

LEARNING BRIEF: Nuyok Activity in Karamoja



Beyond CLTS: Leveraging Social Mobilization to Address Sanitation and Hygiene in Karamoja through the Home Improvement Campaign (HIC)

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SERIES

This learning brief is part of a series bringing together experiences and lessons learned from the Nuyok Resilience Food Security Activity (2017–2023). The briefs are designed for practitioners, including local government representatives, civil society organizations, and other actors working on natural resources management, sanitation, and livelihoods-related issues.

ABSTRACT

This learning brief presents how the Home Improvement Campaign (HIC) approach can motivate households to share resources and tasks to increase sanitation and hygiene coverage, highlighting the Nuyok RFSA's experience implementing HIC in Karamoja. Lessons learned and recommendations in this document intend to help development partners, including local government, civil society organizations, and donors plan and design effective and successful interventions in similar areas.



DISCLAIMER

This learning brief is made possible thanks to the support of the American people through the United States Agency for International Development (USAID). The contents of this learning brief are the responsibility of Catholic Relief Services and do not necessarily reflect the views of USAID or the United States Government.

PHOTOS

Nuyok Resilience Food Security Activity. All photos reproduced with permission.

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ACRONYMS

BCC	Behavior Change Communication
CLTS	Community-led Total Sanitation
CRS	Catholic Relief Services
CU5	Children Under Five
HH	Households
HIC	Home Improvement Campaign
ODF	Open Defecation Free
PBAS	Participant-based Annual Surveys
PHAST	Participatory Hygiene and Sanitation Transformation
RFSA	Resilience and Food Security Activity
RWANU	Resiliency Through Wealth, Agriculture, and Nutrition in Karamoja
USAID	United States Agency for International Development
VHSC	Village Health and Sanitation Committee
WASH	Water, Sanitation, and Hygiene

ACTIVITY BACKGROUND

The Nuyok Resilience Food Security Activity (RFSA) sought to build resilience to shocks, enhance livelihoods, and improve food and nutrition security for at-risk rural families in the Karamoja sub-region of Northeastern Uganda. Funded by the United States Agency for International Development (USAID) Bureau for Humanitarian Assistance, the activity operated for 6 years (2017–2023) under a consortium of seven implementing partners led by Catholic Relief Services (CRS)—Caritas Moroto, Caritas Kotido, Cooperation for Development, The BOMA Project, Communication for Development Foundation Uganda, and YouthBuild International. The activity reached more than 269,000 at-risk people across 524 villages in four Karamoja districts—Abim, Napak, Nakapiripirit, and Nabilatuk—targeting women, men, and youth. Using a multi-sectoral approach, Nuyok worked to strengthen governance, gender equity, community capacity to manage shocks and stresses, and traditional and diversified livelihood opportunities. Nuyok also focused on improving nutrition, health, and water, sanitation, and hygiene (WASH) for pregnant and lactating women, adolescent girls, and children under five years of age (CU5).

Sanitation and Hygiene Context

In Uganda, latrine coverage for Karamoja stands at 36% which is lower than 77% national coverage.¹ According to the guidelines issued by the Ministry of Health, every household must have a latrine but in Karamoja, about 70% of the communities practice open defecation.¹ District local governments and development partners have implemented Community-Led Total Sanitation (CLTS) triggering since 2009, however latrine coverage and hygiene conditions such as hand washing, bathing, cloth washing, and compound cleaning remained poor. Additionally, latrines are often sited close to water sources, in unstable soil, or in non-private settings. The Ugandan CLTS strategy aims to disrupt the fecal-oral contamination route, focusing not only on latrines, but also on broader household hygiene.

