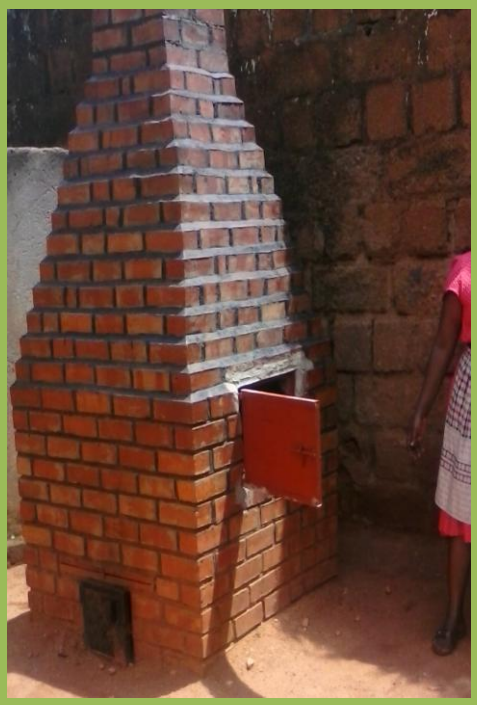
UWASNET

Rapid Assessment and Factors leading to Exclusion of Sanitation, Hygiene, and Menstrual Hygiene in Uganda



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Contents

Acknowledgements (*To be insterted*)

List of Acronymns

C&D	Communication & Development
CHAST	Child Hygiene and Sanitation Transfromation
CRPD	
CSOs	Civil Society Organisations
EVIs	Extremely Vulnerable Individuals
FGDs	Focus Group Discussions
GoU	Government of Uganda
JMP	Joint Monitoring Programme
KCCA	Kampala Capital City Authority
KIIs	Key Informant Interviews
LWF	Lutheran World Federatio
MHH	Menstrual Health and Hygiene
MHM	Menstrual Hygiene Management
MoES	Ministry of Education and Sports
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
MWE	Ministry of Water and Environment
NDP	National Development Plan
NUDIPU	National Union of Disabled Persons of Uganda
OPM	Office of the Prime Minister
OVC	Orphans and Vulnerable Children
PSN	People with Special Needs
PWDs	Persons with Disability
RBA	Rights-Based Approach
RCs	Regional Coordinators
SDGs	Sustianble Development Goals
SHCs	School Health Clubs
SIP	Sector Investment Plan
SMCs	School Management Committees
SNV	Netherlands Development Organisation
SOPs	Standard Operating Procedures
SPR	Sector Performance Report
SWTs	Senior Women Teachers
ToR	Terms of Reference
UBOS	Uganda Bureau of Statistics
UNHCR	United Naions High Commission for Refugees
USAID	United States Agency for International Development
USHA	Uganda Sanitation Health Activity
UNICEF	United Nations International Children's Fund
UWASNET	Uganda Water and Sanitation NGO Network

WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation
WSSCC	Water Supply and Sanitation Collaborative Council

EXECUTIVE SUMMARY *(To be inserted)*

1 INTRODUCTION

1.1 WASH and the Sustainable Development Agenda

The Sustainable Development Goals (SDGs) recognize water and sanitation as a human right and have set targets on "universal" and "equitable" access to Water, Sanitation and Hygiene (WASH) by 2030. Equitable and universal access cannot be achieved without specific gender equality measures in WWASH policy and programming to ensure that the rights of girls and women to water and sanitation are met. Due to the multiple links between gender equality and WASH, dialogue is encouraged as well as mutual understanding and consensus between gender and equality for WASH policymakers and practitioners.

WASH issues, like many other development issues, are highly gendered by nature. Access to WASH is mediated not only by poverty and lack of infrastructure, but by power and inequality. Women and girls are disproportionally affected by a lack of access to adequate WASH. Gender-related power dynamics and discrimination underlie the multiple impacts of living without adequate WASH, and women's and girls' ability to access basic WASH services. Therefore, achieving and sustaining universal and equitable access will require tackling issues of power, participation and inclusion in household and social gender relations, but also with regard to disability, age and other aspects of exclusion.

1.2 National WASH Plans and Strategies

Government of Uganda (GoU) recognizes that the water and environmental resources are critical in contributing to the achievement of Uganda's Vision 2040 and the National Development Plan (NDP) goals and objectives. Vision 2040 focuses on creating opportunities for wealth creation that will transform Uganda into a middle income country. The Vision underscores the importance and the central role of 100% access to water in the process of transforming Uganda[1]. It remains to be seen how this aspiration and commitment translates into proportionate prioritisation in resource allocation and implementation of quality and sustainable programmes.

In order to achieve Vision 2040, GoU has developed NDP III (2020/21-2024/25), whose goal is to increase incomes and improve the quality of life of Ugandans[2]. To achieve this goal, NDP III has set five development objectives one of which is Objective 4 to enhance productivity and social wellbeing of the population (please see summary in Table 1). Issues of water and sanitation and social protection of vulnerable populations fall under development Objective 4. These strategic development objectives provide the framework for streamlining and directing government, private sector, civil society and development partners' investments.

[1] Uganda Vision 2040
[2] Third National Development Plan (NDP III) 2020/21-2024/25), January 2020, National Planning Authority

Table 1: Extract from NDP III Key Development Results

Obj. 4: Increase productivity and wellbeing of the population		Baseline (2017/18)	NDP II Target	NDP III Target	Vision 2040 Target
WASH Coverage (%)	Rural water	74.9	79	85	100
	Urban water	92.3	100	100	100
	Sanitation (Improved toilets)	19	-	40	80
	Hygiene (hand washing)	24	-	50	90
Social Protection Coverage (%)	Social assistance to vulnerable groups (PWDs, OVCs, Elderly, Poor)	-	-	50	-

Source: NDP III (2020/21-2024/25); January 2020.

However, as far as hygiene is concerned, it is very clear that NDP III focuses more on handwashing; issues of Menstrual Hygiene Management MHM are not explicit in the national plan. Also, there is concern that priority for public funding in Uganda has been directed away from social sectors such as water and sanitation and health and education to those perceived to achieve accelerated economic growth and attainment of middle income status.

1.3 Snapshot of WASH in Uganda and the Sector Planning Framework

The Ministry of Water and Environment (MWE), the mandated institution to deliver water and environment services in Uganda, has a Vision, which is "Sound management and sustainable utilization of water and environment resources for the present and future generation". In order to achieve this vision, the sector has set one of its strategic objectives to increase access to safe water in rural areas to 79% of the population and 100% of the urban population by 2020, with 95% effective use and functionality of the facilities3. Further still, the MWE developed: i) the Water and Environment Sector Development Plan (2015/16-2019/20), aligned to Uganda's Vision 2040 and to NDP II (2015/16-2019/20; now NDP III); and ii) the Sector Investment Plan-SIP (2018-2030)4, which provides a logical, transparent rationale behind cross-subsector spending, and to inform sector-wide budgeting beginning in 2019/2020.

However, despite the existence of WASH planning frameworks, the water and sanitation access and coverage figures are still very low. The percentage of population using an improved water source stands at 68% and 70.5% for rural and urban areas respectively; while the percentage of population using an improved sanitation facility not shared with other households stands at only 18% in the rural areas and 44.8% in the urban areas. The percentage of population with hand washing facilities with soap and water at home stands at 38% in rural, 61.1% in urban; and 58% in schools, while 22% of the population still practice open defecation. Access and coverage figures on MHM are not known because menstrual hygiene is not one of the sector indicators for tracking progress on WASH. The low WASH access and coverage figures are partly attributed to low sector funding. According to SIP (2018-2030), the sector

[3] The Water and Environment Sector Development Plan (2015/16-2019/20), Ministry of Water and Environment
[4] Strategic Investment Plan for the Water and Environment Sector, Uganda (2018-2030), Final Report (2018).

requires a nine-fold increase in annual funding to reach 2030 targets. Under the current funding scenario, with an assumed moderate annual growth rate of 3% (approximately UGX 800 billion), the sector will not meet its 2030 targets; the Uganda WASH sector needs almost UGX 7.6 trillion over the next 13 years to 2030.

