility for its health'. Then proceed to show the findings.

6.2 Planning for actions

Presenting the findings above only is not productive enough. It only provides information to the BO members. What should be important at this stage is 'if you found that, so what?' Seeking answers to this questions is the basis for planning for actions to revert the bad practices found among BO membership.

To elicit answers from the entire BO membership:

a) Facilitate a deeper analysis of the findings. While the findings presents the facts on the ground, for an effective action to be taken, there is need to know why such findings are as such. Thus, this part of the session should be concerned with Community Diagnosis of the findings. Simply ask, 'why is the situation so?'

Table 6: Community health issues diagnosis

Issue	Finding	Causes (with examples)	Effects (with examples)
Health status			
Safe water			
Personal hygiene			
Home hygiene			
Community hygiene			
Knowledge of HIV/AIDS			
Drivers of infection			
Mitigation efforts			
Challenges to change			

Table 7: Example of a cause- effect relationships of unsafe sanitation

Problem(s)	Cause(s)	Effect(s)
Sicknesses from preventable diseases like cholera, dysentery, trachoma, bilharzias, malaria, respiratory and gastric infections	Use of unsafe water Poor latrine coverage Poor personal hygiene	Increased infant mortality and general morbidity, Reduced labour force, increased medical costs lost productive days, Social costs like witch craft & conflicts
Environmental pollution and nuisance	Uncontrolled disposal of human excreta and domestic/kitchen wastes	Epidemics of diseases like cholera, dysentery, malaria and bubonic plague General environmental health discomfort.
Influx of rodents like rats	Poor management of solid wastes such as agricultural and kitchen wastes	Epidemics of diseases like cholera, dysentery, malaria and bubonic plague.

b) The analysis done above is an eye and heart opener to many members. Often, many people are simply ignorant of the consequences of what they do to both their and community health. Thus, using the 'heat of the moment' call for action to remedy the situation by asking, 'what should be done to remedy the situation?' This question will help in identifying what the community knows as solutions to their problems.

Do not hesitate to add to the list what the community does not know. Finally develop an action plan as below.

Table 8: A simplified Action Plan

	Proposed Action	Desired output or achievement	Target to be met	When is it to be done?	Who takes responsibility
Safe water					
Safe sanitation					
HIV prevention					
HIV mitigation					

COMMUNITY MOBILIZATION FOR PREVENTIVE HEALTH INTERVENTIONS

7

What is contained in this Part

This part defines community mobilization and shows its benefits. It also delves into providing who should be mobilized, how mobilization can be done, and what critical issues that leads to success and failures of community mobilization.

7.1 Community mobilization

In order to define community mobilization, it is important to foremost understand what a community is. Traditionally, the term community was simply taken to refer to a group of people bonded together for instance by similar belief and values, language, and territory e.g., the Alur community, Islamic community, and Mothers' Union community, etc.

However, community is wider than such a simple denominator of race, religion, politics, education, and even gender. It involves a wide array of people (see 7.3 below for details).

Thus, community mobilization is a process of organizing concerned citizens for collective action towards a common purpose with the aim of facilitating change.

Inherent in this definition are:

Concerned citizens: This refers to community members and local institutions. It is not limited to only the affected citizens but also include their sympathizers and policy-makers.

Common purpose: This refers to an issue of public concern like lack of latrine in many homes that require to be changed for the betterment of all community members.

Collective action: This refers to the teamwork expected in the active engagement of the mobilizers and the mobilized undertaken on equal terms and in a mutually agreed manner.

It is, therefore, important to note is that community mobilization:

- Is not an event (a onetime activity) but it is a continuous process that runs from the issue definition to the realization of the results.
- Is issue specific to the extent that who is affected and what ought to change are very clear from the onset.
- Is limited to decisions and activities that occur to the affected constituency.
- Is not a one (wo)man's affairs but concerns the public. It cannot be monopolized by an individual or institution.
- Does not require people to be forced into an issue that they do not see as relevant for them.
- Is not automatic, that is, people will come forward and participate once an issue has been identified. Instead, community mobilization requires that people are motivated to see the usefulness of the issue and thereby commit to it.
- Does not start with everybody. Different people and institutions take different time to respond to a call for action and so the mobilizer needs patience in building a winning public.

7.2 Benefits of community mobilization

The benefits of community mobilization as a multi-actor initiative includes:

- It is a fulfilment of one's human rights and responsibilities to partake in what affects his/her community and future.
- It opens the arena for the weak to gain presence in public arena and voice their concern and gain audience to being heard as human beings.
- It brings to the attention of leaders the need to co-partake with their community members in identifying and responding to true needs that promotes common interests.
- It promotes democratic decision-making processes where not only leaders but also the let participate in deciding their future destiny.
- In increases awareness on core community needs

and the responsibility centres thereto contrary to the belief that 'government is responsible for everything we need'.

- It promotes community ownership of their problems and solutions and thus a source of good citizenry as people will co-partake (in joint resource mobilization) with government in solving existing problems.
- The team spirit required in community mobilization promotes collaboration between various individuals as well as between organizations thereby promoting cooperation, trust building and social harmony as opposed to competition.
- It provides room for public pressure required to formulate or change laws, policies and practices.
- Successes from previous works promote community confidence.

7.3 Who do we mobilize?

Apart from the various stakeholders who are directly involved in community health, mobilization aims at widening this list so that a concern is addressed from a broader perspective. Below are who to mobilize and what gains they offer.

Actors to involve	Gains therefrom in terms of buy-in, support and involvement:
• Women leaders • Grassroots women and men • Government officials (political and elected) • Religious leaders • Traditional leaders • Opinion leaders • Political party representatives • Business associations • Gender activists • Civil society organization representatives	• Needs responsiveness • Cultural relevance • Trust building • Wider outreach audience • Wider resource base (skills, information, and material support)

7.4 Methods of community mobilization

There are various ways of disseminating information among which are the following:

- Village meetings
- Public celebration days
- Games and sports
- Electronic and print media (websites, e-mails, posters, leaflets, pamphlets, handouts
- Person-to-person discussion
- Public rallies
- Songs and drama (puppet plays, street plays)
- Procession walks
- Door-to-door campaign
- Wall writings and painting
- Debates and quizzes
- Radio and TV programmes

7.5 Critical issues about community mobilization

Success factors for community mobilization	Failure factors for community mobilization
• Relevance: Addressing the right issue • Publicity: Having a wider public aware of the issue • Commitment: having leaders with the will to cause change; those who believe in "we as opposed to I" • Convenience: Choosing the right time	• Lack of able leadership in the community • Lack of trust in the efforts • Inexperienced or unskilled mobilizers • So many whistle blowers • Lack of confidence by the community members • Lack of resources • Issue not considered a priority by the target • Communication breakdown • Past experiences of failures • Indifferent political climate • Cultural and traditional barriers

COMMUNITY PREVENTIVE HEALTH EDUCATION

8

What is contained in this Part

In this part, attention is given to key community education and awareness creation aspects primarily on the strategies for conducting health education. Finally, the part ends with challenges to effective health education.

8.1 Health education

Community health is a function of the way we live; how dangerous it is or not to our health and how it can be changed. Community health education is therefore concerned with the mutual sharing of information and knowledge through effective mobilization and provision of essential education. This is done by involving all members of the BO – young and old, female and male, higher and lower social status because:

1. People are the best agents to know their problem and desire to change it. The decision should then be made by them.
2. Increased adoption is dependent on an incremental approach whereby shift in conditions is based on the progress made.
3. Sustainability can best be built on improving knowledge and practices built on what exist and should be encouraged or discouraged.

Then, community health education is aimed at transforming the BO members' knowledge, attitudes and practices for their improved health conditions.

8.2 Strategies for health education

The following are the key proposed ways of education and awareness creation by CHFAs on safe water and sanitation and HIV/AIDS:

- BO awareness meeting.
- Focus group discussions with special categories of people like women, youths, elders.
- Cleaning up public sanitary facilities
- Home to home visit.
- Inter-BO exchange visits.
- Public hearing, consultations and participation (barazas)
- Establishment of multi-media IEC strategies; mobilization materials like T/shirts, caps, film shows, music dance and drama, home competitions and performance rewards.
- Promotion of model villages through home facility competition
- Public celebration days
- Games and sports
- Electronic and print media (websites, e-mails, posters, leaflets, pamphlets, handouts
- Person-to-person discussion
- Songs and drama (puppet plays, street plays)
- Wall writings and painting
- Debates and quizzes
- Radio and TV programmes

8.3 Challenges to health education

The following are critical challenges to health education:

- Unclear needs assessment.
- Poor education planning.
- Limited involvement of leaders.
- Weak involvement of BO members.

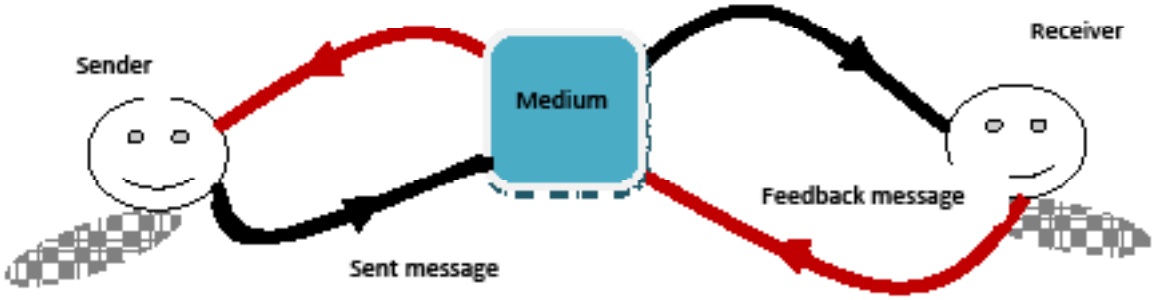
EFFECTIVE COMMUNICATION 9

What is contained in this Part

The effectiveness of CHFAs' work in their communities is dependent on how effectively they can communicate with the other BO members. This part, therefore, delves in effective communication skills and its drawbacks.

9.1 Communications defined

Communication refers to the sending and receiving of messages and feedback through an appropriate message. From this definition, it can be said that communication involves – a Sender – the Message - a Medium – Receiver and Response or Feedback.



From the above definition we can see that:

- Senders and Receivers are individuals or organizations.
- Medium is the channel that they use to send or feedback information.
- Message is the information sent or feedback but particularly its content.

Effective communication is therefore concerned with the sending of a message, having it received by the target audience/recipient, interpreted, understood and implemented as initially intended by the sender. This calls for simplicity, clarity and accuracy in the message you are passing. There is, therefore, need for a two-way flow of communication in form of feedback.

What is a message?

A message is the topic or content of information that the sender wants to convey to the target receiver(s). It is made up of elements, which are structured according to the decisions of the message sender.

Elements of the message are the ideas and assertions of the content.

Structure of the message involves the ordering and sequencing of ideas and the style in which they are presented.

Decisions are made about: elements of the message; how they are to be ordered; and the style or code used (words, drawings, pictures, etc.)

These depend on:

- The message to be conveyed, e.g. complex information may be presented using diagrams, maps, sketches etc., and not in words alone.
- The intended receivers, e.g. the receivers' ability, (reading, viewing, listening).
- Communications channels/media to be used; e.g. if a radio is to be used then many statistics or large amounts of very detailed information may not be successfully communicated; and
- Time/space available, where time is a limiting factor, the main point should be presented first and can be elaborated on later if time allows.

9.2 Why we need effective communication

Effective communication is needed because it:

- Reduces suspicion and build trust among members.
- Identifies the individuals with the community's objectives, and address them both.
- Increases individual role appreciation.
- Creates teamwork - with people working on their problems as seen by them, and in terms of their values and progress.
- Wins individuals support for community's decision.
- Provides opportunity for members to discuss issues of common interest.

9.3 Types of communication

- Verbal communication
- visual communication
- Sign communication

9.4 Channels of communication

- Public gatherings (drama, meetings, celebrations, fair, rallies, walks, games and sports, debates and quizzes, etc)
- Electronic and print media (websites, blogs, e-mails, posters, leaflets, letters, pamphlets, handouts)
- Person-to-person discussion and Door-to-door campaign
- Radio and TV programmes

9.5 Steps in developing effective communication

- Identification of the issue to communicate on
- Identification of the target groups and categorizing them (primary, secondary and tertiary)
- Designing communication approaches/strategies for each of the target group
- Developing communication messages tailored to the different target groups
- Selecting channels and media of communication including feedback that should be cost effective

9.6 Critical factors to consider in effective communication

Success factors for effective communication	Barriers to effective communication
• Type of media used • Timing • Message content • Structure of message • Circumstances when the message was communicated • Attitude of receiver	• Packaging and design of message (Inappropriateness of language used) • Inappropriateness of the channel chosen • Personality conflict of both the sender and receiver • Lack of feedback • Geographical impediments • Negative cultural belief • Insecurity • Too many senders and receivers • Listening difficulties • Inaccuracy • Lack of trust in the source of the message (ie stranger) • Class difference • Difference in interest between the sender and the receive on the subject • Disorganization of the senders of the message

ADVOCACY FOR COMMUNITY HEALTH 10

What is contained in this Part

Often what CHFAs will do to bring change may not all be within their own control. The involvement of other stakeholders to cause the desired change may be vital. This part provides a hint on how CHFAs can conduct advocacy to achieve their goals.

10.1 Advocacy defined

An advocate

An advocate is one who champions the interest of others with a view of influencing a decision. This demands a clear and deeper knowledge and understanding of the situation or conditions surrounding the issues to influence.

Advocacy defined

Advocacy is a strategic approach that combines organized and systematic actions undertaken by groups of committed and convinced individuals or organizations to introduce, change, or obtain support for specific decisions, policies, strategies, programmes or allocation of resources towards addressing a problematic or unwanted identified issue.

This definition makes advocacy a means of:

- getting what is desired;
- Through being heard (in a dialogue manner);
- So that decision making is responsive to multi-actors' needs; and
- It involves a win- win situation between leaders and the led.