Nuyok began its initial sanitation interventions by implementing CLTS. However, the Resiliency through Wealth, Agriculture, and Nutrition in Karamoja (RWANU)² endline report³, and Nuyok’s own mid-term evaluation recommendations and field experiences revealed how poorly the triggering process was perceived by community members. In particular, communities become upset during the food and water demonstrations—in which feces is mixed in with food and water to show the spread of disease. Communities found this insensitive to the food and water insecure. As a result, in 2019, Nuyok changed its sanitation and hygiene implementation approach from shame-based CLTS triggering to the Home Improvement Campaign (HIC). The HIC approach aimed to build a cohort of ten community members in each village to act as community sanitation and hygiene advocates to mobilize and motivate other household members to construct and use hygiene and sanitation facilities required by the Ministry of Health. The HIC approach, designed by CRS, drew on Participatory Hygiene and Sanitation Transformation (PHAST)⁴ and the Village Health and Sanitation Committee (VHSC)⁵ methods of improving both sanitation and hygiene facilities and practices at the household level. The ultimate goal was to see 20 villages in each district reach Open Defecation Free (ODF) status—the highest level of sanitation and hygiene achievement.

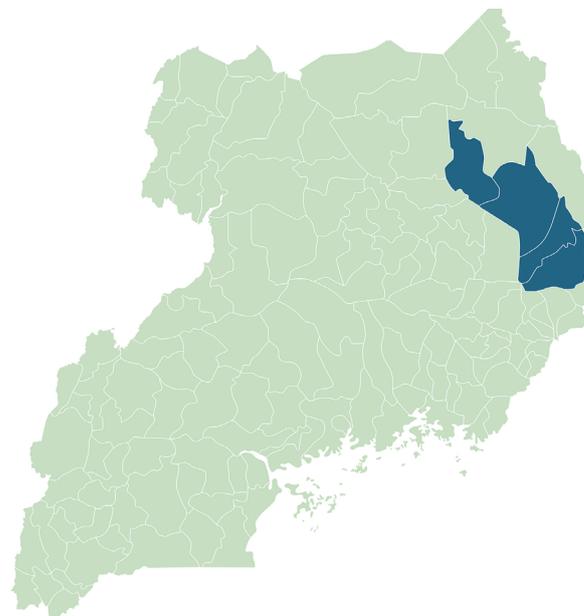


Figure 1. Nuyok’s four project areas highlighted in red: Abim, Napak, Nakapiripirit, and Nabilatuk

1 MWE (2022). [Programme Performance Report 2022](#). Ministry of Water and Environment.

2 [RWANU](#) was an USAID/Food for Peace-funded program in the Karamoja region implemented by ACDI/VOCA (2012-2017).

3 Longley et al. (2019). [Final Performance Evaluation of Resiliency through Wealth, Agriculture, and Nutrition in Karamoja \(RWANU\)](#). USAID.

4 WHO (1998). [PHAST step-by-step guide: A participatory approach for the control of diarrhoeal disease](#). World Health Organization, Division of Operational Support in Environmental Health.

5 National Health Mission, India (n.d). [Village Health and Sanitation Committee Resource Page](#). Ministry of Health and Family Welfare, Government of India.

Village-level Home Improvement Campaigns

The HIC approach focused on creating hygienic households through five key sanitation and hygiene facilities and their related practices. Namely, latrines, handwashing stations, rubbish pits, drying racks, and bathing shelters. Behavior change communication (BCC) materials also included additional facilities including granaries for food storage, and animal shelters such as chicken houses and cattle pens (krals).