1.4 Study problem

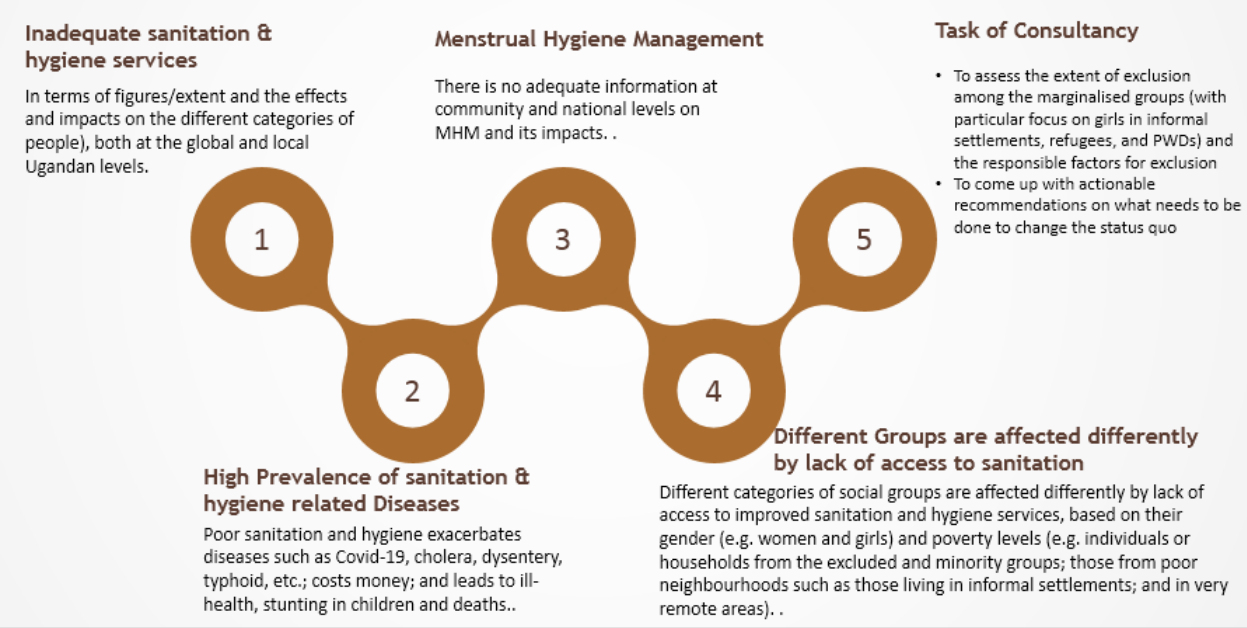
Poor sanitation and hygiene is linked to transmission of diseases such as Covid-19, cholera, diarrhoea, dysentery, hepatitis A, typhoid and polio and exacerbates stunting. Poor sanitation reduces human well-being, social and economic development due to impacts such as anxiety, risk of sexual assault, and lost educational opportunities. Inadequate sanitation is estimated to cause 432,000 diarrhoeal deaths annually and is a major factor in several neglected tropical diseases, including intestinal worms, schistosomiasis, and trachoma. Poor sanitation also contributes to malnutrition.

Sanitation and hand hygiene are critical elements in disease prevention, including preventing the spread of Covid-19. A WHO study in 2012 calculated that for every US$ 1.00 invested in sanitation, there was a return of US$ 5.50 in lower health costs, more productivity, and fewer premature deaths. Poor sanitation costs Uganda $ 177 million annually (World Bank 2012). Some 827,000 people in low- and middle-income countries die as a result of inadequate water, sanitation, and hygiene each year, representing 60% of total diarrhoeal deaths. According to World Health Organisation (WHO 2017), 2.0 billion people still do not have basic sanitation facilities such as toilets or latrines. Of these, 673 million still defecate in the open, for example in street gutters, behind bushes or into open bodies of water.

Globally, many women and girls face challenges when managing their menstruation; at least 500 million women and girls globally lack proper access to menstrual hygiene facilities. Failure to address the menstrual hygiene needs of women and girls can have far-reaching consequences for basic hygiene, sanitation and reproductive health, ultimately affecting progress towards the SDG goal of gender equality. Studies have shown that girls in Uganda miss up to eight days of school every term and up to 30% of girls leave school because of poor access to sanitary products.

However, at both the community and national levels there is not enough accurate information on MHM and the impacts of poor MHM. Girls who live in informal settlements, refugee camps and poor households are mostly affected with lack of sanitation and MHH facilities and products. The situation is worse for girls with disabilities. Menstruation is often a taboo topic and remains a distant discussion from both domestic and public debate. In addition to its effect on education, access to good MHM is a hygiene right which sets a basis for life-long reproductive health of a woman. Beyond access to affordable menstrual ware for girls, availability of private toilet facilities and societal stigma are the other factors that hinder good MHM. Figure 1 below summarizes the key issues related to MHM.

Fig. 1: Summary of key issues related to sanitation and MHM



Based on the above problem analysis WASNET, with support from the Water Supply and Sanitation Collaborative Council (WSSCC), commissioned this study to conduct a rapid assessment to understand the dynamics around the extent of seclusion in terms of accessing sanitation and MHM interventions and services in Uganda.

1.5 Assessment objectives and deliverables

1.5.1 Aims and objectives

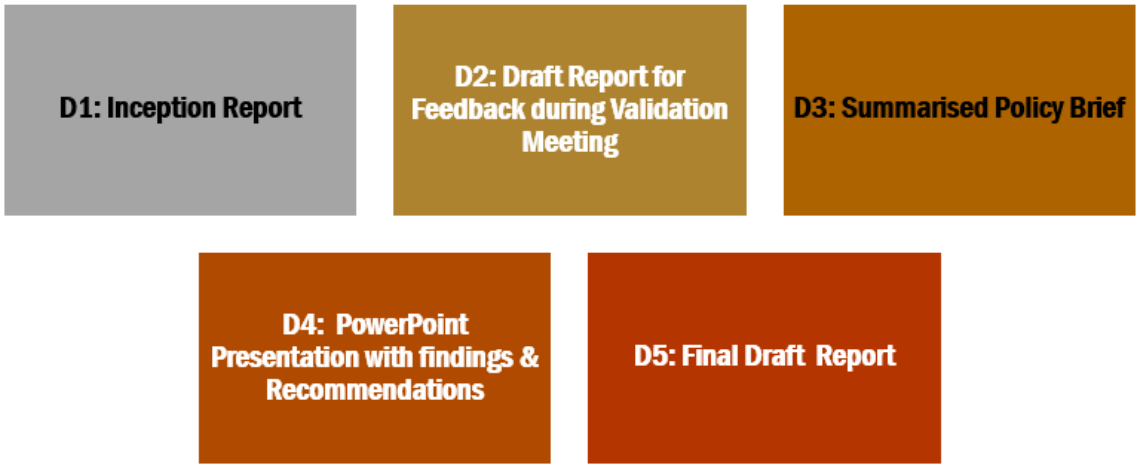
The main aim of the study was to assess the extent of exclusion among the marginalised groups (with particular focus on girls in informal settlements, refugees, and Peoples With Disabilities-PWDs) and the responsible factors for exclusion, in order to come up with actionable recommendations on what needs to be done to change the status quo. These four specific objectives of the study were to:

1. Review the current policies and legal frameworks that guide the implementation of sanitation and MHH in Uganda
2. Establish the current level of service delivery for sanitation and MHH in Uganda
3. Investigate the extent of exclusion among the marginalised groups (Girls, Refugees and PWDs) and factors responsble for exclusion
4. Recommend possible actions both at policy and practice to meet the needs of the marginalised and excluded in accessing sanitation and MHH services

1.5.2 Assignment deliverables

The five key deliverables of the study are as highlighted in Figure 2 below:

Fig. 2: The Deliverables for the Rapid Assessment on Sanitation and Menstrual Hygiene



1.5.3 Scope of work

The work basically involved: i) familiarisation with the sanitation and hygiene sub-sector in Uganda; ii) review of the current policies, strategies and legal framework that guides the implementation of sanitation and MHH; iii) review different sector/UBOS documents to assess who the unserved are and why?; iv) undertake field visits to seleced districts and settlemtns to understand the extent of exclusion; v) discuss with UWASNET the methodology, timing and logistics needed to accomplish the task; vi) conduct individual interviews with selected members of the National Sanitation Working Group (NSWG) and sector responsbile for implementing sanitation and MHH; vii) conduct a validation meeting for the draft report; and viii) develop and submit a final assessment report.

2 METHODOLOGY AND APPROACH TO THE ASSIGNMENT

2.1 APPROACH

The study was guided by three conceptual frameworks:

2.1.1 Approaches to gender and health including the following:

i. **The Women's Health (W&H) Approach** – that focuses on the epidemiological differences, and highlights the specific health needs of women and girls such as female sexuality and reproduction. This partly explains why design and construction of sanitation facilities (toilets & pit latrines, for example) has started to take into consideration the gender and sex differences between women and men and people with special needs.

ii. **Rights Based Approach (RBA) to Health** – that recognizes sexual and reproductive health as a basic right and hence issues of availability, accessibility and affordability are important. Access to information in a confidential setting together with necessary resources to make independent decisions and choice about one's health is also important. Lastly, services and education must be based on the right to dignity, respect and self-determination. The RBA approach recognises MHM as a reproductive issue i.e. what a woman needs to comfortably go through the menstruation period, for example, toilets should be available and safe; and menstrual hygiene materials should be accessible and affordable.