Summary

- What is it: Advocacy is a process of bringing about positive change to the marginalized people.
- What change: policies, implementation of policies, laws and practices.
- Target: Decision makers, leaders, policy makers, those in position of influence.

10.2 Purpose of advocacy

If advocacy is about policy change to the benefit of the marginalized, then an advocacy process is complete only when policy makers, concerned organizations, or communities implement the desired policy action. In this case, advocacy for women's issues arises due to the need to influence and make the lower local governments' plans and budget responsive to women's concerns.

Consequently, advocacy for health issues has the following benefits:

- It is a fulfillment of the fundamental human rights. For instance, it ensures that governments provide services as a right rather than a privilege to its people.
- Ensures access to services, which would have otherwise been denied.
- Promotes government accountability by holding leaders to account for their use of power.
- Contributes to the empowerment of the weak people by voicing their concern and so gaining access to power.

10.3 Advocacy strategies

It is important to choose the right advocacy means that is capable of reaching a bigger targeted audience with greater impact. Below are some of the means you can use to advocate.

Table 9: Various methods of advocacy

Method	Focus	Actions	Common use
Raising awareness	Informing people about the issue so that they are aware. This is often the first step in an advocacy process	• Community meetings • Production and dissemination of IEC materials including radio, drama, songs, poems, leaflets, brochures etc • Public testimonies • Awareness workshops, seminars, conferences	• When information is hidden • When issues are complex
Lobbying	Speaking directly with the target to explain to them in detail the problem and the proposed solution	• Dialogue meetings • Phone calls • Memorundum	• When target is open and will listen to facts and careful argument
Networking	Building alliances with as many people as possible Creating a movement for change	• Alliance and coalition building • Joint conferences • Sharing information via email • Meeting other community leaders	• When you are limited in skills and numbers (resources)
	Harnessing public pressure for change	• Public meeting • Demonstration	• When policy makers can be swayed by public opinion
Media	Popularizing the issue using newspapers, radio	• Press releases • Radio phone-in • Briefing journalist	• When cannot get direct access to decision makers and those outside the local advocacy area
Documentation	In-depth literature on the issue	• Participatory action research • Briefing papers • Policy reports • Opinion polls	• When depth of analysis is critical

10.4 Advocacy pitfalls and best practices

Challenges to effective advocacy	Best practices in advocacy works
1. Working in isolation as well as competing with each other on the same issue. 2. Fear of being marginalized by those in power. 3. Patronization by those in power. 4. Taking a belligerent and fault finding attitude 5. Lack of adequate information. 6. Perception that advocacy can only be done by experts. 7. Poor timing	These means that the best advocacy is one where there is: • A multi-stakeholder participation involving those affected, in power, and concerned. • Effective representation. Ensure that it is the right mix and target that is engaged. For instance, do not target an advocacy issues concerning policy making to an implementer. • Accountability. Always account for your (in)action. Be the first to show the way so that you can hold others responsible for their (in)actions too. • Legitimacy. This refers to who an organization represents and its relationship to them. Be the right person to talk for the right group so that you are easily accepted by both groups of those affected by inactions and expected to act. • Credibility –refers to how much it can be believed or trusted for example whether your information is seen as reliable, programmes and services sound, or team composition viewed as having integrity.

Part III

Basic Facts about Community Preventive Health

BASIC FACTS ABOUT COMMUNITY SANITATION MANAGEMENT

11

What is contained in this Part

While parts 5-10 dealt with critical skills CHFAs needed to have in order to effectively promote community management of preventive health, in this part, what CHFAs need to communicate and educate the community about is discussed.

11.1 Community sanitation

In line with the World Health Organisation (WHO) in 1987 definition of sanitation as the: "means of collecting and disposing of excreta and community liquid wastes in a hygienic way so as not to endanger the health of individuals and the community as a whole" community sanitation and hygiene system refers to:

> *The set of infrastructure, services, and practices available to an individual, a household or a community, which promotes personal, food, and waste management in a hygienic manner for safe health of individuals and the community as a whole.*

Safe Water and Sanitation, therefore, refers to a chain management system where the people equitably and sustainably demand, develop, and use safe water and hygienic practices for a healthy living. It means that there should be adequate facilities and grounded safe practices to ensure safe, accessible, equitable and sustainable sanitation for a community.

11.2 Components of safe sanitation

Safe sanitation practices include:

- Safe collection and storage of water.
- Personal/home and food hygiene.
- Safe disposal of human excreta.
- Safe disposals of solid and liquid wastes.
- Safe food handling and storage.
- Control of insects and rodents.

UNICEF and WHO Progress in drinking water and sanitation: Special focus on Sanitation (2008: 6 & 22) reclassified sanitation and drinking water according to a ladder as follows:

Sanitation ladder	Drinking water ladder
Open defecation: Defecation in fields, forests, bushes, bodies of water, or other open spaces or disposal of human feaces with solid waste.	Unimproved drinking water sources: e.g., unprotected dug well, unprotected spring, cart with small tank/drum, tanker truck and surface water (river, dam, lake, pond, stream, canal, irrigation channel, bottled water.
Unimproved sanitation facilities: Facilities do not ensure hygienic separation of human excreta from human contacts e.g., pit latrine without a slab of platform, hanging latrines or bucket latrines.	Other improved drinking water sources: Public tap or standpipes, tube wells or boreholes, protected dug wells, protected springs, and rainwater collection.
Shared sanitation facilities refers to facilities that otherwise meet acceptable types shared between two or more households e.g., public toilets.	Piped water on premises: piped household water connections located inside the users' dwelling, plot or yard.
Improved sanitation facilities are facilities that ensure hygienic separation of human excreta from human contacts e.g., flush toilets, VIP latrines, pit latrines with slabs, composting latrines.	

11.3. The concern for good sanitation practices

Unsafe sanitation practices causes huge health burdens through a high disease incidences (see part 12). This comes about because it is now well known that unsafe water (according to Bradley) leads to a number of diseases as is shown in table 10 below

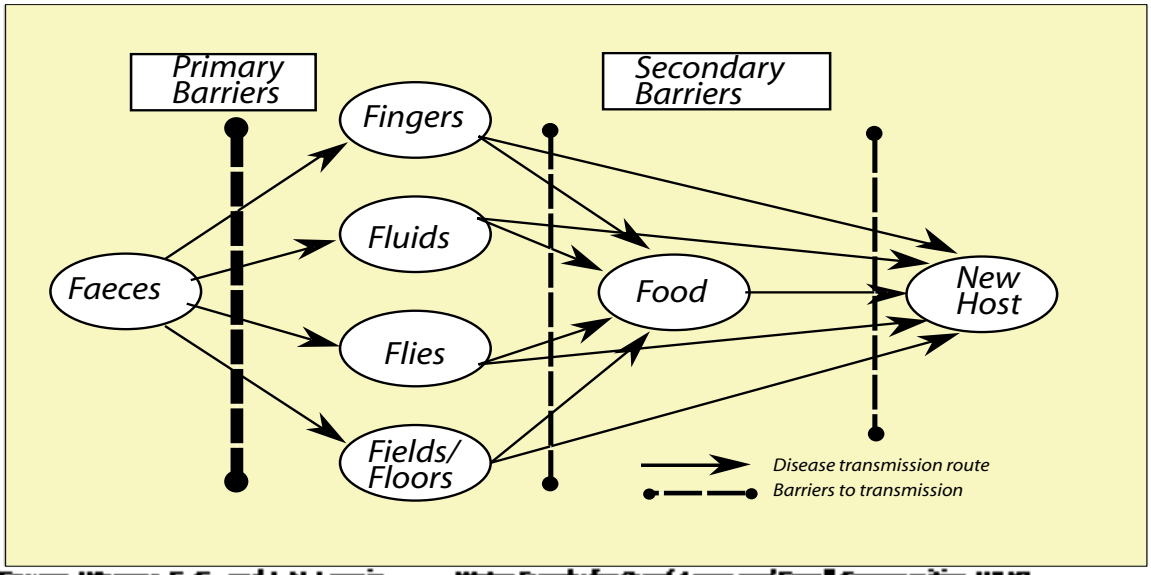
Table 10: Diseases from water transmission routes

Transmission route	Description	Disease group	Examples
Waterborne	The pathogen is in water that is ingested	Feco-oral	Diarrhoeas, dysenteries, typhoid fever
Water-washed (or water scarce)	Person-to-person transmission because of lack of water for hygiene	Skin and eye infections	Scabies, trachoma
Water based	Transmission via an aquatic intermediate host (e.g., snail)	Water-based	Schistosomiasis, guinea worm
Water-related insect vector	Transmission by insects that breed in water or bite near water	Water related insect vector	Dengue, malaria, trypanosomiasis

Source: Cairncross, S., and R. Feachem. 1993. *Environmental Health Engineering in the Tropics*. 2nd ed. Chichester, U.K.: John Wiley & Sons.

Likewise, poor sanitation according to Wagner and Lanoix's popular F-diagram of disease transmission and control identify the following as the primary agents of disease transmission. The diagram below illustrates one of the commonest ways and prevention of faecal contamination that is a problem related to unsafe water and sanitation.

Figure 3: The faecal- contamination roots (7Fs) and barriers



Source: Wagner, E. G., and J. N. Lanoix. 1959. *Water Supply for Rural Areas and Small Communities*. WHO Monograph Series 42. Geneva: World Health Organization.

11.4 Effects of sanitation

Effects of poor sanitation	Effects of good sanitation
• Many days for productive economic activities lost. • Women's burden to care for the sick is increased. • Many children especially girl children fail to attend school regularly and perform well. • More money is lost on medical bills thereby limiting spending on other household use. • Social disharmony is built in the community as witch-crafts are labeled on otherwise innocent people. • Exposure to nutritional defects as lack of latrine forces them to eat less food in fear of where to go for open defecation	• Fewer deaths and savings from days and money spent on burials. • Better health and its associated self esteem as well as less money spent on medical treatment. • More time to engage in productive venture for oneself and the country. • Increased educational participation for children. • Families can spend more time together • Cleaner living environment • Ability to plan for the future

THE DISEASE BURDENS OF UNSAFE SANITATION

12

What is contained in this Part

Parts 11 hinted on the numerous health diseases that unsafe sanitation is associated with. In this part, the various diseases, their symptoms, as well as causes, prevention and treatment methods are explains.

Disease nature	Symptoms	Causes	Prevention	Treatment
Cholera Its outbreak can occur sporadically in any part of the world where water supplies, sanitation, food safety and hygiene practices are inadequate. Overcrowded communities with poor sanitation and unsafe drinking-water supplies are most frequently affected.	Cholera is an acute infection of the intestine, which begins suddenly with painless watery diarrhoea, nausea and vomiting.	Is caused by the bacterium Vibrio cholerae through - Eating food or drinking water that has been contaminated by the feaces of infected persons. - Raw or undercooked food in areas where cholera is prevalent and sanitation is poor. - Vegetables and fruit that have been washed with water contaminated by sewage.	- Provision of adequate safe drinking-water - Proper personal hygiene - Proper food hygiene - Hygienic disposal of human excreta.	Replacement of lost fluids and salts. The use of oral rehydration salts (ORS) is the quickest and most efficient. In severely cases, intravenous fluids can be given.
alaria Is transmitted by mosquitoes which breed in fresh or occasionally brackish water.	Include fever, chills, headache, muscle aches, tiredness, nausea and vomiting, diarrhoea, anaemia, and jaundice (yellow colouring of the skin and eyes). Convulsions, coma, severe anaemia and kidney failure can also occur. Delayed or ineffective treatment, can lead to a severe cerebral form followed by death.	Is caused by four species of Plasmodium parasites (P. falciparum, P. vivax, P. ovale, P. malariae). People get malaria after being bitten by a malaria-infected Anopheles mosquito especially at dusk and early evening, but others bite during the night or in the early hours of the morning. It explodes with 8 to 35 days. The infective form (sporozoite) migrate to the liver, multiply inside liver cells, and spread into the bloodstream. Their growth and multiplication takes place inside red blood cells. The released parasites invade other blood cells.	- Use of insecticide-treated bed nets, especially by children, PLWA, and pregnant women - Apply intermittent preventive therapy in pregnancy - Ensure early detection and control of malaria epidemics, especially in emergency situations. - Reduce mosquito breeding sites by filling in and draining water bodies.	- Prompt treatment with effective anti-malarial drugs

Disease nature	Symptoms	Causes	Prevention	Treatment
Typhoid and paratyphoid enteric fevers Are s a bacterial infection of the intestinal tract and bloodstream.	Symptoms can be mild or severe and include sustained fever, malaise, anorexia, headache, constipation or diarrhoea, rose-coloured spots on the chest area and enlarged spleen and liver. Most people show symptoms 1-3 weeks after exposure. Paratyphoid fever has similar symptoms to typhoid fever but is generally a milder disease.	Caused by the bacteria Salmonella typhi and Salmonella paratyphi respectively. Typhoid and paratyphoid germs are passed in the faeces and urine of infected people. People become infected after eating food or drinking beverages that have been handled by a person who is infected or by drinking water that has been contaminated by sewage containing the bacteria. Once the bacteria enter the person's body they multiply and spread from the intestines, into the bloodstream. Even after recovery from typhoid or paratyphoid, a small number of individuals (called carriers) continue to carry the bacteria. These people can be a source of infection for others.	- health education about personal hygiene, especially regarding hand-washing after toilet use and before food preparation; provision of a safe water supply; - proper sanitation systems; - excluding disease carriers from food handling.	- antibiotic treatment. A vaccine is available, although it is not routinely recommended except for those who will have prolonged exposure to potentially contaminated food and water in high-risk areas. The vaccine does not provide full protection from infection.
Schistosomiasis Is a water-based disease	Rashes or itchy skin. Two months after infection, fever, chills, cough and muscle aches may occur, as the parasites mature. Untreated infections can result in blood in urine and stools, and enlarged liver and spleen. Chronic infection leads to diseases of the liver, kidneys and bladder. Occasionally, the nervous system is affected causing seizures, paralysis or spinal cord inflammation.	Caused by three main species of flatworm, namely Schistosoma haematobium, S. japonicum, and S. mansoni. Infection occurs when free-swimming larvae penetrate human skin during drinking unsafe water or bathing, and washing in lake/rvier. The larvae develop in fresh-water snails. After skin penetration, the larvae transform and are carried by the blood to the veins draining the intestines or the bladder where they mature, mate and produce eggs. Eggs cause damage to various tissues, particularly the bladder and liver. The reaction to the eggs in tissues causes inflammation and disease. When infected humans excrete parasite eggs with feces or urine into water, the eggs hatch releasing larvae that in turn infect aquatic snails. In the snail the parasite transforms and divides into second-generation larvae which are released into fresh water ready to infect humans. Those who work in irrigation or fishing are at increased risk for schistosomiasis. With the increase in wilderness or "off-track" tourism, more tourists are becoming infected.	-Use latrines -Spray latrines -Use water from protected sources -Bath at home -Wash at home	Chemotherapy with praziquantel, targeted at school-age children and high-risk groups, offers the most efficient way to achieve the recommended strategy for morbidity control.