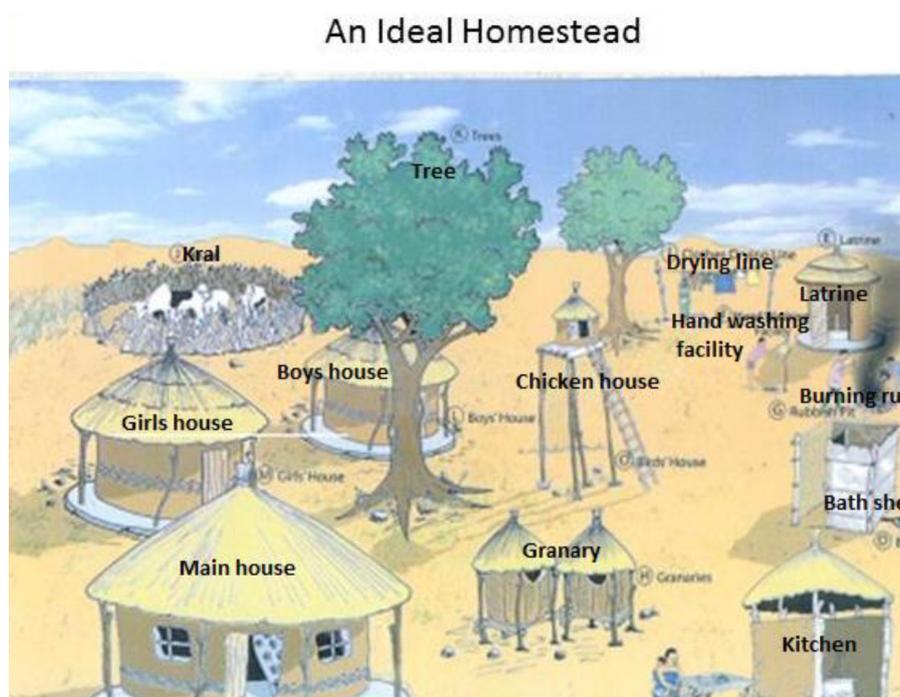


Figure 2. Improved facilities and practices promoted by the HIC. Adapted in 2015 from VHSC Material (not publicly available) from Sudan.

The HIC process involved five steps as summarized in Figure 3 and was adopted in all 524 villages targeted by Nuyok. The HIC process was led by Nuyok field agents who visited communities to introduce the HIC concept and create buy-in from local leadership. This was followed by selection and training of cluster members, who were responsible for rolling out HIC within each village. The project also provided each village with basic construction tools. In each village, Nuyok staff and selected sanitation champions (named cluster members) alongside the then routinely monitored changing access to latrines and other hygiene facilities. The roles and responsibilities of HIC stakeholders are summarized in Table 1.

While there are many similarities between the HIC approach and traditional CLTs, there are three key differences. Firstly, the approach does not have a community triggering event, rather a village meeting with the goal of explaining the objectives of the approach and not triggering behavior change. Secondly, the approach relies on sanitation champions (cluster members) as social mobilizers to advocate for behavior change as first movers. Lastly, the approach goes beyond focusing on ODF (although this was tracked in the project as an indicator of change) to incorporate aspects of an improved home.



Figure 3. Process flow of Nuyok's Home Improvement Campaign model

Table 1. Stakeholders in the HIC approach

Nuyok Field Agents	Nuyok staff acted as the catalysts, introducing the approach to community leaders and members, training cluster members, and supporting the monitoring of changing practices.
Community Leaders	Community leaders provided backing and support for the HIC campaign. In a small number of communities, leaders also enacted by-laws to sanction poor sanitation practices.
Community Members	Community members, including the at-risk, were involved in the hygiene and sanitation campaigns, and the approach encouraged a sense of ownership and commitment. The HIC approach also provided hands-on training sessions on latrine construction and distributed tools to clusters to strengthen community social support for latrine construction.
Cluster Members	Cluster members acted as community advocates and consultants on sanitation and hygiene facilities and practices. Cluster members were first trained on household hygiene and then on the technical specifics for latrine construction. Cluster members started by constructing latrines in their own homesteads to set an example for their communities. They then supported other households to follow suit. Cluster members were actively involved in monitoring the community’s sanitation and hygiene practices and ensuring that latrines were completed, and villages were on track to becoming ODF.
Health Assistants	The Ministry of Health’s sub-county health assistants provided technical support and oversight to the strategy. Involving government staff within the HIC approach helped support campaign sustainability and community impact.

The HIC strategy aimed to move away from shame-based triggering practices, instead leveraging social mobilization techniques, which have proved effective in Uganda (Kasese and Kitgum) and other African contexts. For example, a Ghanaian study found that social mobilization was the most effective part of the CLTS process leading to latrine construction. Such findings resonate with Nuyok’s HIC approach and success indicating that positive social pressures may be more effective than shame-based triggering in Karamoja contexts.