However, millions of people are forced to live without access to water and sanitation not only due to lack of resources and technologies, but as a result of the inequitable power relations that exist in our world. RBA, therefore, helps development practitioners to analyse the issues around inequitable power relations that act as barriers to people having access to safe water and sanitation. RBA helps to identify those who are marginalised, vulnerable and excluded and empowers them to amplify their voice to demand for their rights, while also supporting them to discharge their responsibilities.

iii. **Gender Approach** – that enables a deeper understanding of the factors that affect the health of women and girls; and focuses beyond sexual and reproductive health to identify the determinants of women's health. The approach uses a systematic multi-sectoral approach to address women's health needs. The gender approach presumes that women's reproductive health needs are directly affected by the value placed on women by the community in which women live. It focuses on issues such as social justice and social structures (including cultural institutions) to ensure women' health needs are met.

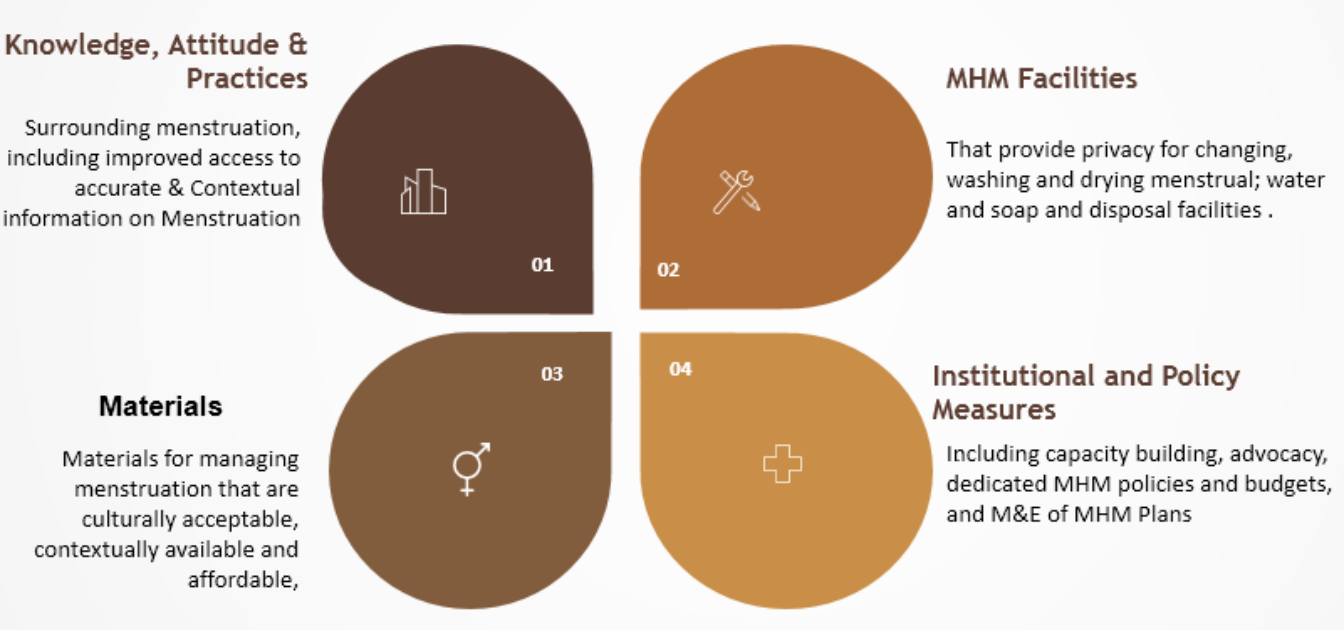
The Gender Approach recognized that menstruation is everyone's issue, and not only a woman's issue and that it is a rights issue as well as a gender issue. The Gender Approach addresses both practical and gender needs such as improving women's conditions through the provision of water and sanitation closer to their houses as well as strategic gender needs:

improving women's position in society by increasing her awareness of her situation and her capacity and her participation and involvement.

2.1.2 Four Pillars of a Comprehensive MHM Programme, ideally incorporated into WASH Interventions

The second conceptual framework that was useful to the study is the Mahon @Sue (2015) approach that is further illustrated the Figure 3 by the World Bank Water Partnership Program (2017). According to this approach, effective MHM should focus on four pillars including hardware (facilities and materials); and software that includes knowledge, attitudes and practices while engaging the policy and institutional level. The four pillars are useful in understanding the links between WASH and MHM and hence should ideally be incorporated in WASH interventions.

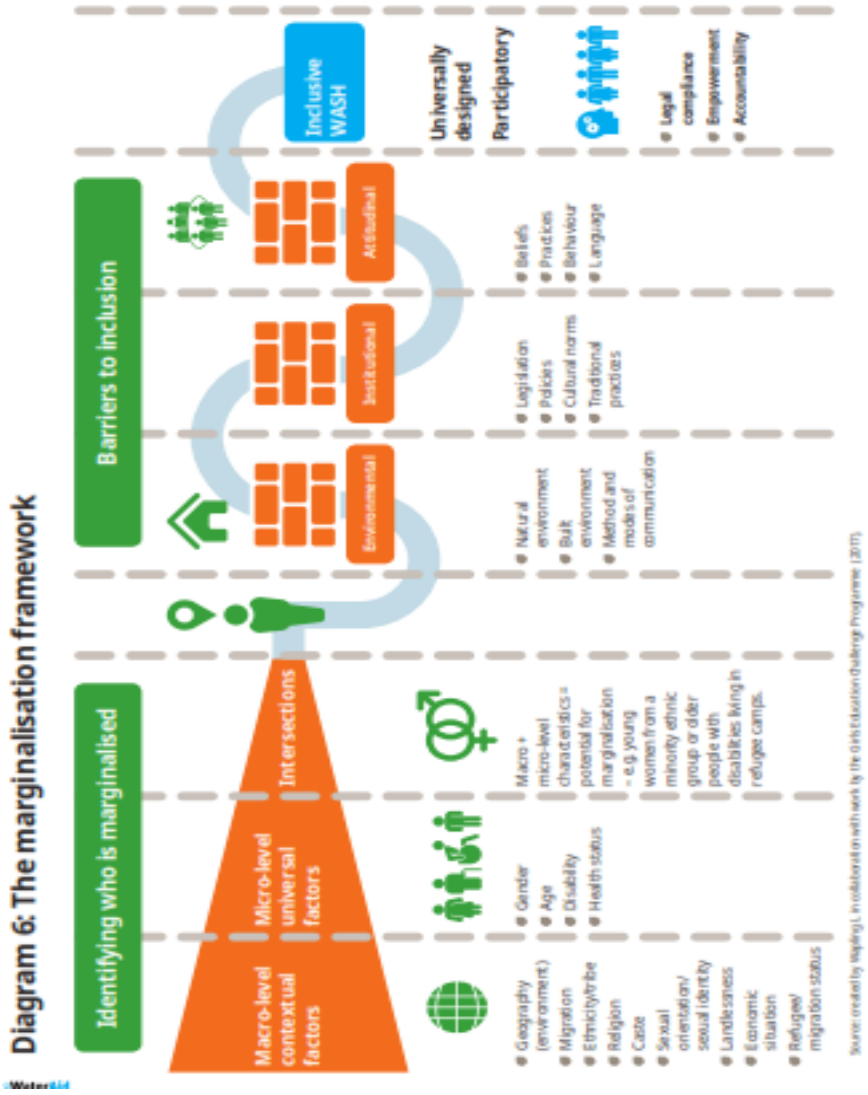
Fig. 3: The MHM Framework (Based on the Four Pillars of a Comprehensive MHM Program)



2.1.3 The Marginalization Framework

The Marginalisation Framework provided in Figure 4 recognises that an individual's experience will be affected by how different aspects of their identity overlap for example their race, class, gender, age, health status or disability state. On the basis of this argument, some people will experience more discrimination and marganalization because of different aspects of their identity. The framework assists in explaining why some groups of people remain hard-to-reach or left behind in the development process. The framework was very useful in understanding barriers to inclusion and making interventions to overcome them.