Disease nature	Symptoms	Causes	Prevention	Treatment
Diarrhoea It is most commonly caused by gastrointestinal infections.	Diarrhoea is the passage of loose or liquid stools more frequently than is normal for the individual. It may be watery (for example in cholera) or passed with blood (in dysentery for example). Diarrhoea is also associated with other infections such as malaria and measles.	Is a symptom of infection caused by a host of bacterial, viral and parasitic organisms. It is caused by: Water contaminated with human feaces. Animal feaces. Poor personal hygiene. Food prepared or stored in unhygienic conditions.	- Use safe drinking water. - Improve sanitation. -Practice good personal and food hygiene. -Health education about how infections spread.	-Give more fluids than usual, including oral rehydration salts solution, to prevent dehydration. -Continue feeding. -Consult a health worker if there are signs of dehydration or other problems.
Ascariasis Is an infection of the small intestine caused by Ascaris lumbricoides, a large roundworm. It is common among children 3-8 years.	A person becomes infected after accidentally swallowing the eggs. The eggs hatch into larvae within the person's intestine. The larvae penetrate the intestine wall and reach the lungs through the blood stream. They eventually get back to the throat and are swallowed. In the intestines, the larvae develop into adult worms.	The first sign may be the passage of a live worm, usually in the feaces. In a severe infection, intestinal blockage may cause abdominal pain, particularly in children. People may also experience cough, wheezing and difficulty in breathing, or fever.	- avoid contact with soil that may be contaminated with human feaces; - wash hands with soap and water before handling food; - wash, peel or cook all raw vegetables and fruits; - protect food from soil and wash or reheat any food that falls on the floor.	The availability of water for use in personal hygiene as well as proper disposal of human feaces. Treat infected individuals (and domestic animals) with mebendazole or pyrantel pamoate.
Scabies Is a contagious skin infection that spreads rapidly in crowded conditions.	A pimple-like rash most common on the hands, especially the webbing between the fingers, the skin folds of the wrist, elbow or knee, the penis, the breast or the shoulder. Infestation often causes intense itching all over the body, especially at night. Scratching of itchy areas results in sores that may become infected by bacteria.	Caused by the microscopic mite Sarcoptes scabei. The fertilized female mite burrows into the skin, depositing eggs in the tunnel behind her. After the eggs are hatched, larvae migrate to the skin surface and eventually change into the adult form. Spreads by direct skin-to-skin contact and with infested garments and bedclothes or between sexual partners.	Improved personal hygiene Use of safe and adequate water. Use acaricide ointments preceded by a hot bath with liberal use of soap. Infested clothing should be sterilized or washed in hot soapy water. Bedding, mattresses, sheets and clothes may require dusting with acaricides. -safe sex practices	Oral dose of ivermectin

Disease nature	Symptoms	Causes	Prevention	Treatment
Trachoma Is an infection of the eyes that may result in blindness after repeated re-infections.	Infection usually first occurs in childhood but people do not became blind until adulthood. The disease progresses over years as repeated infections cause scarring on the inside of the eyelid. The eyelashes eventually turn in. This causes rubbing on the cornea at the front of the eye. The cornea becomes scarred leading to severe vision loss and eventually blindness.	Is caused by an organism called Chlamydia trachomatis. Through the discharge from an infected child's eyes, trachoma is passed on by hands, on clothing, or by flies that land on the face of the infected child to another child, mother or others.	Use of safe water Proper disposal of human and animal waste Reduction of fly breeding sites Increased facial cleanliness (with clean water) among children.	The scaring and visual change for trachoma can be reversed by a simple surgical procedure Antibiotic treatment (Tetracycline eye ointment new antibiotic and azithmycin)
Ringworm (Tinea) Is a contagious skin disease, caused by a fungus, which affects the scalp (tinea capitis), nails (tinea unguium), feet (tinea pedis or "athlete's foot"), or body (tinea corporis).	On the scalp, it begins in the form of a pimple or sore, which then spreads into a ring shape. Hair becomes brittle, breaking easily and falling out, leaving bald spots on the scalp. On the body, it may first appear as red or pink, flat or slightly raised, patches on the skin. The circular sores may be dry or scaly crusted or moist. As the sores become larger, the central area clears, leaving a ring of infected tissue around the clear area. Infection in the nails usually begins at the site of an injured nail and may spread to the other nails. Infected nails become thick, pitted, grooved and abnormal in shape and colour.	Is caused by various types of fungi known as the dermatophytes. It is spread by direct contact with an infected person or animal (dogs, cats, guinea-pigs, cattle), contact with soil or by indirect contact with items contaminated by the fungus, for example clothing, towels, bedclothes, chairs, and toilet articles handled by people with the infection. The link with water is via poor personal domestic hygiene and shortage of water for cleaning and washing.	- An adequate supply of water for personal washing and hygiene. - Regular and thorough bathing with soap and water, with special attention to drying moist areas. - Health education about how its spreading can be prevented.	- The clothing and lin en of infected persons should be frequently laundered in hot water to rid them of the fungus. - Rashes can be treated with topical anti-fungal lotions or creams. - Oral anti-fungal medication may be used.

Disease nature	Symptoms	Causes	Prevention	Treatment
Campylobacteriosis Is a severe form of diarrhoea infection of the gastrointestinal tract.	Include diarrhoea (often including the presence of mucus and blood), abdominal pain, malaise, fever, nausea and vomiting. The illness usually lasts 2 to 5 days but may be prolonged by relapses, especially in adults. In some individuals a reactive arthritis (painful inflammation of the joints) can occur. Rare complications include seizures due to high fever or neurological disorders such as Guillain-Barre syndrome or meningitis.	Is caused by zoonosis (passed to humans via animals or animal products) bacterium, usually Campylobacter jejuni or C. coli common in warm-blooded domestic and wild animals. They are found in food animals such as poultry, cattle, pigs, sheep, ostriches, and shellfish and in pets including cats and dogs. People are exposed to the bacteria after consuming contaminated food such as undercooked meats, contaminated water, or raw milk.	- Safe drinking-water supply including continuous disinfection (chlorination) of drinking-water; - proper handling of production animals; - proper sewage-disposal systems and protection of the water supply from contamination; - thorough cooking of potentially contaminated foods; - adequate personal hygiene (washing hands after toilet use as well as after handling pets or farm animals); - avoiding raw milk.	- rehydration therapy plus antibiotic therapy for those with severe infection.
Dengue and Dengue Haemorrhagic Fever is a mosquito-borne infection. Dengue fever is a severe, flu-like illness that affects infants, young children and adults but rarely causes death. Dengue haemorrhagic fever (DHF) is a potentially lethal complication.	The clinical features vary according to the age of the patient. Infants and young children may have a feverish illness with rash. Older children and adults may have either a mild feverish illness, or the classical incapacitating disease with abrupt onset and high fever, severe headache, pain behind the eyes, muscle and joint pains, and rash. DHF is characterized by high fever, haemorrhage - often with enlargement of the liver—and in the most severe cases, circulatory failure. The fever usually continues for 2-7 days. It may be accompanied by febrile convulsions.	There are four distinct, but closely related, viruses which cause dengue. Dengue viruses are transmitted to humans through the bites of infective female Aedes mosquitos. Mosquitos generally acquire the virus while feeding on the blood of infected people. Infected female mosquitos may also transmit the virus to the next generation of mosquitos.	Eliminate the mosquito breeding-sites. Proper disposal of solid waste helps to reduce the collection of water in discarded articles. Preventing mosquito bites with screens, protective clothing and insect repellents. Apply insecticide	

Disease nature	Symptoms	Causes	Prevention	Treatment
Leptospirosis Is a bacterial disease that affects both humans and animals.	The early stages of the disease may include high fever, severe headache, muscle pain, chills, redness in the eyes, abdominal pain, jaundice, haemorrhages in skin and mucous membranes (including pulmonary bleeding), vomiting, diarrhoea and a rash.	Caused by pathogenic Leptospira spp. Human infection occurs through direct contact with the urine of infected animals including rodents, insectivores, dogs, cattle, pigs and horses or by contact with a urine-contaminated environment, such as surface water, soil and plants. Leptospires can gain entry through cuts and abrasions in the skin and through mucous membranes of the eyes, nose and mouth. Human-to-human transmission occurs only rarely.	- control the infection source (e.g. rodent control, animal vaccination); - interrupt the transmission route (e.g. wearing protective clothing, refrain from contact with infected animals and from swimming in contaminated water, provide clean drinking-water); or - prevent infection or disease in the human host (e.g. vaccination, antibiotic prophylaxis, information to doctors, veterinarians, risk groups and the general population).	Use appropriate antibiotics
Fluorosis Is an ingestion of excess fluoride, most commonly in drinking-water, can cause fluorosis which affects the teeth and bones. Moderate amounts lead to dental effects, but long-term ingestion can lead to potentially severe skeletal problems.	Is characterized by staining and pitting of the teeth. In more severe cases all the enamel may be damaged. The early symptoms of skeletal fluorosis, include stiffness and pain in the joints. In severe cases, the bone structure may change and ligaments may calcify, with resulting impairment of muscles and pain. Acute high-level exposure causes immediate effects of abdominal pain, excessive saliva, nausea and vomiting. Seizures and muscle spasms may also occur.	Requires multiple exposed to sources of fluoride, such as in food, water, air (due to gaseous industrial waste), and excessive use of toothpaste.	Use safe drinking-water with safe fluoride levels. De-fluoridation using bone charcoal, contact precipitation, activated alumina Health education regarding appropriate use of fluorides. Mothers in affected areas should be encouraged to breastfeed since breast milk is usually low in fluoride.	

WHAT A SAFE AND HEALTHY HOME MUST DO/HAVE

13

What is contained in this Part

While parts 5-10 dealt with critical skills CHFAs needed to have in order to effectively promote community management of preventive health, in this part, what CHFAs need to communicate and educate the community about is discussed.

13.1 Safe water management

Only safe water is recommended for human consumption. This can be by drawing it from a safe source (see Part 11 above) or by processing the water to become safe. Below are how water can be made safe.

- Boiling; this method kills pathogens, although boiled water tastes'' flat'' but the it loses the flat taste once left covered and cools for some hours as it absorbs air.
- Canvas filtering; use of canvas or cloths removes suspended particles/solids but does not kill pathogens; should be boiled after filtering.
- Settling; solid impurities settle, water is collected and boiled to kill pathogens.
- Heating in plastic bags/bottles; some households filter water, fill in plastic bags/bottles, place on iron sheet roofs, heat for the whole day and cool at night. This is similar to boiling process except that it is a local initiative.
- Fully protected/closed/capped water source where no surface water can run directly into it.
- People do not step into the water while collecting it.
- Latrines are located as far as possible (about 30 metres) from the water source and not on a higher ground.
- Solid wastes pits, animal excreta and other pollution sources are located as far as possible.
- There is no stagnant water within 5 metres from the source.
- In case of wells, the collection buckets are kept clean and off the ground or a hand pump is used.
- Trees or cover grasses are planted around the source to enhance water re-charging capacity and control of soil erosion/water catchments area management).
- Protected water sources.
- Presence of legal and institutional frameworks for WATSAN management like local bye-laws and WATSAN management committees.
- Clean and safe water collection, handling and storage facilities.

13.2 Personal hygiene

Body
- Bath at least twice a day
- Use soap when bathing
- Use clean water to bath
- Ensure occupational safety
- Use safe oil/Vaseline to smear
- Have enough rest/sleep
- Do some exercise

Teeth
- bush teeth at least once a day
- use toothpaste or ash to brush
- use a toothbrush or small tree stem

Clothes
- maintain clothes clean
- Iron after washing especially work cloth
- Wash, dry and iron under wears regularly

Head
- maintain short hair
- comb hair always
- remove lice when available

Nail
- keep nails always short
- clean underneath nails always

Hand washing
- wash hand with detergent after defecating, cleaning a child, before handing food and before eating

13.3 Safe home facilities

A good home has all the following basic facilities that make it clean and safe.

<table>
<tr>
<td>The House:
• Separate for humans, animals, storage and kitchen.
• Well ventilated to allow free air circulation
• Spacious and adequate for the number of the inhabitants.
• Different/separate rooms for adults and children.
• A bed at least 7ft high
• Well kept floor and walls to make it difficult for vectors to hide in.
• Strong doors and windows for securities.
• Where the ceiling is applicable, it should be high enough to provide easy movement and adequate ventilation.</td>
<td>Kitchen:
• Well constructed (roof, wall window and a floor)
• Have a raised fire place.
• Have a raised place for utensils.
• Have a hand washing facility in the kitchen.