A homestead with a latrine, bathing facility, and handwashing tippy-tap in Opopongo village, Nyakwae sub-county, Abim district, Karamoja (Photo Credit: Felix Achunge)

Measuring Impact

The impact of the HIC approach has been explored through a variety of monitoring and assessment approaches. Each of these had unique focuses, objectives, seasonality, and sampling and as such can be read together to create a picture of Nuyok’s impact. This learning brief highlights four of the evaluation approaches: 1) an externally managed qualitative assessment of the HIC approach; 2) an annual participant-based survey (APBS); 3) routine monitoring; and 4) case studies of household-level impact. Together, these four approaches illustrate the non-linear nature of sanitation and hygiene improvements at the community and household levels.

Qualitative Assessment

In 2023, CRS conducted a study⁶ to assess the effectiveness of the HIC approach in increasing acceptability and use of latrines in Karamoja. While the study did not compare differences between HIC and CLTS villages, the study was able to explore which aspects of the HIC approach were most important in motivating change. The study was conducted in four operational districts (Abim, Nakapiripirit, Nabilatuk, and Napak) and involved purposive sampling of cluster members and non-cluster members, as well as key informant interviews (KIIs) and observation of latrines. A total of 220 participants took part in 22 focus group discussions (FGDs), and 60 latrines in 12 villages were inspected for quality assessments. Participants were from both ODF and non-ODF villages. The data collected was thematically analyzed to examine how HIC was changing attitudes towards latrine construction and use.

The study found that, overall, the HIC approach positively impacted latrine construction and use among households in villages, largely because of the social mobilization component.

- **Leveraged learned experiences.** HIC created opportunities for a small number of people (cluster members) to construct latrines and then replicate these facilities and practices within their village. As such, cluster members were not relying on secondary information, but on their own recent experiences in sanitation and hygiene.
- **Fostered social support structures.** HIC created a cohort of over 5,000 community advocates who were trained on both communication and technical aspects of sanitation and hygiene. However, training alone was not sufficient, the success of the strategy depended on the interest and motivation of members.
- **Promoted community-based monitoring.** HIC initiated community-based monitoring and evaluation of improvements where the cluster members and the village health team members voluntarily and informally move, observe, and note new sanitation and hygiene facilities in their village. With the knowledge of ODF, they evaluate and pronounce a village ODF and inform project staff to verify and confirm the status.

However the study also identified barriers to latrine construction and use, namely cultural norms and beliefs and upkeep of constructed latrines. The HIC approach aimed to address these challenges, but further modalities of refinement and reinforcement are required to strengthen future HIC outcomes.

- **Complex cultural norms and beliefs about sanitation.** The study found that social and cultural norms play a significant role in latrine ownership and use. Nearly half (46%) of the respondents believed open defecation was not a shameful act. However, the majority (58%) of the respondents did not agree that it was okay for women and girls to defecate in the open. Forty-nine percent agreed with the false statement that “open defecation doesn’t make people sick.”
- **Inconsistent upkeep of constructed latrines.** Most participants stated that latrines were not used due to bad odor (68%), lack of privacy (63%), lack of cleanliness, namely, human fecal matter littering latrines (63%), and safety and privacy threats arising from latrine locations (66%).

Box 1. Reflections from Respondents of the Qualitative Assessment

“The home improvement campaign program made it very easy for us to construct latrines due to new methods of taking measurements, how to site, and availability of tools provided.”- **Cluster member from Abim District speaking about the construction of latrines in his village.**

“...I think we can continue with this work [latrine construction and use] since we now know how to train people to build latrines. Maybe we can do it at a fee or even continue to train when we are approached with an objective of improving sanitation in our areas.”- **Cluster member from Nakapiripirit district speaking about the construction of latrines in his village.**

“...and another thing I can say that really helped to achieve the changes was the way Nuyok activity used the local people we know to reach us; even the materials they were training us to use, are readily available here.”- **Young man from the Napak district speaking in a focus group discussion about the HIC approach**

6 CRS (2023). Effectiveness of the Home Improvement Campaign Cluster Approach in increasing acceptability and use of latrines in the Karamoja sub-region.