Fig. 4: The Marginalisation Framework



2.2 STUDY METHODOLOGY

2.2.1 Overall 3-Stepwise plan

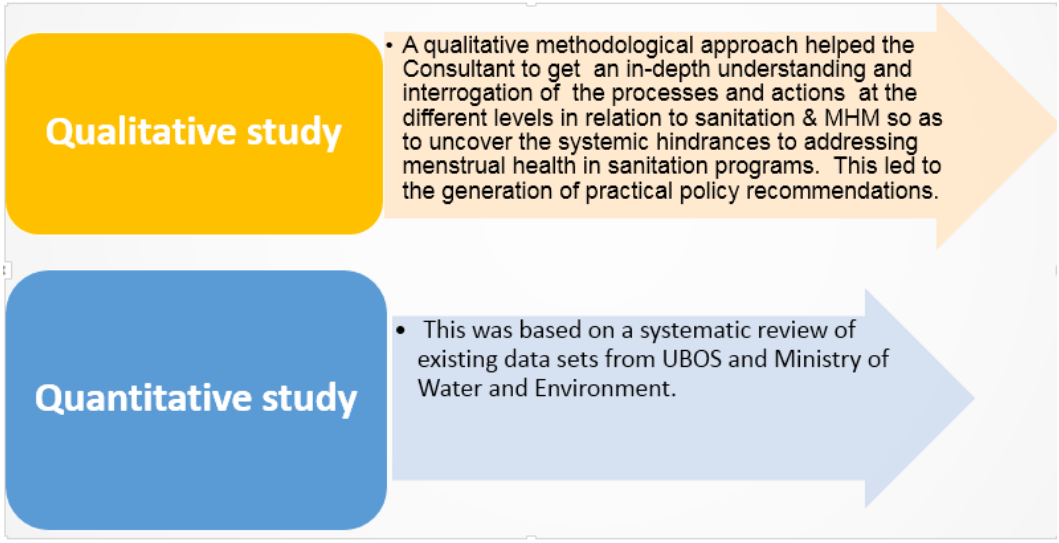
A qualitative approach and methodology was used to gather information from participants, both at the national and districts/regional levels. Qualitative data was collected through Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs). Collection of data from marginalised regions such as Karamoja was prioritized. In order to get the dimension on MHM from refugee populations, FDGs were held with MHM and CHAST Clubs in schools and with selected groups of People with Special Needs (PSNs) in Parolinya refugee camp in Obongi district and Adjumani refugee camp in Adjumani district in West Nile region. A virtual/online validation meeting was held to present the findings of the study for comment, which involved UWASNET staff and other invited stakeholders. Based on the feedback received on the draft report a final report was compiled and submitted to UWASNET. The final draft

report informed the development of the Policy Brief, and the final PowerPoint presentation detailing the findings of the study and the key recommendations.

2.2.2 The mixed method approach

While the study was majorly qualitative in nature; the assessment also used statistical data based on existing data sets such as the Uganda Bureau of Statistics (UBOS) data; data from the WASH sector such as the Water and Environment Sector Report (2020); and the JMP/WHO-UNICEF data on WASH. Figure 5 provides a justification of the application of the qualitative and quantitative approaches to the study.

Fig. 5: Justification for Qualitative and Quantitative Study Methodology



2.2.3 Methodological considerations

The methodological considerations as shown in Figures 6 and 7 were based on the study objectives. The specific focus was on the following: a) literature review of policies and legal frameworks; b) mapping of who would be interviewed as a key informant; c) assessment of who is excluded and why; d) establishment of the current levels of service; e) field research to understand the extent of exclusion among marginalised groups and the reasons for exclusion; and f) development of policy brief and PowerPoint presentation with key findings to support advocacy at all levels.

Fig. 6: Methodological Considerations for the Study

Fig. 7: Methodology and Approach to the Assessment

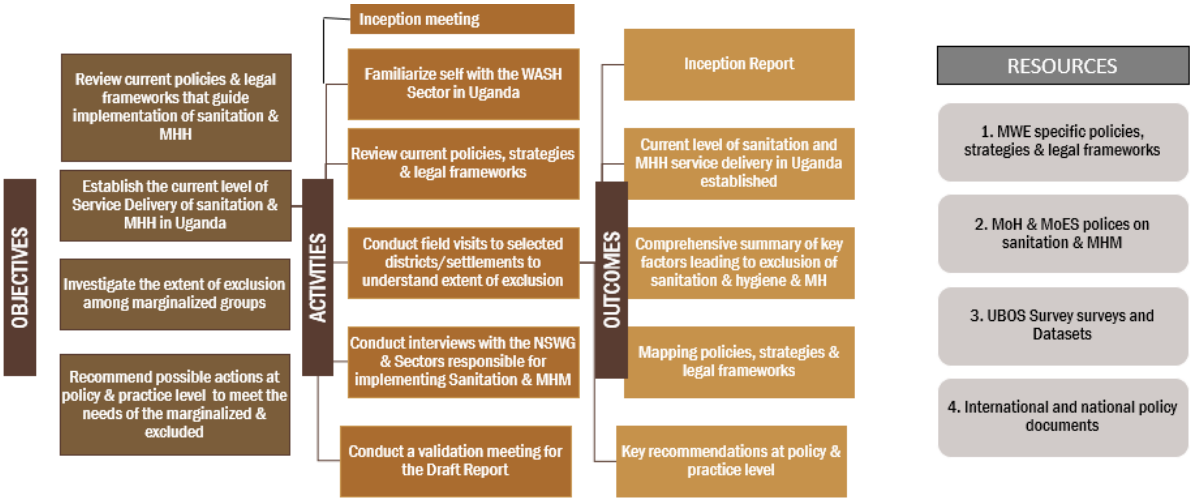


Figure 7 above provides a snapshot of the objectives of the assessment, the activities that were implemented as agreed with UWASNET, the outputs and outcomes of the study and the resources that were utilized to undertake the assessment.

2.2.4 Literature review

Literature review was conducted on relevant documents including the relevant sector reports; the policies and legal frameworks that guide implementation of sanitation, hygiene and MHH in Uganda; and programme and study reports for previous studies on gender and social inclusion and MHM. The documents were reviewed across four relevant ministries of Gender, Labour and Social Development (MoGLSD); Health; Education and Sports; and Water and Environment.

For this assessment, datasets with detailed information on gender, public health, poverty, sanitation, MHM, disability and refugees were analysed from national surveys including the National Census (2014); the 2016 Uganda Demographic and Health Survey; the 2016/17 Uganda National Household Survey; the Uganda National Panel surveys; and the Country Poverty Assessment Reports, among others. It also involved review of online documents published by different WASH agencies involved in implementation of programmes on MHM and equity and social inclusion (please Annex 1 for references). The documents search criteria was guided by the specific objectives of the assessment. The development of the FGD and KII guides was informed by both the literature review as well as the analysis frameworks under sub-section 2.1 above.

The literature review process also focused on understanding key concepts relevant to this study such as menstrual health and menstrual hygiene management; familiarization with the institutional framework for the WASH sector in Uganda to understand how sanitation and MHM services are delivered; and understanding who the marginalised and excluded are in matters of sanitation and MHM and why.

2.2.5 Key Informant Interviews (KIIs)

The Consultant conducted in-depth interviews with national-level actors from the relevant national-level Ministries of Health; Education and Sports; MoGLSD; and Water and Environment to provide an overview of the gender, social inclusion and MHM dynamics in Uganda, and information on factors that are responsible for limited access to sanitation, hygiene and MHM for the groups that are socially excluded. The multi-sectoral approach was also considered for selection of the district-level respondents, with representation from water, health, education, and community development departments at the districts. Due to limited time and being a rapid assessment, it was not possible to interview key informants from the sub county level as planned.

Specifically, the assessment was conducted using questions aligned to the Mahon @Sue (2015) MHM framework (please see section 2.1.2 above) in order to obtain information in line with the objectives of the assessment, which included among others: i) the policies, legal frameworks and the gaps therein; and ii) the general understanding of the concepts of marginalization and social inclusion and exclusion in WASH, in order to arrive at the contextual definition of social exclusion. The aim was to develop the characterisation of people who have been socially excluded or marginalised in terms of access to sanitation and hygiene services; iii) the manifestations and drivers of discrimination or bias faced by these groups; and iv) the key recommendations to be undertaken by UWASNET at policy and practice levels.

Respondents from the National Union of Disabled Persons of Uganda (NUDIPU) were also interviewed. NUDIPU is an umbrella organization with a vision of having dignity for every person with disability. It exists to advocate for the rights of PWDs in a unified voice for improved livelihoods. This is pursued through participation in policy planning, information sharing and optimizing knowledge and skills inherent among stakeholders, capacity building, awareness enhancement and resource mobilization.

2.2.6 Focus Group Discussions (FGDs)

The Consultant conducted FGDs in selected schools and refugee camps in the Parolinya and Adjumani in West Nile region. Participants were mainly gotten from selected schools that had benefited from MHM interventions by Lutheran World Federation (LWF). Members of School Management Committees and School Health/CHAST/MHM clubs were interviewed in the primary schools in Obong and Adjumani districts in West Nile region. Members of the SHCs comprised both girls and boys aged between 12 and 18 (i.e. girls of schools-going and menstruating age). However, for privacy the girls and boys were interviewed separately.