The drying line:
• Must be at least two meters high and away from the home entrance direction</td>
</tr>
<tr>
<td>Bathing shelter:
• Well constructed with a soak pit
• Provides privacy.
• Not shared with e.g. urination</td>
<td>The drying rack:
• Raise at least one meter from the ground.
• Has a soak pit
• For single purpose
• Should be near to the kitchen and in the direction chosen by the main kitchen user.</td>
</tr>
<tr>
<td>The Home environment:
• Clean and regularly maintain compound.
• Trees planted in the compound
• Not water logged.
• No harmful objects in the homestead.
• Enough playing place for children.</td>
<td>House for animals and birds:
• Birds and animals should be kept in their own houses. The house should be swept and cleaned regularly. It is advisable to use recommended insecticides to keep away insects.</td>
</tr>
</table>

13.4 Safe management of human excreta

The worst human waste is feaces as compared to urine. However both need to be properly managed for a home to be healthy. This can be done by:

- Constructing a pit latrine about 30 meters from the main house and away from the kitchen and the water source direction. The latrine must:
- Have door shatters to provide privacy.
- Have a pit-hole cover to avoid contamination by flies.
- Always be kept clean.
- Have anal cleaning materials to avoid wasting of the walls with feaces.
- Have a hand washing facility nearby.
- Smoking the latrine regularly to avoid it developing bad smell.
- Pouring ash regularly into the pit to kill the maggot and mosquitoes that often breed in pits.
- Depositing feaces of children in latrines and not on a garbage pit.
- Washing hands after every use of a latrine with ash or soap.
- Always urinate in the latrine.

13.5 Safe solid and liquid waste management

We produce solid (refuse) and liquid waste from domestic and at time business uses on a daily basis.

Untreated wastes are:
- Unsightly because a look at it is disgusting.
- Smelly making a home less or landing site less habitable.
- Provide breeding ground for disease vectors like mosquitoes, flies, and rats.
- Often brought home by animals and children get in contact with them.

The best option is to reduce such waste or to manage them well is by:
- Having garbage/refuse pits for solid waste at least 30-50 meters from the main house.
- Destroying regularly after piling up waste.
- Having soak pits for liquid waste and ensure that it is well constructed to avoid flies and mosquito invasion.
- Recycling solid organic waste into compost manure.
- Burying wastes that are not needed.
- Turning organic waste into fuel especially those from vegetables or animal waste.

13.6 Food hygiene

Food hygiene is concerned with food safety. It is about preparing, serving, and storing food well. For instance, it is recommended to keep hot foods HOT and cold foods COLD. The appropriate measures include:

1. Wash hands frequently using warm and soapy water. Wash your hands after: Using the toilet, changing children's nappies, petting animals, coughing or sneezing into your hand, blowing your nose, smoking, and always before handling food or changing food functions.
2. Sanitize the food preparation area (kitchen) frequently.
3. Make sure your utensils are clean and not contaminated by children, pets, insects or dirty hands.
4. Use clean cloth to clean up your hands and a separate cloth for utensils during food preparation and serving.
5. Have one person serve.
6. Let people wash their hands individually, with soap before eating.
7. Serve food for each member on her/his plate.
8. Destroy leftovers that are not safe to store, e.g., food that has already been mixed with soup.

How to deal with food leftovers

- Never taste food that looks or smells strange to check if you can still use it. Just throw it away.
- Allow cool air to circulate around food to keep food safe.
- Do not mix unused and uncooked foods with leftover foods.

13.7 Community hygiene

In many communities there are communal areas gazetted for community use like grazing. However, some of these places are used for defecating. These uses pose a threat to the entire community. The community should therefore:

- Ensure that a community water point is kept clean and safe.
- Set up a communal refuse pit where collection is centrally managed.
- Regularly clean communal dumping grounds.
- Construct drainage where wastewater (sullage) can flow uninterrupted
- Destroy mosquito breeding sites.
- Set up rules and enforce them for areas abused by some members by defecating.

There are also good public places that need to be handled with care. These are local markets, landing sites, and schools. These must:
- Have good latrine facilities with hand-washing facilities.
- Have a garbage pit for refuse disposal.
- Have safe water sources.
- Ensure that food sold in them follow right food handling procedures.

BASIC FACTS ABOUT HIV/AIDS 14

What is contained in this Part

The preoccupation of this part is on the basic facts about HIV/AIDS. These are core facts considered vital in comprehensive knowledge about HIV/AIDS. The primary objective is to provide a summary information about HIV/AIDS especially with regards to its definition, transmission, progression, symptoms, prevention, treatment, and positive living. These are aimed at enabling CHFA to disseminate and impart comprehensive knowledge about HIV/AIDS so that BO members can counter the many myths circulating about HIV/AIDS but most of all to adopt positive behavior for the prevention and mitigation of the effects of HIV/AIDS.

14.1 What is HIV and AIDS

What is HIV?

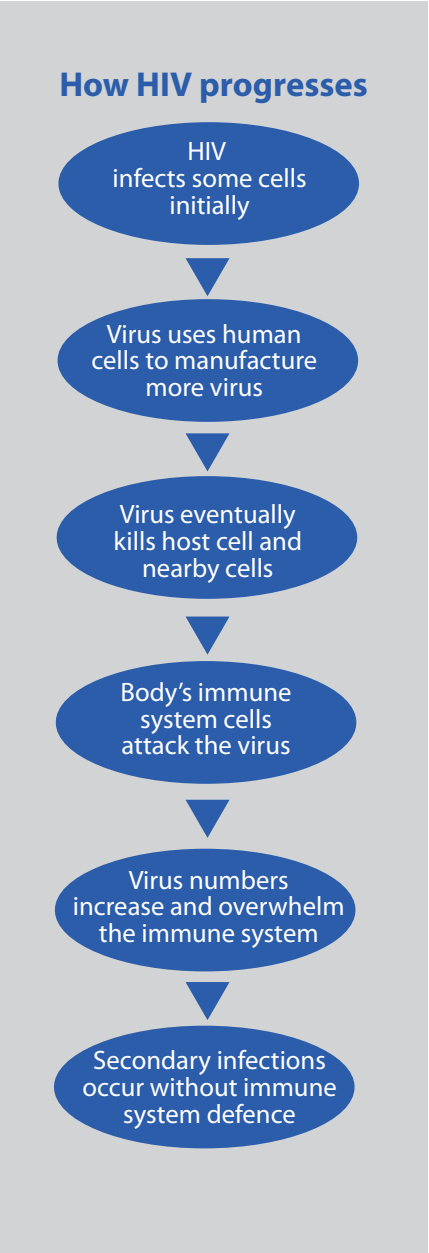
HIV is an abbreviation for "human immunodeficiency virus" an infectious viral disease that attacks and severely damages the body's immune system and ability to fight disease.

The virus starts by attaching itself into human blood cells. This is followed by its entry into the cells, uncoating of its membrane and finally integration into the human gene. It hijacks human blood cells to manufacture viral building blocks for multiple copies that are subsequently assembled, eventually breaking out of the infected cell in search of other cells to infect. By so doing, the virus kills the cells it infects and also kills uninfected bystander cells. The virus ensures that the human cell survives until its own multiplication is completed.

Soon after HIV infection occurs, the body's immune system mounts an attack against the virus by means of specialized killer cells and soluble proteins called antibodies that usually succeed in temporarily lowering the amount of virus in the blood. HIV still remains active, though, continuing to infect and kill vital cells of the immune system. Over time, viral activity significantly increases, eventually overwhelming the body's ability to fight off disease.

What is AIDS?

If left untreated, HIV will almost always deplete the immune system. This stage of HIV infection is called "Acquired immunodeficiency syndrome" - AIDS. The more the immune system has been damaged, the greater the risk of death from opportunistic infections. AIDS is the latter stage along a continuum of HIV infection and disease. Someone with HIV does not have AIDS unless their immune system has been severely weakened. By this point, the person will have developed one of a number of particularly severe illnesses, or will have lost most of their immune system cells.



In the absence of treatment, HIV generally takes 8 to 10 years to progress to AIDS. The interval between initial infection and the appearance of symptoms, however, varies and appears to be shorter for persons infected through blood transfusion and for paediatric patients. A fraction of people infected with HIV develop symptoms early in the course of infection, while others remain without symptoms for 15 or more years after they become infected. However, detectable antibodies to HIV appear within 3-4 weeks of infection. These can be detected by a simple test. This 'window period' during which recent infections can be missed may be shortened by looking for portions of the virus (using antigen tests) and viral genetic material (nucleic acid-detection methods). Positive tests are normally repeated once to protect against laboratory error. Since the HIV antibody test can miss very recent infections, it is recommended that an initial negative test be followed by another antibody test within 3-6 months.

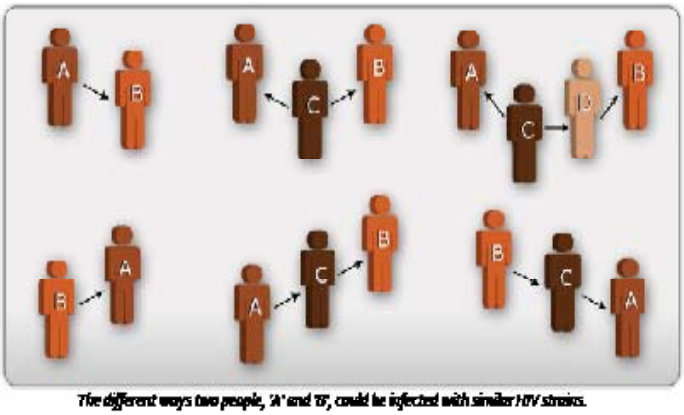
14.2 HIV Transmission

HIV is known to be mainly transmitted:

- By sexual intercourse with an infected person.
- Through Mother-to-child from infected pregnant mother to the unborn baby during pregnancy, labour or delivery, or through breast feeding.
- Through blood contacts like by sharing unsterile materials and contamination of open wound with secretion from an infected person.

How this happens is described below

- Unprotected sexual contact with an infected partner. In this way, women are more likely to contract HIV from men than vice versa. Among females, the risk is greatest for adolescent girls and young women, whose developing reproductive systems make them more likely to become infected.
- HIV is found in the sexual fluids of an infected person. For a man, it is in the pre-come and semen fluids and in a woman it is in the vaginal fluids.
- If a man with HIV has vaginal intercourse without a condom then HIV can pass into the woman's body through the lining of the vagina, cervix and womb. The risk of HIV transmission is increased if the woman has a cut or sore inside or around her vagina; this will make it easier for the virus to enter her bloodstream. Such a cut or sore might not always be visible, and could be so small that the woman wouldn't know about it.
- If a woman with HIV has sexual intercourse without a condom, HIV could get into the man's body through a sore patch on his penis or by getting into his urethra (the tube that runs down the penis) or the inside of his foreskin (if he has one).
- Any contact with blood during sex increases the chance of infection. For example, there may be blood in the vagina if intercourse occurs during a woman's period.
- Some sexually transmitted infections – such as herpes and gonorrhoea – can also raise the risk of HIV transmission.



The different ways two people, 'A' and 'B', could be infected with similar HIV strains.

- Transmission from a mother with HIV infection to her child, during pregnancy, during delivery or as a result of breastfeeding.
- Once the blood or fluids of an infected pregnant woman gets into contact with unborn baby during pregnancy, labour or delivery or with a born baby through breastfeeding, HIV can be transmitted.
- Exposure to infected blood through
- Blood transfusion using unscreened or poor screened blood of infected blood.
- Blood-to-blood contacts during the use of contaminated unsterilized instruments e,g., safety pins for removing jiggers, fish bones, etc; injection needles and syringe, drug injections.
- Exposure of health personnel during health care provisions to contaminated blood and fluids.

4.3 Myths about how HIV/AIDS transmission

HIV/AIDS cannot be transmitted by:

- Shaking hands or hugging because HIV does not stay alive in open air.
- Kissing. Saliva does contain HIV, but the virus is only present in very small quantities and as such cannot cause HIV infection. Unless both partners have large open sores in their mouths, or severely bleeding gums, there is no transmission risk from mouth-to-mouth kissing.
- Coughing or sneezing
- Using a public phone
- Sharing food, eating or drinking utensils
- Using drinking fountains
- Using toilets or showers
- Using public swimming pools
- Getting a mosquito or insect bite. HIV only lives for a short time and cannot reproduce inside an insect. So, even if the virus enters a mosquito or another sucking or biting insect, the insect does not become infected and cannot transmit HIV to the next human it feeds on or bites.
- Working, socializing, or living side by side with HIV-positive people

14.4 Criminal transmission of HIV

We live in a world where there are those who are HIV+ and HIV-. While there is need to prevent further spread of HIV, HIV+ people need a lot of precautions in order to block the infection route. However, there is a growing number of reckless HIV+ people who knowingly and deliberately infect others. This is what is called "criminal transmission'.

In some countries, like in Canada, some of these people have been tried in court, criminalized, and convicted to prisons. While this is still not a practice in Uganda, criminal transmission takes 3 forms:

a) Intentional

Intentional (or deliberate or wilful) transmission, is considered the most serious form of criminal transmission. Some cases have involved individuals (both HIV+ and HIV-) who have used needles or other implements to intentionally infect others with HIV. Others have been based on HIV+ people who have had sex with the primary intent of transmitting the virus to their partner.

Intentional transmission also sometimes takes place when a negative partner has an active desire to become infected with HIV (a practice sometimes referred to as 'sexual thrill seeking' or 'bug chasing'). This is unlikely to lead to prosecution however as both parties consent.

b) Reckless

This is where HIV is transmitted through a careless rather than deliberate act. If for example a person who knows they have HIV has unprotected sex with a negative person, but fails to inform them of the risk involved, this could be classed as reckless transmission in court. "Reckless" here implies that transmission took place as part of the pursuit of sexual gratification rather than because the HIV+ person intended to give their partner HIV (HIV is of course not 'automatically' transmitted every time someone has unprotected sex).

c) Accidental

This is the most common way that HIV is passed on. A person is generally said to have accidentally transmitted HIV if:

- They were unaware that they had the virus, and therefore did not feel the need to take measures to protect their partner.
- They were aware of their HIV+ status and they used a condom during sex, but the condom failed in some way.