Annual Participant-Based Survey

Nuyok also conducted annual participant-based surveys (PBASs) with participants to track changes over the course of the activity, including structured interviews with a sample in each district. Related to WASH, the surveys investigated latrine and handwashing station access. As Nuyok was implemented during the COVID-19 pandemic, hand hygiene was strongest during the peak of the pandemic in alignment with global messaging campaigns and health support. As such, the number of handwashing stations decreased from fiscal year (FY) 2021(32%) to FY2023 (19%). However, basic latrine access did see a 15% improvement over the life of the project (Figure 4). However, it should be noted that the majority (61%) of households share latrines with their neighbors and 22% of latrines are used by 10 or more households. It should be noted that this survey was not conducted as a census and so small variations are seen based on sampling, most notably in the number of ventilated improved pit latrines in FY23. However, the most important trends include the number of households who now have a latrine.

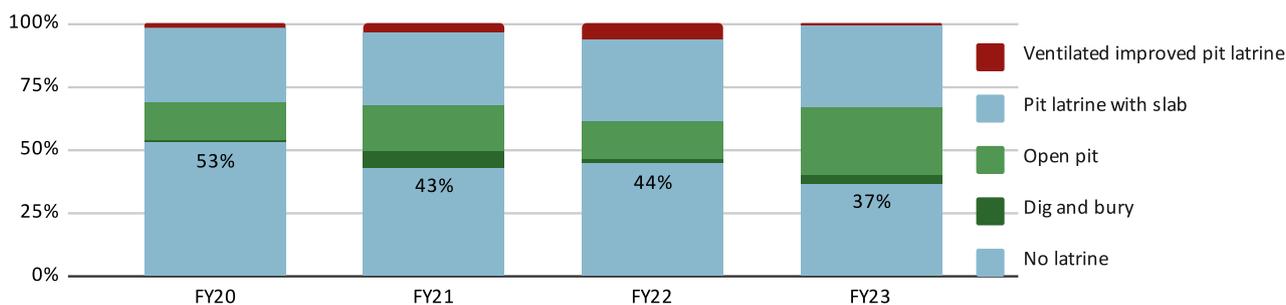


Figure 4. Improvements in latrine access over the course of the activity

Routine Monitoring

While the PABS studies focused on latrine and handwashing facilities, this information was triangulated and expanded with routine monitoring data as the HIC strategy emerged. Results from routine monitoring show both the uptake and continued use over the period from FY2020 to FY2023⁷ across each of the four districts related to five key HIC facilities (Figure 5): latrines, rubbish pits, handwashing station, drying racks, and bathing shelters. The largest overall average increases were seen in latrines (21%), rubbish pits (14%), and drying racks (9%). The impact on hand washing facilities, and bathing shelters was less sustained over time. This indicates that hand washing and bathing shelters may require different forms of support and further research is required. The monitoring also illustrates the significant differences between districts, with Nakapiripirit showing marked improvements in the last year of the activity. Further work is needed to identify if these impacts are due to the sampling strategy (Table 2) or connected to a localized implementation approach.

Notably, the PBAS and routine monitoring results were not always aligned due to sampling differences, seasonality, and different focuses. While latrine access saw similar trends, handwashing stations did not. As such, it is important to recognize that access to and use of less “durable” facilities such as handwashing stations may be more volatile, while more “durable” facilities such as latrines may be more easily monitored using traditional approaches.