FGDs were conducted with various socially excluded groups, a special category of refugees called Persons with Special Needs (PSNs) and Extremely Vulnerable Individuals (EVIs) with each group representing their own interests and experiences in their community, and reflecting the realities (including social, cultural, economic, religious, and physical/environmental factors) affecting refugees and MHM in the settlements. The participants included adult men and women; and PWDs. Again, to ensure privacy, each category of respondents were interviewed separately. A discussion guide (Annex 2) was developed specifically for each group to ensure that information collected from each group was relevant and detailed. All discussions were conducted in a language understandable to the participants, which is mainly Sudanese local dialects. The Consultant hired interpreters to help with translations of questions into the local language and back into English during the discussions. The discussions were led by a Moderator, while another research assistant took notes and recorded the discussions. Each discussion took approximately one hour. In addition, the discussions were audio-recorded and translations and transcriptions were in English. All discussions were conducted within the boundaries of confidentiality agreed at the time of the discussions.

Specifically for informal settlements in Kampala city, the Consultant used information/literature from previous studies conducted on MHM in schools by WaterAid and Kampala Capital City Authority (KCCA), and a study on access to basic services by refugees and host communities residing in vulnerable neighbourhoods that was conducted by KCCA and partners (AGORA, ACTED, Norwegian Refugee Council and AcTogether). Additional information was gatehred from UWASNET's Regional Coordinator for the Mid-Central region who works in the informal settlements in Kampala. Table 2 provides a snapshot of the persons that were included as respondents for the FGDs.

Table 2: Respondents for Focus Group Discussions (FGDs)

Participants	Thematic Area of Discussion
• Members of School Management Committees	• MHM in schools; Roles and responsibilities of SMC in MHM for School girls. Challenges faced and possible solutions.
• Members of SHC/CHAST/MHM clubs (including boys and girls, and interviewed separately.	• Knowledge, Awareness, and attitude towards MHM; access to MHM information; access to sanitation facilities and changing rooms; access to menstrual pads; disposal of used menstrual pads; other challenges faced and possible solutions

• Women at risk (including GBV Survivors, Women in Safe Spaces, female-headed households, PSNs such as PWDs, and EVIs) • Older men • Local leaders/equivalent of LCs	• Access and control of resources, knowledge, services and decision-making in relation to sanitation and hygiene • Social, economic and cultural factors that hinder marginalized groups such as women, PWDs, and refugees to participate in sanitation programs • Knowledge, attitude and practices related to exclusion of marginalized groups to access sanitation and hygiene and MHM services • Possible solutions to ensure the needs of marginalized and excluded groups are met.

2.3 SAMPLING

2.3.1 Selection of Key Informants

At the national level, the Consultant purposely selected respondents who were knowledgeable on gender, social inclusion and MHH issues from each of the four line ministries of: Health, with ficus on the Uganda Sanitation Fund; Education and Sports (Gender Unit); Gender, Labour, and Social Development (WASH Focal Point); and Water and Environment (Rural Sanitation); the National Sanitation Working Group (NSWG); the national level sector agencies (including SNV Netherlands Development Organisation, IRC, Rotary International, Uganda Sanitation and Hygiene Activity-USHA, and Lutheran World Federation-LWF working with refugees in Obongi and Adjumani districts. A mix of both government and non-government respondents was purposely considered, in order to capture issues both at policy and practice levels. A similar multi-sectoral approach was used for selection of respondents at the decentralized level.

Specifically, UWASNET recommended inclusion of: i) UWASNET's Regional Coordinators (RCs) for the nine (9) UWASNET Regions (*please see Annex 3)*; ii) respondents from Karamoja region, being one of the most marginalised regions; iii) a respondent from the National Union of Disabled Persons of Uganda (NUDIPU); and iv) respondents from refugee camps.

At community level particularly in the refugee settlements, the consultant specifically interviewed women at risk (e.g. GBV Survivors, female-headed households, respondents from households with Persons with Special Needs (PSNs), and respondents from a category of refugees called Extremely Vulnerable Individuals (EVIs). A total of 30 participants were interviewed as key informants, both at national and district/regional levels as compared to the planned 24 respondents representing 125% as outlined in Table 3.

Table 3: Summary of Key Informants interviewed per District/Ministry/Agency

SN	Key Informant/Category	Designations of the Respective Officials interviewed	Number of Interviews
1.	Ministries of Health; Education and Sports; MoGLSD; and Water & Environment.	Uganda Sanitation Fund (USF), Gender Focal Point; WASH Focal Point; Sanitation Coordinator for Rural.	4
2.	National Sanitation Working Group	Chairperson	1
3.	UWASNET's Regional Coordinators	Regional Coordinators and/or their representatives	8
4.	District-level officials for Obongi and Adjumani districts	District Water Officers/Sanitation Officers (DWO-Sanitation), District Health Inspectors-DHIs; District Inspectors of Schools-DIS; and District Community Development Officers-DCDOs.	8
5.	International Agencies in MHM: SNV & Rotary International	Project Officers and WASH Advisors	2
6.	Uganda Sanitation Health Activity (USHA) project funded by USAID and implemented by Tetra Tech and SNV USA;	WASH Advisors	1
5.	Agencies implementing WASH & MHM in Refugee Settlements (e.g. LWF)	Programme Managers and Project Officers in LWF Obong/Moyo and Adjumani.	4
6.	UNICEF Implementing Partner in Karamoja region	C&D	1
7.	NUDIPU	Programme Officer	1
	TOTAL:		**30**

2.3.2 Selection of districts/regions

For easy coordination, the nine (9) Regional Coordination Structures of UWASNET represented districts and regions (with at least one Regional Coordinator-RC targeted per region). The RCs work in different districts across Uganda and hence provided perspectives on MHM from the different regions and districts. The Consultant was advised by UWASNET to specifically target Karamoja region. A total of eleven districts were selected as focus districts for district level interviews, including the nine districts with representation of UWASNET's RCs, and Obongi and Adjumani districts in the West Nile region. The selection criteria was based on level of marginalisation and remoteness of the district (e.g. the UNICEF supported districts in Karamoja region), presence of refugees (e.g. Obongi and Adjumani districts) and easy access, given the Covid-19 situation.

2.3.3 Selection of participants for Focus Group Discussions (FGDs)

Due to Covid-19 Standard Operating Procedures (SOPs) provided by Ministry of Health, instead of the recommended 8-10 people per FGD, only a total of 5 people were selected to participate in each group discussion at community and school levels, in order to maintain social distance. A total of 10 FGDs were conducted in Obongi and Adjumani districts/refugee camps. These comprised of four School Management Committees (SMC) from four schools (2 schools in Obongi and 2 schools in Adjumani); four School Health/MHM Clubs from the same schools and districts; and two community-level FDGs conducted specifically with women at risk in the refugee settlements in both districts.

The schools were purposely selected because they had received some interventions on sanitation and MHM by LWF. Gender balance and inclusion of all categories of people including PSNs and EVIs and school pupils (both boys and girls) was emphasised during selection of respondents to participate in the FDGs. Lists of PSNs, EVIs, SHC, SMC, and Women at Risk were obtained from LWF project office to help with the selection process. While SMC and SHC were given, a random sampling method was used to arrive at the final list of community participants for the FGDs. These lists were based on the UNHCR and OPM own categorization of vulnerable groups amongst refugee populations into two broader categories: Persons with Special Needs (PSNs) and EVIs.

A total of 50 people participated in FGDs as compared to the planned 80 participants representing 63% of the targeted respondents. A summary of the overall sample size that was used for the qualitative research is outlined in Table 4 below.

Table 4: Overall Sample Size for Qualitative Research

Category of Respondent	No. of Interviews/Discussions
Key Informant Interviews (National)	09 Key Informant Interviews
Key Informant Interviews (District/Region)	21 Key Informant Interviews
Focus Group Discussions	50 (10 FGDs of 5 people each).

2.4 ANALYSIS AND REPORTING

2.4.1 Data Quality Assurance

All the interviews and discussions were recorded after obtaining participants' consent; notes were taken too. The digital recordings particularly for the FGDs were later transcribed and typed out in English. Data quality for the assessment was assured through various ways including use of two knowledgeable Research Assistants (RA) with the skills to conduct interviews and do transcriptions. They received some brief training to ensure that the study objectives, concepts and tools were understood in the same way. This ensured that the data collected was of the same quality across the areas and the interviewers. The two RA were closely supervised by the Consultant to ensure results of their work was in line with the expectations of the study. Additionally, the Consultant ensured that there was adequate logistics support to enable the RAs to perform their duties and collect high quality data.