14.5 HIV and AIDS Progression

The process of HIV infection occurs as is described below. However, once infection has occurred, HIV takes different stages to progress into AIDS. This is also described below.

a) Infection processes

Any exposure to HIV infection occurs as HIV searches for cells that have protein-rich CD4 surface receptors in order to bind to the blood cells mainly targeting the T4-lymphocyte (also called the "T-helper cell"), a kind of white blood cell that has lots of CD4 receptors. The T4-cell is responsible for warning your immune system that

there are invaders in the system. Once HIV binds to a cell, it hides HIV DNA inside the cell's DNA: this turns the cell into a sort of HIV factory by replication.

- After the binding process, Reverse Transcription occurs as the viral capsid (the inside of the virus which contains the RNA and important enzymes) is released into the host cell. A viral enzyme called reverse transcriptase makes a DNA copy of the RNA. This new DNA is called "proviral DNA."

- Then, by integration another viral enzyme called integrase hides the proviral DNA into the cell's DNA. Then, when the cell tries to make new proteins, it can accidentally make new HIVs.

- By transcription HIV's genetic material inside the blood cell's nucleus, directs the human cells to produce new HIV.

- By translation many new HIV cells are produced.

- Through Viral assembly and maturation new viral particles are assembled shielding off the host cell by fully creating new viruses that at the maturation stage only produce viral proteins and not blood cell proteins. At this stage, the virus is able to infect new cells. Each infected cell can produce a lot of new viruses.

b) The different stages of HIV infection

HIV infects cells in the immune system and the central nervous system. By attacking the critical cell (T-helper/ CD4+lymphocyte) that is the chief coordinator of immune system, HIV is able to retard HIV+ people's immune system.

Although different people react differently to HIV infection, generally HIV infection takes four distinct stages noted below:

STAGE 1 : *Primary HIV Infection*

This stage of infection is also known as "window period or seroconversion". It lasts for a few weeks. Often diagnosis of HIV infection is frequently missed at this stage especially when the immune system has not yet started to undertake "seroconversion" i.e., producing HIV antibodies and cytotoxic lymphocytes.

STAGE 2 : *Clinically Asymptomatic Stage*

This stage lasts for an average of 7-10 years in some people. The infected person is usually free from major symptoms, although there may be swollen glands. The level of HIV in the peripheral blood drops to very low levels but people remain infectious and HIV antibodies are detectable in the blood, so antibody tests will show a positive result.

STAGE 3 : *Symptomatic HIV Infection*

Over time, the immune system becomes severely damaged by HIV because:

- The lymph nodes and tissues become damaged or 'burnt out' because of the years of activity;
- HIV mutates and becomes more pathogenic (stronger and more varied) leading to more T-helper cell destruction;
- The body fails to keep up with replacing the T-helper cells that are lost.

As the immune system fails, so symptoms develop. Initially many of the symptoms are mild, but as the immune system deteriorates the symptoms worsen. It is also at this stage that opportunistic infections pronounce themselves.

STAGE 4 : *Progression from HIV to AIDS*

As the immune system becomes more and more damaged the illnesses that occur become more and more severe leading eventually to an AIDS diagnosis.

Clinical Stage I:	Clinical Stage II:
• Asymptomatic • Persistent generalized swelling on the lymph nodes	• Moderate unexplained weight loss (under 10% of presumed or measured body weight) • Recurrent respiratory tract infections (sinusitis, tonsillitis, otitis media, pharyngitis) • Herpes zoster • Recurrent oral ulceration • Fungal nail infections
Clinical Stage III:	**Clinical Stage IV:**
• Unexplained severe weight loss (over 10% of presumed or measured body weight) • Unexplained chronic diarrhoea for longer than one month • Unexplained persistent fever (intermittent or constant for longer than one month) • Pulmonary tuberculosis • Severe bacterial infections (e.g. pneumonia, empyema, pyomyositis, bone or joint infection, meningitis, bacteraemia) • Unexplained anaemia (below 8 g/dl), neutropenia (below 0.5 billion/l) and/or chronic thrombocytopenia (below 50 billion/l)	• HIV wasting syndrome • Recurrent severe bacterial pneumonia • Chronic herpes simplex infection (orolabial, genital or anorectal of more than one month's duration or visceral at any site) • Extrapulmonary tuberculosis • Kaposi sarcoma

Source: World Health Organization, 2006

14.6 Signs and symptoms of HIV & AIDS

The most noted symptoms (see table above) of HIV/AIDS are:

- Marked weight loss
- Persistent fever
- Persistent Cough
- Generalized skin rashes
- Enlargement of lymph nodes
- Oral thrush
- Recurrent diarrhea
- Herpes Zoster

14.7 Sexual and blood related HIV/ AIDS infection prevention

Different methods to prevent further infection exists, namely:

- Abstain from having sex by delaying the onset of sexual debut (initiation) or, once sexually active, refraining from having sex.
- Be absolutely faithful to one's sexual partner regardless of the number one has.
- For those sexually-active individuals, correctly use the condoms (male or female) always (i.e., correct and consistent use) to prevent HIV infection, other sexually transmitted diseases infection, and pregnancy.
- For HIV+ people, it is also advisable to use condoms to protect oneself and one's partner too from reinfection.
- Use only safe and screened blood should the need for blood transfusion arise.
- Avoid contact with open wounds and body fluids by use of protective wears such as gloves and coats.
- Do not share with another person a needle, syringe or equipment used for injection.
- In difficult areas, sterile injecting devices by boiling them or by washing them repeatedly, at least three times, with full strength household bleach, followed by thorough rinsing three times with water (ideally sterile).

14.8 Prevention by use of condoms – explained

Condoms must be used consistently and correctly to provide maximum protection. Consistent use means using a condom from start to finish with each act of intercourse. Correct condom use should include:

- Use a new condom for each act of intercourse
- Put on the condom as soon as erection occurs and before any sexual contact.

- Hold the tip of the condom and unroll it onto the erect penis, leaving space at the tip of the condom, yet ensuring that no air is trapped in the condom's tip.
- Use only water-based lubricants on latex condoms. Oil-based lubricants such as petroleum jelly (vaseline), cold cream, hand lotion or baby oil can weaken the latex condom and are not recommended.
- Withdraw from the partner immediately after ejaculation, holding the condom firmly to keep it from slipping off.

Table 11:Reasons why people hate condoms and why they should use it

Reasons why people dislike condoms	Reasons why we should use condoms
1. It is noisy 2. Delays orgasm 3. Prevents pregnancy 4. It hurts 5. Its oil is smelly 6. Its temporary 7. Dirty to look at after sex 8. For sero-positive people 9. Not always accessible 10. Against religious values 11. For prostitutes 12. Breeds distruct 13. Can't be used when drunk 14. For the rich 15. Is infected with AIDS virus 16. Sign of sex with a condom 17. Denies full strength 18. Easily breaks	1. Condoms are the only contraceptive that help prevent both pregnancy and the spread of sexually transmitted diseases (including HIV) when used properly and consistently. 2. Condoms are one of the most reliable methods of birth control when use properly and consistently. 3. Condoms have none of the medical side-effects of some other birth control methods may have. 4. Condoms are available in various shapes, colours, flavours, textures and sizes - to increase the fun of making love with condoms. 5. Condoms are widely available in pharmacies, supermarkets and convenience stores. You don't need a prescription or have to visit a doctor. 6. Condoms make sex less messy. 7. Condoms are user friendly. With a little practice, they can also add confidence to the enjoyment of sex. 8. Condoms are only needed when you are having sex unlike some other contraceptives which require you to take or have them all of the time.

However, the critical challenges related to condom use include the limited access to a steady supply of condoms, the negative ways in which sexual intercourses are conducted, limited information and misconceptions about the pros and cons of condoms and religious dogmas

Confidence tips

Here are also some tips that can help you to feel more confident and relaxed about using condoms.

- Keep condoms handy at all times. If things start getting steamy - you'll be ready. It's not a good idea to find yourself having to rush out at the crucial moment to buy condoms - at the height of the passion you may not want to.
- When you buy condoms, don't get embarrassed. If anything, be proud. It shows that you are responsible and confident and when the time comes it will all be worthwhile. It can be more fun to go shopping for condoms with your partner or friend. Nowadays, it is also easy to buy condoms discreetly on the internet.
- Talk with your partner about using a condom before having sex. It removes anxiety and embarrassment. Knowing where you both stand before the passion stands will make you lot more confident that you both agree and are happy about using a condom.
- If you are new to condoms, the best way to learn how to use them is to practice putting them on by yourself or your partner. It does not take long to become a master.
- If you feel that condoms interrupt you passion then try introducing condoms into your lovemaking. It can be really sexy if your partner helps you put it on or you do it together.

14.9 Preventing mother-to-child transmission of HIV (PMTCT)

Mother-to-child transmission (MTCT) is when an HIV positive woman passes the virus to her baby. This can occur during pregnancy, labour and delivery, or breastfeeding. These modes of transmission can be prevented by:

- Preventing HIV infection among prospective parents through voluntary testing and counseling to help know expectant mothers' sero-status for an appropriate mechanisms adoption.
- Avoiding unwanted pregnancies among HIV positive women by effective use of condoms and other contraceptives.
- Preventing the transmission of HIV from HIV positive mothers to their infants during pregnancy, labour, delivery and breastfeeding through antiretroviral drugs and safer infant feeding practices as below depending on the HIV stages in the woman:
    - o Women who have reached the advanced stages of HIV disease require a combination of antiretroviral drugs for their own health. This treatment, which must be taken every day for the rest of a woman's life, is also highly effective at preventing mother-to-child transmission (PMTCT). Women who require treatment will usually be advised to take it, beginning either immediately or after the first trimester. Their newborn babies will usually be given a course of treatment for the first few days or weeks of life, to lower the risk even further.

    - o Pregnant women who do not yet need treatment for their own HIV infection can take a short course of drugs to help protect their unborn babies, i.e.,:

- A single dose of nevirapine given to the mother at the onset of labour and to the baby after delivery.

- A combination of AZT and single dose nevirapine. The woman should begin taking AZT after 28 weeks of pregnancy (or as soon as possible thereafter). During labour she should take AZT and 3TC, as well as a single dose of nevirapine. Her baby should receive a single dose of nevirapine immediately after birth, followed by a seven-day course of AZT. The mother should continue taking AZT and 3TC for seven days after delivery, to cut the risk of drug resistance still further.

The most effective PMTCT therapy involves a combination of three antiretroviral drugs taken during the later stages of pregnancy and during labour.

- Safe management of infant feeding. This can be by:
    - o Using breastfeeding exclusively without any other substitute including water in the first month and this must be discontinued immediately.

    - o Using breast milk substitutes (formula) exclusively without any other alternatives like local foods or even giving breast milk at times. Breast milk substitute should only be used where clean water exists.

    - o An HIV-positive mother can improve the safety of her own breast milk by pressing it into a container and submitting it to either flash-heating or Pretoria pasteurisation. Flash-heating is achieved by placing the covered container in a pot of water and heating until the water bubbles, then removing the container and letting it cool. Pretoria pasteurisation involves boiling a small pot of water, removing it from the heat, immersing the container, covering the pan and leaving it to cool for 20 minutes. Both of these methods, if performed correctly, destroy HIV while preserving much of the goodness of the milk.

14.10 HIV testing

The standard HIV test looks for antibodies in a person's blood. When HIV (which is a virus) enters a person's body, special proteins are produced. These are called antibodies. Antibodies are the body's response to an infection. So if a person has antibodies to HIV in their blood, it means they have been infected with HIV. There are only two exceptions to this rule. Firstly, babies born to positive mothers retain their mother's antibodies for up to 18 months, which means they may test positive on an HIV antibody test, even if they are actually HIV negative. This is why babies born to positive mothers may receive a PCR test after birth. Secondly, some people who have taken part in HIV vaccine trials may have HIV antibodies even if they are not infected with the virus.

Why have an HIV test?

It is important to test one's sero-status because it:

- Helps in avoiding worries and its associated anxieties.
- Enables doctors to provide care and support to one who tested HIV+.
- Ensures one adopt positive living behaviors without waiting until life-threatening diseases occurs (often with fatal consequences).
- Helps in knowing when to start antiretrovirals treatment.
- Reduces the chances of criminal transmission thereby morally making people protect the those they care about.
- Enhances the ability to plan the future well.

Because of the above reasons, HIV testing is important. To do so, there are three main types of HIV tests, namely:

1. HIV antibody test is also known as ELISA (Enzyme-Linked Immunosorbent Assay) tests. This test shows whether a person has been infected with HIV, the virus that causes AIDS.

2. An antigen test detects HIV earlier than standard antibody tests. Antigens are the substances found on a foreign body or germ that trigger the production of antibodies in the body. The antigen on HIV that most commonly provokes an antibody response is the protein P24. Early in the infection, P24 is produced in excess and can be detected in the blood serum by a commercial test (although as HIV becomes fully established in the body it will fade to undetectable levels).
3. A PCR test (Polymerase Chain Reaction test). The whole process of extracting genetic material and testing it with a PCR test is referred to as Nucleic Acid-amplification Testing or 'NAT'. PCR tests detect the genetic material of HIV itself, and can identify HIV in the blood within two or three weeks of infection.

To note is that most people develop detectable HIV antibodies within 6 weeks to 6 months of infection. During this window period people infected with HIV can transmit HIV to another person even though they do not test positive on an antibody test.

However, a negative test at three months will almost always mean a person is not infected with HIV. If an individual's test is still negative at six months and they have not had unprotected sex or shared needles again in the meantime, it means that they do not have HIV, and will not therefore go on to develop AIDS.

14.11 Disclosing HIV Status

With increasing behavior change communication and education, there is a rising level of HIV status testing. Although much of the tests for now are driven by suspicions or doubts from one's past lifestyle given the awareness on past risk behavior, limited effort is being done to help with post test living. Often those who go to test receive pre-test counseling and after testing HIV positive (HIV+) they are left to "deal with life as usual". Humanly, it is bad news to be declared HIV+. It is painful and difficult to deal with this news alone. When this happens, it is important that at an appropriate time one shares the news with others who matter in her/his life. Doing so is what 'disclosing your HIV status' is all about.