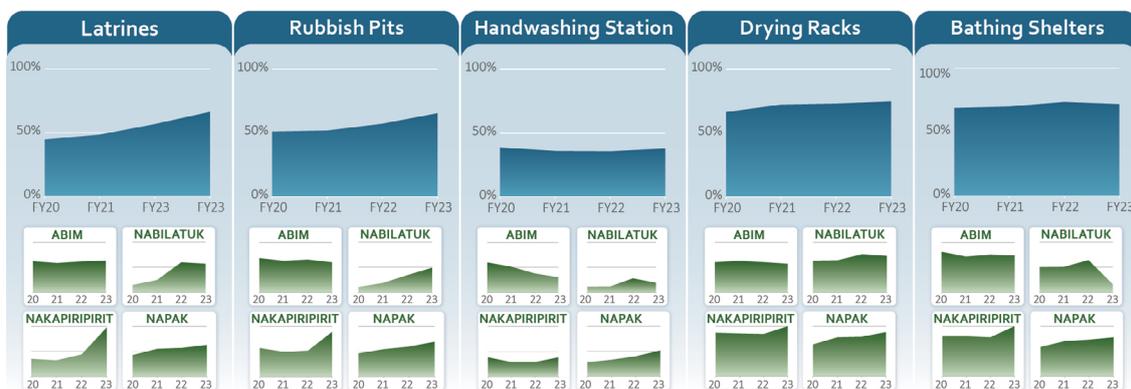


Figure 5. Routine monitoring for the five HIC facilities

⁷ Monitoring was conducted in FY2018 and FY2019, but in smaller sample sizes. FY2023 monitoring was conducted until July 2023

Table 2. Sample Size of Routine Monitoring Process

District	FY2020	FY2021	FY2022	FY2023
Abim	274	11,519	40,972	5,877
Nabilatuk	222	4,267	1,687	324
Nakapiripirit	292	7,578	5,106	33
Napak	1,542	5,885	7,596	751

Case Study: The benefits of having a latrine and handwashing facility

Longora John, a 35-year-old resident of Lolita Village (Lotome Sub-county, Napak District) is married with 3 children, including a new baby. In the second quarter of 2020, Nuyok rolled out HIC in the 41-household village. After two quarters of implementation, the first ODF verification was conducted in February 2021 and was declared open defecation free on the 13th April 2021. As of February 2023, Lolita was still ODF.

Before constructing a latrine and a handwashing facility, John's family used to practice open defecation and never washed their hands with water and soap after using the bush. Visits to the clinic and health center were frequent because of diarrhea cases. In January 2020, a cluster member (Acia Mark) visited his family and expressed concern over the sanitation and hygiene status of his home. Mark maintained that his household was the reason Lolita village was referred to as a "backward village" (a village where people practice open defecation). John then explained to Mark his household limitations (limited construction skills and inadequate family labor) and Mark offered to mobilize the other cluster members to support. In collaboration with Mark and his colleagues, John was able to obtain local materials and construct a latrine and a tippy tap. Mark also helped John and his family understand what an ideal homestead is and the importance of handwashing at critical times. John now confidently relates with communities including cluster members without fear of being mocked by community members for keeping the village in a "backward state." Since constructing and using a latrine and handwashing facility, John's family has not experienced diarrhea and his medical bills have reduced. John is now interested in becoming a cluster member to support his village and other villages in his parish to reach ODF status.



John from the Lolita Village uses a tippy-tap next to his latrine and the household garden. (Photo Credit: Crinima Loum)

Box 2. Overall Impact and Results

- **Increased sanitation and hygiene.** After implementing HIC for 3 years in the four districts, routine monitoring data and PBAS highlight improvements in latrine coverage ranging from 15% (PABS) to 21% (routine monitoring) and potential improvements in rubbish pits (14%) and drying racks (9%). As this monitoring data adopted different sampling modalities, these values can be interpreted as improvements, but further research is required to explore the sustainability and scale of these improvements.
- **Achievement of open defecation status.** Open defecation free status was confirmed and declared in 50 villages out of 60 targeted across the four districts.
- **Improved social support systems.** Training 10 cluster members-per village (over 5,000 in total) to act collectively as community consultants on latrine construction enhanced the ability of vulnerable households (single headed, elderly, female headed) to construct their own latrines.
- **Improved latrine siting.** HIC study found that 87.3% of pit latrines were positioned at least 30 meters away from the nearest water source, preventing contamination and improving safety.