2.4.2 Data Management and Analysis

The KIIs were conducted in English virtually via telephone or Zoom and audio-recorded and then transcribed into word format, while the FDGs were audio-recorded and translated from the local language directly into English during interviews. However, there was no back-translation of the transcripts from the FGDs into the local language due to time limits of the consultancy.

In order to analyse the qualitative data, a blended approach of thematic and content analysis was used. Study questions were developed guided by a combination of three conceptual frameworks as outlined in sub-section 2.1.2. The assessment questions were also developed to guide thematic analysis of the qualitative data. Recording of the FGDs, field notes from KIIs, and from the review of documents/reports were transcribed and summarized based on the study questions. All data and information about each theme was grouped together for manual coding and analysis. The analysis involved drawing out key salient findings, identifying themes, patterns and issues relating to the focus of each assessment objective, and comparing and contrasting within and between different stakeholder groups and FGD respondent groups to enhance triangulation of data.

A virtual validation meeting was conducted with support from UWASNET to present the findings and key recommendations for feedback. The purpose of the validation meeting was to disseminate the key findings from the study, but most importantly to discuss the key conclusions and recommendations for validation by the stakeholders. Based on the feedback received during the validation meeting a final report was drafted and submitted to UWASNET. The final draft report informed the drafting of the Policy Brief as well as the PowerPoint Presentation detailing key findings and recommendations as provided for in the Terms of Reference (TOR).

2.4.3 Study ethics and considerations

Confidentiality – all collected information was held confidential. Names of respondents, their places, organisations were not disclosed in the report. Findings, including quotes and specific examples were presented in ways which do not threaten confidentiality. Information about the source of data was not shared, that could allow the participant to be identified. All identifying information was removed on any information transmitted over electronic means. All information was held in password protected computers only accessed by the Consultant and her two RA.

Informed consent – informed consent was sought from all individual respondents who participated in the assessment activity. Consent forms were used appropriately for each category of respondents (i.e. literate, illiterate, etc.).

2.4.4 Challenges experiences and lessons learnt

Particularly for the national and regional interviews, key informants were quite busy and hence getting respondents to commit time for the interviews was a big challenges which led to some interviews being conducted as late as 8.00 or 9.00 pm.

The location of Obongi district in West Nile region involves use of a Ferry to cross River Nile from Adjumani to Obongi district. With only one Ferry working due to the high rise in the Nile river water, crossing the River Nile involved a lot of waiting and travelling late at night on bad roads. Finally, mobilising women in refugee camps and SHC and SMCs was also a challenge.

3 KEY FINDINGS OF THE RAPID ASSESSMENT

3.1 Key concepts on inclusion and exclusion – Literature review

3.1.1 Vulnerable groups

The Uganda National Household Survey (2016/17) identified vulnerable groups and individuals to include: orphans, working children, widows and older persons (those aged 60 and above and considered too weak to perform productive work). The Human Development Report (2016) refers to them as disadvantaged groups to include women and girls; ethnic minorities; people in vulnerable locations (e.g. geographically isolated or disproportionately exposed to environmental pressures); migrants and refugees; indigenous peoples; older people; and Persons with Disabilities (PWDs).

3.1.2 Gender

The Uganda National Gender policy (1997) refers to gender as the social relationship between women and men as opposed to the biological sex differences. It entails social roles and relations of women and men of all ages. The Uganda National Equal Opportunity Policy (2006) defines gender as the social and cultural construct of the roles responsibilities, attributes, opportunities, privileges, status, access to and control over resources and benefits between men and women, boys and girls in a given society.

Sanitation, hygiene and water issues, as much like any other development issue, are highly gendered by nature. Access to WASH is mediated not only by poverty and lack of infrastructure, but by power and inequality. Women and girls are disproportionately affected by lack of access to adequate WASH due to biological and social factors. Meeting women and girls' WASH needs, therefore, requires recognizing the gendered barriers to WASH access, as well as addressing women and girls' specific WASH needs, namely sexual and reproductive health needs like menstrual hygiene, which are often overlooked or ignored by WASH policy and programmes.

3.1.3 Social inclusion

The World Bank (2013) defined social inclusion as the process of improving the terms for individuals and groups to take part in society[5]. It is the process of improving the ability, opportunity and dignity of people, disadvantaged on the basis of their identify, to take part in society. Social inclusion is the direct opposite of social exclusion.

3.1.4 Social exclusion

Is the process by which individuals or groups of people are systematically denied access to rights, opportunities, and/or services - based on various axes e.g. age, gender, sexual orientation, geography, disability, etc.6 Social exclusion is the state in which individuals are unable to participate fully in

[5] GESI Assessment of the Netherlands WASH SDG programme in Uganda (2018); Agago Final Assessment Report.
[6] National Disability-Inclusive Planning Guideline for Uganda (2017), National Planning Authority.

economic, social, political and cultural life. Social exclusion, the opposite of inclusion, is closely related to marginalization, discrimination or stigmatization for various reasons including age, illness or disability.

3.1.5 Marginalisation

UKAID Direct (note dated) defines marginalisation as both a process and a condition that prevents individuals or groups from full participation in social, economic and political life. It refers to persons in society who are deprived of opportunities for living a respectable and reasonable that is regarded as normal by the community to which they belong (MoGLSD, 2014). The four interconnected forms of exclusion are identified as political, economic, social and cultural and are relevant too in this study. Social exclusion, for example, takes the form of discrimination along gender, ethnicity and age, which reduces the opportunity for such groups to gain access to social services; and the cultural exclusion refers more to the extent to which diverse values, norms, and ways of living are acceptable and respected.

Marginalisation is closely related to vulnerability. Vulnerability is defined as a state of being in which a person is likely to be in a risky situation, suffering significant physical, emotional, or mental harm that may result in his/her human rights not being fulfilled[7]. Social and physical vulnerability reflect a decreased capacity for a person to cope, especially if the state is sustained or if any additional threats to social well-being and/or physical health are added. Vulnerability is a position of risk from threats to one's physical or emotional well-being; being vulnerable implied lack of protection from such threats[8].

3.1.6 Menstrual Hygiene Management (MHM)

MHM refers to the practice of using clean materials to absorb menstrual blood that can be changed privately, safely, hygienically, and as often as needed for the duration of the menstrual cycle[9]. The Joint Monitoring Programme of WHO/UNICEF defines MHM as: "(1) Women and adolescent girls are using a clean menstrual management material to absorb or collect menstrual blood, (2) that can be changed in privacy as often as necessary for the duration of a menstrual period, (3) using soap and water for washing the body as required, (4) having access to safe and concenient facilities to dispose of used menstrual management materials, (5) understanding the basic facts linked to the menstrual cycle and (6) how to manage it with dignity and without discomfort or fear"[10].

3.1.7 Definition of Disability in Uganda

The Persons with Disabilities (PWD) Act 2006 defines disability as "a substantial functional limitation of daily life activities caused by physical, mental or sensory impairment and environmental barriers resulting in limited participation".[11] By recognizing that disability is the result of the interaction between impairment and external barriers, the PWD Act aligns the legal definition of disability in the Ugandan law

[7] Uganda National Bureau of Statistics (UBOS), 2018, Uganda National Households Survey 2016/2017, Kampala, Uganda; UBOS.
[8] Ibid
[9] Menstrual Hygiene Management, Uganda (2017); Performance Monitoring & Accountability (PMA2020).
[10] Kansiime c, Hytti L, Nalugya R, et al, Menstrual health intervention & school attendance in Uganda (MENISCUS-2): a pilot intervention study: BMJ Open 2020:e031183.doi:10.11366bmjopen-2019-031182
[11] Persons with Disabilities Act, Article 2 "Interpretation"

to that enshrined in the CRPD[12], implying a significant paradigm shift away from the medical/charitable models, to understanding disability as a social phenomenon. Furthermore, of particular value is the recognition that physical, mental and sensory impairments, can all result in a disability.

3.1.8 Persons with Disability

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others[13].

3.1.9 Poverty

To live in poverty is to lack the resources needed to meet basic needs. It can be measured in economic terms (income, expenditure or wealth), or using other measures including social, nutritional and cultural (or even multidimensional measures). Poverty can be defined by a fixed value (absolute poverty) or by a value in relation to the rest of the population (relative poverty). Absolute poverty is measured by the minimum amount of money required to meet basic needs, known as a poverty line. The international standard for measuring poverty is the extreme poverty line. This measure of absolute poverty has a threshold equivalent to US$1.90 per person per day[14].

Uganda is a low-income county and among the poorest countries in the world. In Uganda, absolute poverty is officially defined as a 'condition of extreme deprivation of human needs, characterised by the inability of individuals or households to meet or access the minimum requirements for decent human wellbeing such as nutrition, health, literacy and shelter.