Who should know your status

No one leads a solitary life. We are all connected in one way or another to at least one or more people who mean a lot to our lives. These people need to know if we test HIV+ for varied reasons as are summarized below/

Table 12: Who needs to know your status and why

Who should know	Why they should know
Spouses or partners	• They need to also test their sero-status • They need to adopt or accept safe sexual practices • They are our source of emotional support • They provide the first line of relationship that determines our family life • To avoid cases of criminal transmission
Who should know	**Why they should know**
Family (including parents & children)	• To secure their acceptance of our status as its associated shortcoming. • We need their emotional support always. • It is our responsibility to plan collectively with them for life during the different stages of sicknesses and after death should it occur.
Friends	• They are our life bedrocks with whom we plan, guide, and co-participate in family/relational issues. Their emotional and economic support is beneficial for positive living.
Employers (& co-workers)	• They need to support us at our work place with health care and acceptable work environment. As we spend more time at our places of work, we relate with many people there too. Avoiding discrimination at workplace enhances one's positive living.
Medical workers	• We need to help them become conscious in dealing with our health needs beyond generic medical care provisioning • They also need to protect themselves from infection by avoiding all risky treatment practices that can endanger their lives.

General disclosure tips

- Not everyone, even from among the list proposed above, is entitled to know your HIV status. Choose who to tell and who not to tell.
- Be clear of what you want to tell whoever you have chosen to know. This is helpful in making your discussion with whoever short, simple and straight to the point. It is emotionally breaking to start telling a tale of your lifestyle!
- Besides, make it a point to specifically know why whoever should know your status. Having the reasons very clear helps in communicating to the people why you have chosen them to know. It will also be good reason to avoid gossip.
- When and where you should tell whoever is absolutely your choice. It is only important to note that rushing with breaking the news may not be helpful because one's HIV status disclosure is an issue of privacy that cannot be retracted once spoken about.
- Do not break down when telling your story. It is your story and no one else. It is not the end of everything to discover that you have HIV. Know that in the long run we are all dying from different causes and HIV is just one among the many. This is self-esteem assertiveness.
- Do not isolate yourself about your status because doing so give people opportunity to wonder what you are hiding and labeling you for whatever they do not know. If you are confident, declare your status in public at an opportune time.
- Know that different people will react differently to the news. Expect anxiety, anger, abuse, or even walking away on you. All these are normal reactions that should not worry you because people digest information differently.
- Normally to counter sympathy call for empathy. Ask whoever you have chosen to always be there for you as and when you need them. Emphasize how they are important in your life.

In all, as the saying goes, for any secret you hide in your heart, you carry them as guilt, distrust, and a log. It is therefore better and easier once you have gone over the "discovery shock fence" to declare your status to those who matter to you. It is your choice to tell them what you feel is good for them to know at a time that is convenient to you. But do caution them of your privacy.

14.12 HIV/AIDS Treatment

Several different types of drugs and positive behavior exist to treat HIV infection. Currently, combination anti-HIV therapy known as antiretroviral therapy, or ART is preferred over single dose medication. However, ART is not a cure. And given the different regimens these drugs have, it is important to:

- First, you take a sero-status test to know your whether or not you are HIV+. Drugs are only for those who are HIV+ with a given level of HIV in their blood.
- Second, take a CD4 count and a viral load test to know the HIV infection status. While the CD4 count tells us how many immune system cells are at work in the blood, the viral load test measures how much HIV is circulating in the blood. The more HIV in the blood, the quicker the disease will progress.
- Third, depending on the result of CD4 count/Viral load tests, trained medical personnel will advice on what medication to take.
- Fourth, once ART (a combination drug) is recommended, develop a treatment adherence plan to guide in the taking of the drugs, timely and regularly.
- Fifth, take ART drugs as is recommended because any variation in treatment regime causes drug resistance.
- Sixth, because of high susceptibility to other infections, treat all other opportunistic infections everytime infections occurs.
- Seventh, ensure that you regularly monitor your immune system performance through regular HIV/AIDS clinic visitation.

14.13 Living positively with HIV and AIDS

Many people are HIV+ just like many are affected by HIV/AIDS. While many have died, it is now possible to revert early death of HIV+ people through living positively. Positive living provides HIV+ people the opportunity to live longer a healthier and productive life. All it requires are:

- Do not live in denial. Simply accept the disease and live openly.
- Take your drugs (when one has started) with strict 'treatment adherence'.
- Avoid all risky behaviors like drinking alcohol and smoking.
- Eat adequate foods cooked hygienically.
- Drink plenty of fluids avoiding tea, coffee, colas, chocolate that causes the body to loose more fluids.
- Drink plenty of clean water. Always boil your water if you do not have a safe source.
- Exercise regularly to keep the body physically fit.
- Have adequate (8hrs) sleep to give the body enough rest.
- Treat all opportunistic infections timely.
- Join a support group where to share experiences, reduce anxieties, learn new strategies, and build care friendships.

14.14 Essential support services

These services help support both HIV/AIDS prevention and mitigation:

- Voluntary Counseling and Testing (VCT)
- Prevention of Mother-to-Child Transmission
- Skills training for Income Generation
- Life Skills training
- Orphaned and Vulnerable Children's Skills training
- Safe motherhood services
- Community Awareness Programmes

14.15 Effects of HIV/AIDS

The effects of HIV/AIDS are varied ranging from individual to the macro-economy. This includes:

- Lost self esteem; weakened social harmony; increased medical expenses; reduction in household assets; and lost economic productivity.
- Food and often the associated income insecurity in many farming communities.
- Reduction in educational participation by both pupils/students and teachers.
- Increased stress on medical workers as well as medical budget to provide for opportunistic infection and ART.
- Reduction in life expectancy thereby increasing dependency ratio with reduced individual, household and national economy productivity and resilience to shocks and stresses.

14.16 Desired positive attitude and behaviors

The fight against HIV/AIDS takes two prongs: the first deals with preventing further spread; and the second one focuses on mitigating the effects of HIV/AIDS. Table below summarizes some of the critical positive attitude and behaviors.

Preventing further spread	Mitigating HIV/AIDS effects
• Learn more about HIV/AIDS in order to dispel myths • Adopt ABC depending on your marital and HIV status. • Test your sero-status • Participate in community awareness creation programmes • Adopt positive living	• Care for Persons Living with AIDS (PLWA) at their homes • Care for Orphans and Vulnerable Children affected by HIV/AIDS • Voluntarily associating with PLWA be it at home, church/mosque, markets, and business places. • Encourage a PLWA to confess their HIV status. • Join a Post Test Club

14.17 Roles of community in preventing and mitigating HIV/AIDS

HIV/AIDS has come to stay with us. There is no cure as yet. Even if we had any cure, the fact that there are HIV+ and HIV- people means that we will for long continue to live with the disease. As a result, every community has a responsibility to prevent and mitigate HIV/AIDS. This can be done by the following:

- Adopting an open approach to talk about HIV/AIDS.
- Shunning down risky behaviors like drinking, early and multiple sexual engagement.
- Legislation of policies that restricts driving forces for infections like late nite videos, discos, sales of alcohols to teenagers.
- Forming into community education and care clubs that can help spread comprehensive information about HIV/AIDS.
- Active engagement in Post Test Clubs.
- Having community leaders who provide role models and exemplary leadership in fighting HIV/AIDS.

Part IV

Community Facility Management

KEY ISSUES IN FACILITY MANAGEMENT 15

What is contained in this Part

The safety of a community is in part dependent on community facilities like safe water sources. The sustainability of these facilities in providing services to the community limits falling back into the use of unsafe sources. This part explains how that can be done through a Facility Management Committee (FMC) who must be effective and accountable.

15.1 Formation and Strengthening of Facility Management Committee

A community facility is everybody's facility. If no one takes or is given responsibility to oversee its functionality, it may end up breaking down without anyone to care for it. Thus, it is important to set up a FMC as directly responsible for the sustainable functioning of facility.

The FMC is established by a user-community through a transparent election to ensure the safe and sustainable management of water and sanitation facilities. In the case of water facility, it is known as a Water Source Committee (WSC) while for sanitation is called a Sanitation Facility Committee (SFC).

In WENDI, the provision of safe sanitation facilities to a BO need requires that the BO is fully responsible for the operation and maintenance (O+M) of the facility. It is at the discretion of the BO members to set up FMCs either exclusively from their membership or by incorporating other members from their wider community given that they will share in the use (and expectedly the cost) of O+M of these facilities.

Selection criteria

The committee is selected based on a set of criteria as below:

- Willingness to work on voluntary basis.
- Trust worthy of the person.
- Interest in developing the community he/she resides in seen in involvement in previous community work.
- A relatively permanent residence of the locality with minimum chances of relocating elsewhere.

Composition of the committee

There is no set standard for the number of committees as this may also depend on the number of villages served and therefore having influence on the number of committee members. However, it is generally agreed that the committee should be composed of at least eight people half of whom should be women. The executive positions are:

- The Chairperson and his/her Vice
- The Secretary and his/her Vice
- The Treasurer
- The Caretaker (preferably a woman closest to the water point)
- Other Committee members (number determined by catchment area and need to ensure representative from a cross section of the population-geographically and culturally)

15.2 Functions of the committee members

Table 13 below summarizes the roles and responsibilities the various FMC committee members are expected to play.

Table 13: Roles and functions of committee members

Responsibilities (Positions)	Roles
Chairperson	• Heads the committee and is its general manager • Maintains close collaboration with outsiders on behalf of the committee • In collaboration with the secretary, calls for meetings and shares such meetings • Operates the committee finances in collaboration with the Treasurer and is a co-signatory for the water source bank account • In collaboration with other committee members, heads and spearheads the development of the committee workplans • Make emergency decisions on behalf of the committee • Supervise and monitor activities being implemented
Secretary	• Is the custodial of all records of the committee • Write all correspondences (in and out) of the committee and keep a record of such correspondences • Records all minutes of meetings and maintains an up-to-date register or file of minutes • Calls meetings in collaboration with the Chairperson • Is a co-signatory for the water source bank account • Maintains a register of all the water users hat clearly spells out the sanitary status in each households • Make follow up on all decisions made by the committee
Treasurer	• Is the general manger of all the finances of the committee • Keeps an up-to-date register of all the users • Collect all user fees and other income for the water point • Make all payments related to O&M and other costs incurred • Keeps all financial records of the committee • Maintains an up-to-date register of all payments made by the users • Together with other committee members, develops the fundraising plan • Maintains the register of assets that the users might have acquired • Prepare financial report from time to time to the committee and the general user community • Account on the use of the user funds to the committee and the general users • Is the principle signatory of the users funds account
Caretaker	• Maintains the water source together with the users • Ensure among other through education the safe water chain at source level • Organize for general cleanliness of the water point • Ensure the security of the water points against animals and other unwanted elements • Organize for preventive routine O&M of the source • Monitor the water level and yield
Other committee members	• Assist the executive committee members • Represent the interest of their consistencies

15.3 Effective Operations of Committee

As a committee charged with safe and sustainable facility management, its effectiveness is determined by four cardinal management functions, namely:

- Regularity of effective meetings
- Operation and maintenance (O+M) of facilities
- Financial mobilization and accountability
- Stakeholder management.

For each of these functions, see a brief below.

1: Meetings of the Committee

It is essential that the WSSC hold meetings for its proper functioning. This is because meetings among others provide a forum for:

- Information sharing and exchange
- Collective decision making
- Common planning
- Responsibility sharing

Each WSSC is obliged to organize the following meetings:

Table 14: Committee meetings

Type of meeting	Called by who?	When?	Attended by who?	Why called?
Executive Committee meeting	Chairperson	Monthly	Executives	to discuss the affairs of the water point and other sanitation elements within the community; for review of previous month's performance; receiving reports from other committees for assignment provided previously and; planning for next month's interventions.
Extra Ordinary Executive Committee meeting	Chairperson	As and when required	Executives or all users	Depends on the nature of the unplanned for event.
User Community General meeting	Executives	Quarterly	All users & stakeholders	to inform (and seek opinion from) the community; to approve new bye-laws; assess performance of previous bye-laws; to make funds accountability; seek approval of new strategies to be adopted for the promotion of good use of the water facility and sanitation in the community; and planning for next quarter's interventions.
Extra Ordinary User Community General meeting	Chairperson	As and when required	Executives or all users	Depends on the nature of the unplanned for event.

2. Managing meetings of the Committee

For the various meetings to be effective, the Committee must do the followings:

a). Community mobilization for meetings

For good attendance it is important that the community is mobilized a head of time and thus, provided ample time to prepare to attend the meeting. This could be done by:

- Making announcements in form of speeches in public places such as mosques, churches, at funerals, markets, landing sites etc
- Writing letters
- Writing and posting public notices
- Use of community acceptable communication strategies such as drum beating, gongs, etc.

b). Organizing and conducting meetings

The energy and commitment put in organizing any meeting determines its success. It is therefore important to take note of the following when planning for a meeting:

- Determine the need: Let the purpose for the meeting be worth it. The need for any meeting should be determined by the Chairperson and the Secretary of course informed by the agreed schedule of meetings.

- Be clear on the agenda: This is the main body of the discussion; the list of items that people will talk about. This needs to be planned ahead of time and if possible communicated to the people who will attend the meeting. It is also good practice to offer a chance for the people to modify the agenda items or agree on the agenda before the meeting begins.

- Time, venue and space should be convenient to all: For good attendance:
  - o the time for the meeting need not to conflict with people's daily activity calendars. For instance, it is not good to plan for a meeting on a market day or very late in the evening when women will be very busy cooking.
  - o The venue need to be central, easy to reach and known by all the targeted participants. I
  - o t is important to check for sitting space, light and other materials that are necessary for the success of the meeting.
- Prepare yourself very well: Be prepared for the unexpected at all times. If you are going to make a speech have all supporting documents on the table. Items of list of users, status of paid up members and expenditure items are issues that normally attract people's attention. It is also important that as a committee you hold a pre-meeting to enable you all speak the same language. Besides apportioning blames, it is very shameful when the committee starts speaking in different tongues in front of the people they lead.