LESSONS LEARNED AND RECOMMENDATIONS

Building on the multiple forms of measuring and understanding impact, the project has identified a series of lessons learned and related recommendations for future programming.

- **Shame-based triggering can hinder improvements in food- and water-insecure areas by creating barriers between project staff and communities.** In Karamoja, CLTS shame-based triggering approaches were poorly received. Communities regarded the demonstration of fecal contamination of food and water as a misuse of the much-needed food most households lack. Some members think the action is an insult to their dignity and the right to good food. *Development partners and the government can avoid CLTS' shame-based triggering through tools such as the HIC which promote healthy homes through sanitation and hygiene facilities and practices.*
- **Not all clusters were equally effective.** Non-commitment from some cluster members resulted in low household interest and limited skill to construct a latrine, affecting the coverage and quality of some latrines. Some communities were unwilling to accept the approach, stating that they had inadequate construction tools and materials. *Future assessments could explore which traits and features facilitate successful clusters (such as gender, social status and capital, and age) to better select and support communities.*
- **Latrines and handwashing stations need to be designed to context, balancing local knowledge and external support.** Focusing on latrines, there is a need to design, test, and promote appropriate latrine designs and construction procedures for communities on top of mountains, in areas of high winds, and in areas with black cotton soil. These challenges lead to downhill water quality concerns, roofs blowing off, and ground instability respectively. Nuyok began this task by trialing two methods of pit lining (sandbags and wood poles) to address the problem of pit collapse in Karamoja. However future work could continue the testing and review of these pit technologies. Additionally, tippy taps were found to not foster sustained use, and more substantial hand washing stations are required. *Future development partners should explore research and prototyping approaches such as human-centered design to design contextual latrine and handwashing solutions which are technically feasible, durable, affordable, and desirable. The design work should also consider aspects of latrine construction which have led to latrine collapse within Karamoja more generally.*
- **Latrine access is not latrine use.** While Nuyok was successful in increasing sanitation and hygiene coverage, the endline qualitative study raised some concerns around latrine use in some groups. This included: (a) people working far from home in the fields; (b) young children scared to use the latrine without dirtying it or falling into the pit; (c) pregnant women afraid of harming their unborn babies in latrines; (d) people with disabilities requiring appropriate and inclusive latrines or support from others to access and use latrines; and (e) older adults requiring support for using and accessing latrines. Additionally the high numbers of shared latrines offers opportunities to encourage further household construction rather than a community-focus. *Future development partners could also utilize research and prototyping approaches such as human-centered design to adapt latrine designs and support behavior change campaigns around safe and appropriate use of latrines.*
- **Monitoring of sanitation and hygiene improvements is non-linear and complex.** As the HIC strategy emerged and evolved within the project, monitoring and assessing impacts became more complicated, requiring triangulation through a series of different assessment tools. The results highlighted the variability in monitoring results between “more-durable” and “less-durable” facilities such as latrines and tippy taps, respectively. *Future partners could explore different tools to monitor household level change as activities shift from a community to household approaches. Effectively, this represents a shift in monitoring from community-level ODF status towards a collection of household-level sanitation and hygiene facilities with varying levels of durability and life-spans. Future monitoring should ideally go beyond measuring access to facilities to include measures of use, maintenance, and repair.*
- **Social mobilization was an effective approach to move households up the sanitation and hygiene ladder.** Overall the HIC approach was effective in creating a cohort of village-based trained sanitation advocates with lived experiences of improving their own sanitation facilities and practices. *However, as sanitation and hygiene facility access was quite variable based on routine monitoring data, future partners could consider post-project monitoring to explore the sustainability of sanitation and hygiene improvements including risk factors and motivators. Such explorations could also involve collaborations with local government actors for information sharing, technical support, and data collection.*