Uganda has experienced increasing regional inequalities since the 1990. While extreme poverty at a national level has generally declined since 1990s, this trend has not occurred evenly across the country. Although northern and western regions have seen a decrease in the share of population in poverty since the 1990s, the eastern region has recorded an increase in poverty (from 24.3% in 1999/2000 to 35.7% in 2016/17), overtaking the northern region as the poorest.

3.2 Extent of Exclusion among the Marginalised Groups (Girls, Refugees and PWDs) – Based on Literature Review

3.2.1 Knowledge, Attitude and Perceptions on MHM

Cultural, religious and traditional beliefs - deeply affect the progress and actions to promote gender equality. Where taboos are at the fore front, most people, and the men in particular find menstrual hygiene an issue of the women alone. In Uganda, the cultural norm is to keep menstruation a secret. In Western parts of the country cattle owners do not let menstruating women attend to their cows, for fear that the milk may turn bloody (Guerry, Elisabeth, 2013).

[12] CRPD, Article 1 "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others"
[13] National Disability-Inclusive Planning Guideline for Uganda (2017), National Planning Authority.
[14] Poverty in Uganda: National and Regional Data and trends; Factsheet, Development Initiatives (October 2020).

A Ministry of Education and Sports-MoES Study (2020) confirms that culture is largely responsible for the current MHM practices at individual, home and community level; and that culture is responsible for the limited knowledge about MHM by both men and women, as they are locked them out from accessing MHM information. Menstruation is called names that disguise it from men and boys "Ekibada, Maama Peter, Red Car, etc.). Menstruation is largely considered "dirty and unhygienic" by mainly men; and it is largely considered a women's issue. The men (60%) were found least knowledgeable about MHM

Stigma and discrimination – women and girls often face stigma that affects their daily lives. Such stigma restricts them from many practices, for example, not to eat certain types of foods; not to cook or go in the kitchen area when menstruating; and not to receive Holy Communion in a Catholic church when she is menstruating, etc. . Instead of men and boys being supportive to women and girls in menstruation, they instead laugh at them, stigmatize, embarrass and ridicule them (especially true for girls in school) as demonstrated by the following quotes:

> *"I cannot eat food prepared by a woman who is in her menstrual periods because she is unhygienic. She cannot touch blood and then prepare and cook for me food", men in Kyenjojo FGD.*
>
> *"There are times when the male teachers and the boys unwrap our sweaters tied around our waists to prevent leakage of the menstrual blood through our uniforms", said the girls in school in Gomba, Wakiso, Kasese and Kyenjojo FGDs.*
>
> *"There is a lot of victimization experienced especially from the boys. The boys describe us 'silly and dirty girls", said the girls in Moroto FGD*
>
> ***Source: MHM Situation Analysis Study (2020), Ministry of Education and Sports.***

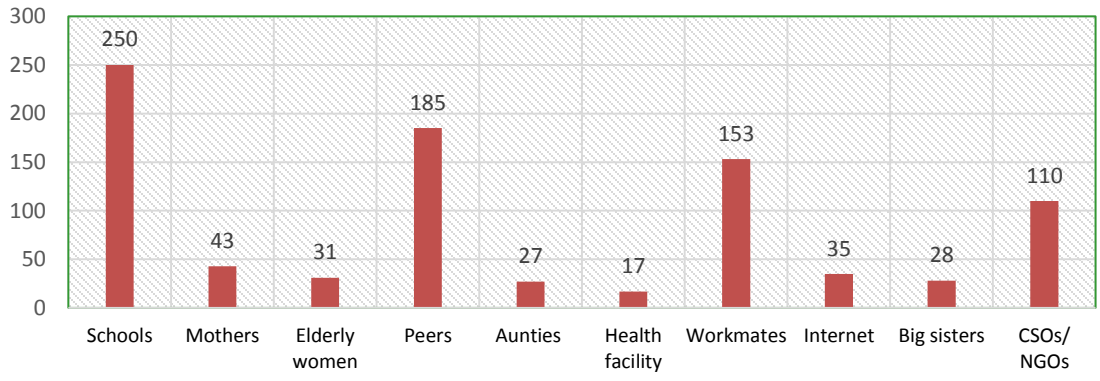
Lack of information and awareness among young girls and women – limits their potential to be included and benefit from improved sanitaion, hygiene and MHM services. The channel through which information and awareness is spread, and the attitude of service providers are a detriment to accessibility of information about MHM by women and girls. In addition, mothers who are the primary source of information for their girls at homes shy away from discussing menstruation with them. The men and boys know very less about menstrual hygiene, yet their presence and commitment would help to avert the challenges the women, girls, the disabled and refugees are facing in schools and at homes. Thus so, an estimated 66% of adolescent girls in Uganda have no prior knowledge on the menstruation cycle of a woman until they start their menses, which contributes to a traumatic experience for their first menstrual periods (Mooijman, 2010) as quoted by a woman respondent in Bungugyo district:

"It was a shock and embarrassing when I experienced menstruation because I had no idea about it. I felt shy, isolated and an odd man out. Generally, it is not a good experience for a starter",

Source: MHM Situation Analysis Study (2020), Ministry of Education and Sports.

The MoES study on MHM confirms that access to MHM information was a challenge. Access to MHM information varied across different categories of respondents; many participants did not know where to access the right, timely and adequate MHM information, and that access was determined by age, sex, culture, level of education and affordability for some of the information sources. Schools were found to be the major source of information mainly through the Senior Women Teachers (SWTs), science subjects, and CSOs (for school going children and teachers). Other outstanding sources included; peers, and work mates. According to the respondents, some of the information was found to be traditional, conflicting and not right. Also, mothers and aunties that used to be the major source of information were reported to rarely play their roles.

Fig. 8: Major Sources of MHM information (n=420)



Source: MHM Situation Analysis Study (2020), Ministry of Education and Sports

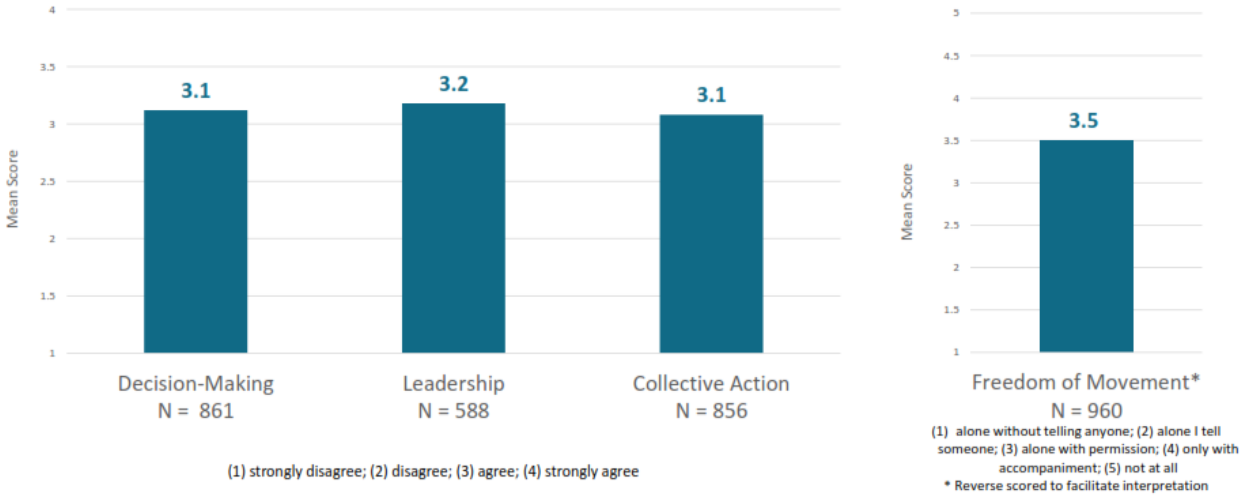
3.2.2 Access to resources and menstrual materials

Lack of involvement in decision-making – women and girls are often excluded from decision-making and management in development and emergency relief programmes. They lack control at household level over resources, which affects their access to a private latrine or the money to spend on sanitary materials (Sarah H, Thérèse M, and Sue 2012). Women and girls in poor families tend not to seek medical help because over half of them follow their husband's direction on whether to seek treatment and what treatment to seek; many of the women cannot travel alone to a hospital or health center, and there is no liberty to discuss reproductive health issues with their spouses.