When conducting a meeting remember to:

a) Follow the agenda as much as possible
b) Take one agenda item at a time. Avoid the tendency of mixing issues (handling several agenda at a time)
c) Keep order; let discussions and contributions be done orderly often after permission from the chair
d) Give chance for everybody to participate; avoid the tendency of a few monopolizing the discussions
e) Keep yourself focused within the agreed time and avoid dragging discussions
f) The chair should not monopolize discussions; only give guidance on issues being discussed
g) Enable each time to reach a conclusion

c). Recording minutes

All proceedings of the WSSC as well as of the general meetings should be well recorded, documented and filed by the Secretary. This therefore, calls for quality in the recording of the minutes. It has to be emphasized here that it is only important issues that should be recorded in minutes otherwise it will be bulky and not focused. The following forms a general guide about good minute writing:

- Heading: A minute should be headed with details on the title of the meeting, the date it took place and the venue
- Participant list: List of people who attended (and absentees fr committee members)
- Agenda items for discussion: All the agenda should be highlighted
- Time when the meeting started and ended: the starting time is normally stated at the start of writing the first minute while the end time is contained as the last sentence in the minute.
- Records of proceedings: Each agendum provides the starting point for recording and numbering the minutes. All minutes should be numbered. Even if there is no universally agreed format for recording minutes, generally the numbering should reflect the first order of the agenda items, followed by the month it is held and lastly the year. For example a meeting held in November with four agenda in the year 2006

can be recorded as follows: 01/11/2006, 02/11/2006, 03/11/2006 and 04/11/2006 for agenda one up to four respectively. This will at least show that in November of the year 2006 four agenda items were discussed.

- Signed by the Chairperson and the Secretary: It is a rule that space be provided at the end of the minute for the signatory of both the secretary and the chairperson. This is normally implemented in the next meeting when the minutes is read and okayed by all the parties who attended the meeting.

15.4 Operations and Maintenance

What is Operation and Maintenance (O&M)?

For the facilities provided to a community to work sustainably, without any breakdown, it must be given due attention in the form of O+M. Thus, O+M refers to the sum total of activities required to achieve smooth running and continuous sustenance of a water and sanitation facility to ensure long-term service (DWD: 2004).

The effectiveness of O+M is fully reliant on how the facility users are committed to doing so. Hence, a community based maintenance system that emphasizes community total support, innovativeness, responsibilities and authority over the development and discharge of the O&M interventions is of paramount importance.

Box 1: About O+M

Operation refers to the everyday running and correct handling of facilities. The proper operation of a water and sanitation facility results in its optimum use and contributes to a reduction in breakdown and maintenance needs.

Maintenance refers to the activities that are aimed at ensuring the proper working conditions and steady use of the facility over a long period of time.

The point to note here is that whereas operation handles the day to day activities, maintenance is geared towards sustaining the life span of the facility.

Key aspects of O+M are:

- Major operations: This is required to convey safe services to the users.
- Correct handling of facilities: This is to be done by the users to ensure long life span of a facility.
- Preventive maintenance: Refers to regular and routine activities that are undertaken to preserve, protect, and minimize breakdown. This entails regular inspections on either a daily, weekly, monthly or yearly basis. For the case of a borehole this may include activities such as greasing, fencing, checking of bolts and nuts etc.
- Corrective maintenance: This is undertaken when some problems have been detected with the facility and if use is continued there will be a likelihood of the entire breakdown. This may include such activities such as minor repairs and replacement of broken and worn out parts.
- Crisis maintenance: these are responses to major breakdowns.

The choice of which type maintenance to focus on depends on the prevailing situation and attitude of the users. However, for sustained use of the water and sanitation facility and cost effectiveness, preventive maintenance is being emphasized.

15.5 Financial mobilization and accountability

Financial mobilization

There are various sources of funds for the FMC, however, the most reliable one is the user fee charges. The amount charged and duration of payments should be determined by the respective users. The following practices are highly recommended for the generation and management of the water user funds:

- The amount to be charged should be agreed upon by all the users by consensus. Impliedly, the amount should be affordable to all users. This therefore, demands that a community meeting must be held to decide on the amount and duration of payments.
- When the amount is agreed upon, it is important that this be minuted and signed by all the LCI and WSSC executives.
- The minutes of the meeting should be submitted to the office of the sub-county chief as well as the chairperson LCIII for support in case of seeking support in management of defaulters.
- A register of all the users must be generated, maintained and updated from time to time. Note that this register will prove useful in tracking payments.
- When any payment is made, a receipt dully signed by the treasurer and stamped must be issued out.

Financial Records and Accountability

Public funds must be properly utilized and accounted for. This thus, demands for proper documentation and acceptable accountability procedures of all the proceeds and expenditures. WSSC hold a lot of public funds and it is a necessity that some basic simple accounting procedures be put in place. Some simple basic books keeping practices is therefore prudent. For this purpose, the simple accounting/ bookkeeping practices being emphasised is the use of receipts, household ledgers and income and expenditure books.

Financial Records

Receipts

Use: Receipts play a leading role in acknowledgement of payments (income). For any income accrued to the committee, a receipt must be issued. It is normally filed in duplicate with the original issued to the person who made payments while the carbon copy is retained for record purposes. The Treasurer or the Caretaker can issue receipts for all monies received.

How often is it used? When any payment is being made to the committee.

NAME OF THE BO - Facility
P.O. BOX .....TEL: .....
No:.....

Date:.....

Received with thanks from.....

Being payment of.....

Amount in words.....

Cash/Cheque No:..... Amount Balance: .....

Signature: .....

Household payment ledgers

Use: To record all payments made by a particular household through out the year on a discounted basis. This is because individuals may not have all the money to pay at once and can therefore pay in installments. It is the installments that are recorded in the book which should reflect cumulative amounts paid over time and the net balance due. It is the responsibility of the Treasurer to fill this book.

How often is it used? The moment a household makes its payments

Name of household head: *Rejinal Opio*		Village:*Oryeyire*	
Total amount to be paid in a year: *2,400 (based on payments of shs. 200 monthly*			
Date	**Amount paid**	**Paid by**	**Balance**
2/04/06	*400*	*Apio*	*2,000*
4/07/06	*200*	*Apio*	*1,800*
15/10/06	*800*	*Acen*	*1,000*

Income and expenditure book

Use: To record all income and expenditure items by date and sources/recipients. It helps in showing main income sources and expenditure areas and cash balance at any one time. This book is managed by the Treasurer.

How often is it used? When any income or expenditure is made.

S/No	Date	Particulars	Income	Expenditure	Balance
01	*2/7/06*	*User fees from Opar*	*2,500*		*2,500*
02	*8/7/06*	*User fees from Opio*	*1,200*		*3,700*
03	*20/8/06*	*Greasing*		*200*	*3,500*
04	*27/8/06*	*Fine from Acen*	*600*		*4,100*
05	*2/9/06*	*Replacement of nuts*		*1,850*	*2,150*

Community relevant accountability practices

It is not enough to just have books of accounts in place without developing a usable system through which the community could critique the contents of the financial records. It is being proposed that, accountability for funds utilized be done in the following ways:

- During community meetings especially when feedback is being provided on WATSAN surveys
- Pinning of notices that show all funds collected and utilized
- Liaising with the LLG extension workers to cross check used funds and make reports to the community on a quarterly basis
- Banking all funds and making bank statements/bank books public after every quarter

PART V

Community Sanitation Policing

COMMUNITY POLICING: STANDARDS AND ENFORCEMENT

16

What is contained in this Part

Three units are contained in this part with the first handling formulation of bye-laws and standards; the second unit is on bye-law education and awareness while the third focuses on enforcement of laws. The purpose of this part is to enable communities understand their own situation and develop bye-laws that are relevant, acceptable to them, and easy to enforce.

16.1 Formulation of Standards and Bye-law

While sanitation is used by individuals and households, failures to do so have bad spill-over effects on the entire community. For instance, having no latrine by one household would mean they dispose off their waste in the open and flies that are disease spread vectors will know no boundary when spreading the diseases in the community. To avert this, there is need to ensure that everyone in the community adhere to best sanitation practices. Doing so is what is called Community Sanitation Policing. Inherent herein are:

- The community must set its own standards of best sanitation practices. This is the sanitation Bye-law.
- The community must conduct an education and awareness creation among its members about the bye-law so as to enable the enforcers to be accepted.
- The community must enforce the bye-law after the agreed upon grace period.

16.2 The legal framework of safe sanitation

In Uganda sanitation management and practices are guided by both institutional and legal frameworks. The legal framework comprises of the sector policies, other statutory instruments and local bye-laws and structures. Therefore, other lower legal systems such as the district ordinances, lower local governments and community bye-laws can be built on these because all other laws should be consistent with the existing state laws, especially with the constitution, which is the supreme law of the country.

The following are the key policies and laws that govern water and sanitation management in Uganda:

- The National Environment Management Policy (1994) among other objectives emphasize on environmental health and sustainable water resources management.
- The Constitution of the Republic of Uganda(1995): Article 39 states that, Every Ugandan has a right to a clean and healthy environment
- The National Environment Act (1995) Cap.153 emphasizes on environmental quality and sustainability, and legal and institutional frameworks for the sustainable management of environmental resources, which include water.
- The Local Government Act (1997) Cap. 243 2ndschedule spells out environment and sanitation as part pf the functions of Local Governments. This means that local governments should plan and budget for the management of environmental resources and sanitation facilities.
- The Water Act 1999 Cap.152 provides for rights in access to safe water, planning for water use and easements and sustainable management of water resources.
- The National Water Management Policy (1999) emphasizes on the provision of adequate quantity and quality of water for all social and economic needs.
- There are standards and regulations related to wastes management and pollution, water resources management/conservation and sanitation. Examples of such standards and regulations include; standards on discharge of effluent into water and land(No.5 of 1999), regulations on the use of wetlands(No.59 of 2001), regulations on riverbanks/lakeshores (No.3 of 2000) and hilly/mountainous areas (No.2 of 2000) , regulations on sewerage(1999), the water supply regulations (1999) and regulations waste on management (No.52 of 1999)
- Community service orders in polluter pays principle; for example in this case, if a person pollutes water

that is used by a community, s/he is forced to either clean up the water source or do other work like cleaning a public sanitary facility to compensate the community.

- Nebbi District Public Health Bill (2003); this bill spells out primary health care, occupational safety, water and sanitation.

Thus, in order to ensure effective enforcement of the above legal systems and enhancement of the formulation and enforcement of the local/community bye-laws, there is need to first educate the community as mentioned in the previous unit of this manual. However, it is not enough to sensitize the community but rather customize the existing legal systems into acceptable local/community bye-laws for a popular and effective compliance and enforcement on safe WATSAN management.

16.3 Community Bye-law formulation

It should be noted that:

- It is best practice to take the initiative of community policing (bye-law formulation and enforcement) after the supply of facilities and effective community education on sanitation. This is because the community would have known the benefits of sanitation practices.
- The process should be spearheaded by the Village Health Committee who are knowledgeable of the reasons for sanitation but owned by the Community with vested powers in the elected leaders.

Below is the summary of the process of formulation of local bye-laws on safe sanitation:

- Hold a caucus meeting with LCs and other community leaders to spell out the urgency of the sanitation Community Policing process. This can be derived from the proposed actions during the community planning held in Part II – Baseline Feedback meeting.
- Mobilize the community for the community bye-law formulation meeting. Use the different channels to ensure that all community members attend the meeting.
- Hold a community meeting. During this meeting, dwell on the need for having a Community Policing framework in place. Use evidence from the results of your work and the consequences of stubborn failure to drive the point home.
- Allow the community to set their own standards in respective to sanitation. This discussion should be allowed to be weighed on what the community see as its priority needs rather than taking the entire sanitation chain management which is ideal but ambitious. Such an agreement, after an elaborate discussion should specify:

    - The core sanitation practices desired within a specified period of time. For instance, in the next 3 months, all households must have a toilet facility, in 6 months all must have garbage and soak pits, etc. These will be core benchmarks and indicators to start with.

    - The enforcement frameworks, that is:

1. The enforcement agency that must comprise of the LC courts, CHFAs as monitors, and the community as beneficiaries.

2. The penalties for defaulting to do so. E.g., failing to have a pit latrine will cost Ushs 50,000.

3. The grace period within which enforcement of the bye-law will commence because everyone would have been given reasonable time to put in place the standards required.

4. Post penalty management whereby should one default even after LC Court ruling how s/he will be handled.

5. Roles of LCs in the management of community land especially dumping grounds.

- Draft the agreed upon bye-law. A small team of VHC and the LCs should then compile the community agreed upon views for on-use.

- Seek legal assistance. To make the bye-law consistent with the existing laws of Uganda, the service of a legal mind should be sought be it from a resident magistrate or a lawyer. This put the draft bye-law in consultation with the community leaders in a format that is consumable by courts.

- Secure approval by the sub county council. It is a requirement that LC3 approve of any community bye-law before its enactment and enforcement. This makes the LC 3 responsible for its implementation should there arise the need for arbitration.
- Launch the bye-law with participation of all the key stakeholders. During this launch, invite the district and sub county leadership. Their presence with echo the importance of the bye-law and provide support for its enforcement. Equally, disseminate copies of the launched bye-law to the various organizations and leaders.
- Educate the community. Create community and stakeholder awareness on the bye-law especially on its penalties as well as the agreed upon grace period.

- Enforce the formulated bye-law.

16.4 Community education and sensitization on bye-law

As soon as the bye-law has been launched, it is important that the community is made aware of it. This community education on the bye-law will enhance people's knowledge of its implications for themselves as individuals and as a community.

The following methods can be used:
- Passing the message during any public gathering as in churches, mosques, funeral sites.
- Organizing community education meetings.
- Through LCs mobilizers to pass it to their communities.

16.5 Bye-law enforcement

Sanitation enforcement is a set of actions set to achieve sanitation compliance to correct or halt conditions that can endanger community health. Enforcement relates to the existing legal and institutional frameworks established by the community in its bye-law.

The following are the key practices to ensure sanitation enforcement:
- Declaration of public clean-up and enforcement week.
- Conduct routine home inspections to identify defaulters.
- Facility audit and inspections by extension workers.
- Compile the list of defaulters and submit to LC Courts.
- Enable the court to mobilize the LC leaders, the community and the defaulters.
- Stand as a plaintiff against the defenders (defaulters) during the court session.
- Monitor LC Court decisions to ensure compliance.
- Provide feedback to the community to assess how the bye-law is being used or abused.

16.6 Post penalties management

There may be difficult cases of non-adherence and defiance to the established local/community bye-laws. This will depend on the attitudes and behaviours of individuals or norms, values, beliefs, practices and qualities of a community or household. Such differences in society can cause complications in community action planning and local bye-law formulation and enforcement.

The following strategies/alternatives could be applied in difficult cases:
- Holding a VHC meeting with LCs to ask for the next step.
- Warning and sensitization of the culprit(s).
- Using community service orders
- Referral to higher courts to deal with the case in line with other laws of Uganda.

16.7 Bye-law review

Overtime, the community may realize that its growth path in terms of bye-law implementation requires a review of their bye-laws. Once the community has realized this, the existing bye-law must be subjected to scrutiny by the community members. In doing so, they must:
- Know what achievements they scored with the past bye-laws.
- Explore what worked well for replication.
- What did not work well for modification.
- What more needs to be done (new plan).

PART VI

Performance Assessment and Review

PARTICIPATORY PERFORMANCE ASSESSMENT

17

What is contained in this Part

After going through the entire process, this part provides insights into how CHFAs together with their BO members could check back and (re)design alternatives for better health

17.1 What performance assessment is

Performance assessment is concerned with routine monitoring of what CHFAs are doing for the benefit of their BO members. This monitoring is all about checking progress of work done within a given interval. The purpose is to collect information for timely decisions (sometimes corrective) to be made. The decisions to be made should be accepted to the people concerned. This therefore, calls for collective involvement and genuine participation of the BO members and leaders so that the monitoring results are accepted and owned. This is because monitoring results help us to know what we are doing well (to design strategies to strengthen), what we are doing badly (to make corrective interventions) or whether we not producing change at all (to look for alternatives).

17.2 What participatory monitoring is

Participatory monitoring can be referred to as:
A process of joint tracking of mutually agreed-upon commitments (procedures, targets, resources, and outcomes) to ensure that CHFAs are effectively impacting in the lives of their BO members.

This definition carries the following core issues:

A process	Inherent herein is that monitoring is not a snapshot event that is done once and for all. Rather, it is conducted throughout the different stages of the community management of Preventive Health process.
Joint tracking	Herein emphasis is on the fact that monitoring is not done by one individual or institution. Rather, that it is done collectively by all the Bo members as well as other stakeholders.
Mutually agreed upon	This means that monitoring is based on a meaningful understanding among different stakeholders on how things are to be done and what results are expected.
Commitment	Commitment goes beyond adherence to the principles and regulations regarding the work of CHFAs to real action to ensure that planned results are also achieved.

17.3 Monitoring scheme

As is shown in the diagram above, performance assessment will also focus on:

- Where the BO started from in terms of sanitation and HIV/AIDS status.
- What has been done so far.
- What results are visible among the BO membership.
- What challenges are curtailing increased change processes.
- The way forward in causing more change.

17.4 Monitoring methods

The following methods will be used in monitoring CHFA performance:

a) BO Committee home visits: Every BOs committees will be required to co-participate with CHFA by ensuring that they also make home visits to BO members' homes so that they are able to support and or counter whatever reports they are receiving.

b) Bi-annual AFARD review meetings: During the joint (bi)annual reviews, AFARD team will observe, require CHFAs to discuss in-depth, and probe the BO members on what is taking place in their areas with regards to water, sanitation, and HIV/AIDS.

c) Household surveys: CHFA can from routinely conduct such a survey using the template provided to ascertain quantitative progress made in their area.

d) Photography and video: AFARD team will from time to time undertake to document CHFA work in photos and videos that can help visualize WENDI. It is also envisaged that every BO will by year 2-3 be taken through participatory photography training in order that they can collect and document their own sets of photos that can tell their story better.

17.5 Periodic reporting and accountability

CHFAs are required to report to AFARD quarterly on their performance using the form below. A copy of this form should be signed by the leader of the CHFAs of the BO as well as by the BO chairperson. It must be attached to the main BO quarterly report. However, this report form simply captures outputs of CHFAs work. Outcomes, as is set in WENDI document, will be monitored periodically after every 3 year. Doing so in the interest of WENDI programme, however, should not be construed to curtail every BO in conducting its routine outcome performance.

Table 15: Community Health Frontlines Advisors Quarterly Report Form

Name of beneficiary organization……..
Report filed by: ……Report verified by: ……
Date of report…….

Parameters	Key aspects to report on	Performance status
Assessment of health needs	Number of assessment for Safe water conducted	
	Number of assessment for Safe Sanitation conducted	
	Number of assessment for HIV/AIDS conducted	
Planning for health education	Number of planning sessions for Safe water held	
	Number of planning sessions for Safe Sanitation held	
	Number of planning sessions for HIV/AIDS held	
Mobilizations for health education	Number of mobilization for Safe water held	
	Number of mobilization for Safe Sanitation held	
	Number of mobilization for HIV/AIDS held	
Community education on health issues	Number of sessions held	
	Number of male sensitized	
	Number of female sensitized	
Participation in community actions	Number of Safe water events	
	Number of Safe Sanitation events	
	Number of HIV/AIDS events	
Reporting & accountability	Submitted report to BO (Yes / No)	
Exemplary leadership	Number of CHFA who drink water from safe source	
	Number of CHFA who have pit latrines	
	Number of CHFA who tested for HIV/AIDS	
Advocacy for community health	Number of sessions held	
	Number of leaders reached	
Bye-law enforcement	Number of Households visited	
	Number of culprits taken to court	
	Number of cases won	
	Number of beneficiaries expelled	
Initiating innovations	Name of new idea initiated	
Leverage building	Activities implemented with government officials	
	Activities implemented with non-BO members	

ANNEX 1

ABOUT GORTA

Gorta (the Irish word for extreme hunger) was founded in 1965 under the aegis of the Department of Agriculture as the agency with responsibility for tackling hunger through small-scale agricultural development projects in the developing world. From its formation, Gorta's approach to the reduction of poverty and the elimination of hunger has been through helping people in developing countries grow their own food especially through direct small and rural projects' support. Gorta's vision is "a world where there is no hunger and where the poorest communities have the means to create a prosperous future for themselves and their children". Herein, hunger is addressed from a broader focus such as food and water security that sustains life; healthcare that saves lives; education that empowers; and livelihoods that create prosperity in a manner that strives to achieve sustainable social, environmental, and economic justice for all.

ANNEX 2

ABOUT AFARD

The Agency for Accelerated Regional Development (AFARD) is a local professional, not-for-profit, non-denominational NGO. It was formed in July 2000 by professional sons and daughters of West Nile because: First, the west Nile region is the poorest in Uganda with over 6 in ten people living below US$ 1 a day. Second, many development interventions have been 'external to local context' and imposed. Third, decentralized governance has not made people citizens of the state. Finally, the high human resource flight of natives of the region has continued to limit innovations and enthusiasms to work for self-development. Thus, the vision of AFARD is "a prosperous, healthy and informed people of West Nile" and the mission is "to contribute to the moulding of a region in which the local people, including those who are marginalized, are able to participate effectively and sustainably and take a lead in the development of the region".

ANNEX 3

Water and Sanitation household questionnaire

Name of Group: ……..Name of Enumerator: ……Name of Supervisor: …… Date of Enumeration: ……

1. Beneficiary identification & Household characteristics

Name of respondent	Sex 1 Male 2 Female	Age in full years	Marital status 1 Single 2 Married 3 Widow(er)	Educational status 1 None 2 Primary 3 Secondary 4 Tertiary	Number of people in the household		Main source of livelihood 1 Farming 2 Fishing 3Business 4 Employment income 5 Property income 6 Family support 7 Sale of labor 8 Others (specify)	What is your main water source for drinking? 1 Borehole & protected springs 2 Rain harvesting tank 3 Stream, lakes, rivers 4 Others	What is the distance in KM to the water source?	How long (in hours) does it take to & fro fetch water from this source?	Housing type 1 Permanent 2 Semi-permanent 3 Temporary	What is the main source of lighting? 1 Electricity 2Paraffin lantern 3 Tadooba 4 Firewood 5 Candles 6 Others (specify)	What is your cooking technology? 1 Sigiri 2 3-stone stove 3 Improved cook stove 4 Electric cooker 5 Gas cooker 6 Others (specify)	What is your main means of transport? 1 Foot 2 Bicycle 3 Motor cycle 4 Vehicle 5 Boats /Canoes	What is your main source of extension information? 1 Radio 2 Television 3 Print media 4Mails 5 Community meetings 6Mobile phones 7 Neighbours 8 Extension staffs 9Others (specify)
					Males	Females									
1															
2															

2. Human development (Safe water and sanitation chain anagement practices and outcomes)

How many people in your households (in numbers)						Does you home have..? 1 = Yes 2 = No								Do you practice the following for vector controls? 1 = Yes 2 = No								Health and socio-economic effects											
Have smart hair?	Brush their teeth once a day?	Have clean nails?	Bath once a day?	Have no skin disease?	Have clean cloths?	A kitchen	A bath shelter?	Utensil drying racks?	Cloth line?	Soak pit?	Garbage pit?	Pit latrine?	Hand washing facility?	Use safe drinking water	Cover water storage facility	Use 2 cups for drinking water	Have separate sleeping room	Sleep on a raised bed (Kitanda)	Cover latrine pits	Sleep under a mosquito net	Serves food on individual plates	How many people fell sick in the last 1 month from water related diseases				How many days were they sick?	How many died of malaria?	How many children 4-15 years fell sick?	How many days were children 4-15 years sick?	How many children under18 year fell sick of malaria?	How many children under18 year died of malaria?	Did you not point a finger at witchcraft?	Where were they treated? 1 Health centre 2 Home 3 Herbalist 4 None	How much money was spent on their medical treatment (in '000 UGX)
																						All kinds of ailment	Malaria	Gastro intestinal worms	Respiratory tract infections									

ANNEX 4

HIV/AIDS prevention and mitigation individual questionnaire

Name of respondent (Copy from page 1)	What is HIV/AIDS? 1 A germ 2 A bad omen 3 Normal sickness 4 Bad air originating from witchcraft 5 Others (specify)	In what ways may HIV/AIDS be acquired from one person to the other? 1=Yes; 2=No						What are the main symptoms of HIV/ AIDS? 1=Yes; 2=No								How can you prevent acquiring HIV/ AIDSs? 1 = Yes; 2 = No								How can Persons Living with HIV/AIDS live positively? 1=Yes; 2=No									
		From infected pregnant mother to the unborn baby	From infected mother to baby through breast feeding	Sharing unsterile materials	Contamination of open wound with secretion from an infected person	Sexual intercourse with an infected person	Able to state 3 modes of transmission	Marked weight loss	Persistent fever	Persistent Cough	Generalized skin rashes	Enlargement of lymph nodes	Oral thrush	Recurrent diarrhea	Herpes Zoster	Able to state 3 symptoms	Abstaining from sex if not married	Being faithful to one's marital partner	Use of condom with those of unknown status	Use of contraceptive pills	Testing and knowing your status	Avoiding use of unsterilized instruments	Avoiding injections from untrained persons	Using screened blood	Able to state 3 modes of prevention	Accepting to live openly without hiding status	Eating nutritious and well balanced diet	Being faithful to ones partner	Avoiding infecting other people	Carrying out income generating activities	Seeking advice and counseling	Treating opportunistic infections promptly	Avoiding risky behavior like drinking, smoking	Using condoms	Able to state 3 modes of positive living
1																																	
2																																	
3																																	
4																																	

Name of respondent (Copy from page 1)	What is HIV/AIDS? 1 A germ 2 A bad omen 3 Normal sickness 4 Bad air originating from witchcraft 5 Others (specify)	What services are essential for HIV/ AIDS prevention and mitigation? 1 = Yes; 2 = No														Are you willing to....? 1 = Yes; 2 = No												Sexual behavior:												Critical behavior change information 1=Yes; 2= No; 3= Not applicable											
		Voluntary Counseling and Testing (VCT)	Prevention of Mother-to-Child Transmission	Skills training for Income Generation	Life Skills training	Orphaned and Vulnerable Children's Skills training	Safe motherhood services	Community Awareness Programmes	Able to state 3 support services							Test for HIV/AIDS?	Care for PLWA?	Care for OVC?	Buy from and sell products to PLWA?	Encourage a PLWA to confess his/her status?	Share food with a PLWA?	Voluntarily associate with a PLWA?	Has at least 5 positive attitudes for care/support					Do you have casual sexual partner(s)? 1=Yes; 2=No	How old (in years) is s/he?	Did you have sex with her/him in the last 1 month? 1=Yes; 2=No	Do you always use a condom during sexual intercourse with this casual sexual partner? 1= Yes; 2=No	Was payment in cash or in-kind involved in the relationship? 1=Yes; 2=No					Are you abstaining from sex (if not married)?	Are you faithful to your married partner?	Are you a member of a Post Test Club?	How many Persons Living with HIV/AIDS are you supporting?	How many Orphans and Vulnerable Children are you supporting?	Have you tested your HIV/AIDS sero-status?	Are you currently using ARV if tested positive?	Did you deliver your last baby under medical supervision?					
1																																																
2																																																
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4																																																
5																																																