A Study on Women's Empowerment and Sanitation (2020) in in the informal settlements in Kampala by Kampala Capital City Authority (KCCA) and partners (Athena Infonomics and Emory University) looked at the Agency domain of empowerment (Decision-making, collective action and leadership). The women's sanitation-related agency score was high, with a mean score of 3.1 of respondents who said

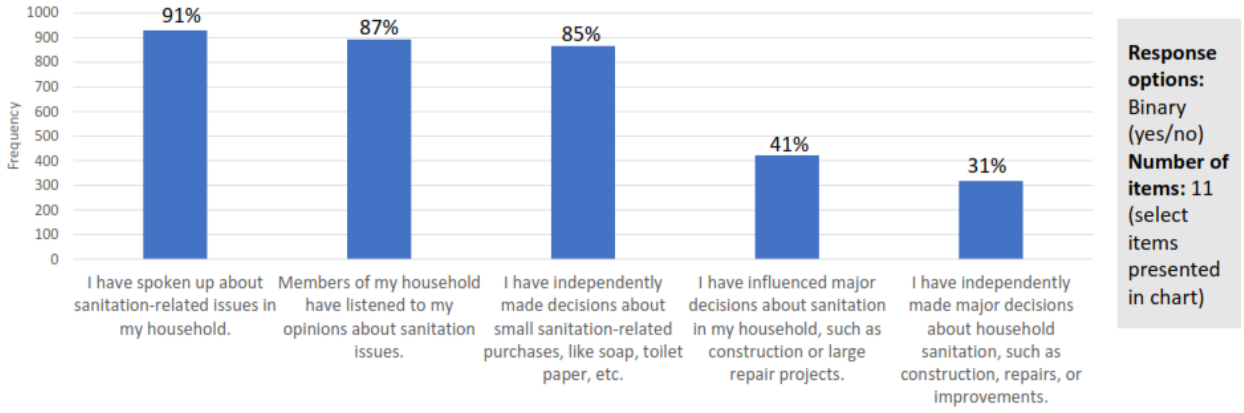
they strongly agreed that women participate in decision-making at household level, while 3.5 scored regarding freedom of movement (please see figure 9). Regarding the safety index, some women knew othee women who had ever experienced violence when accessing sanitation facilities, with more known experiences of harrassment than of physical or sexual violence

Fig. 9: Agency: Scales – Mean Agency Scale Scores



However, fewer women reported participating in decision-making when large expenditures are involved (e.g. regarding construction of latrines). While 50% of women reported having attended a sanitation-focused community meeting in the past one year, fewer women reported having participated in other aspects of community-level decision-making (please see Figure 10).

Fig. 10: Agency: Household Decision-making Index Responses by Item (N=991)



Lack of access to menstrual materials – there has been a general understanding that women in low income countries usually use homemade sanitary materials rather than shop bought products due to purchasing cost and also the fact that disposal items cannot be reused (WHO 1983). However, few studies have investigated the details of such practices and the attitudes of the women. A study on MHM by MoES

(2020) established that 52% of women used disposable pads, 32% used pieces of cloth, 6% used re-usable pads, 5% used cotton wool, while 3% used toilet paper as menstrual materials.

Some studies have also shown that girls miss up to eight days of school every term and up to 30% of girls leave school because of poor access to sanitary products. Women and girls often find it difficult to access appropriate sanitary products due to their costs, limited privacy when using them and poor disposal facilities, among others. Disposable sanitary towels are often expensive and unavailable in some rural settings, in refugee camps and for women and girls living in informal settlements. In Uganda, it is important to note that sanitary towels for one girl can cost up to 10% of household income (Averbach et al., 2009). Therefore, due to high cost, some of the hygiene products and facilities in the market excludes certain groups of people from accessing and using them. According to Bhardwaj and Patkar 2004, minimal efforts has gone into the production and social marketing of low cost napkins, reusable materials and research into bio-degradable.

Fig. 11: Commonest types of menstrual materials, (n=250)

Source: MHM Situation Analysis Study (2020), Ministry of Education and Sports

While it is often assumed that women and girls prefer disposable pads if they are available and affordable, this is not always the case. Studies show that women and girls use cloth material (rags) for menstruation. Alternatives to pads and tampons are used including reuse of cloth. The challenge with the use of the cloth may be its management due to the stigma around periods in some communities (SNV/IRC, 2012). The cloth is used because it is more available and if water is not available, the women and girls use toilet tissues although it is not a common practice. Many of the women and girls begin to use the pads at a later age, when they are not comfortable walking with pieces of cloth. This is because they begin to visit their relatives and friends in the city/town and get to experience the pads.

According to the Study by MoES, some of the factors affecting access to and use of sanitary pads included the following:

- Affordability – as not many girls and women are able to afford the decent, safe and hygienic menstrual pads. This makes them resort to use materials that are deemed unsafe.
- Negative attitudes towards the use of re-usable pads

- Traditional life style especially in respect to Karamoja, where the girls and women are not used to wearing pads and knickers.
- Limited incomes to purchase materials for making the re-usable pads
- Limited coverage of trainings aimed at skilling girls and women in making re-usable pads. The few trainings conducted target the girls in school as opposed to girls out of school, community women and boys.
- Some girls indicated that washing re-usable pads required touching blood and using a lot of water which could not be sometimes readily available

3.2.3 Access to sanitation facilities

Access to sanitation in households;

Women and girls need clean sanitary facilities to manage their menses. Yet, according to the Ministry of Water and Environment, the population with access to safely managed sanitation stands at only 7% in rural areas and 39.2% in urban areas (SPR 2020). In households, community men and women indicate having at least 1 stance that is shared by all family members. A Study on Women's Empowerment and Sanitation (2020) in in the informal settlements in Kampala by Kampala Capital City Authority (KCCA) and partners (Athena Infonomics and Emory University) established that pit latrines were the most common facility used by women for defecation, both during the day and at night and for urination during the day; 53% of respondents used buckets, hanging toilets, or flying toilets for urination at night (please see a snapshot in Figure 12).

Fig. 12: Type of Sanitation Facility Most Commonly Used, by Time of Day.

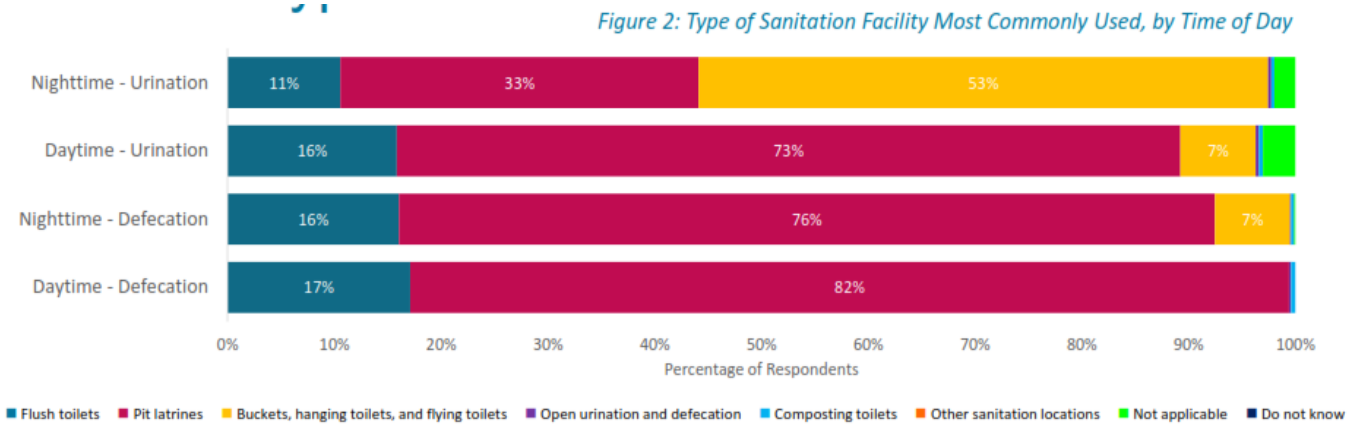


Fig. 13: Characteristics of daytime defecation location

Table 2: Characteristics of Daytime Defecation Location

Indicator		N = 1,024
Qualities and characteristics of defecation locations		
%	5 or more households use sanitation location	50.9
	5 or more minutes to walk to sanitation location	14.9
	Pay for use of sanitation location	7.9
	Carry water to sanitation location	61.7
	Can be seen using the sanitation location	16.9
	Not lockable from inside	15.0
	Location lacks sufficient lighting inside	33.4
	Lack of lighting on the way to location	18.8
	Physically challenging to access/use	13.5
	Insufficient room inside	16.6
	Has not been functional in past 30 days	16.7
	Usually have to wait at this location	55.2
	Not located in a private place	16.3

According to the KCCA Study, 51% of respondents reported that their primary daytime defecation location was shared by five or more households; 55% required waiting to use the latrine; while 62% of facilities required water to be carried to the sanitation location. The KCCA Study also looked into the quality and characteristics of daytime defecation sites/locations for women including sharing of facilties, time taken to walk to the facility; pay for use; privacy; lighting, among others. A total of 50.9% of respodnets indicated that 5 or more households were using one sanitation location; 14.9% reported that they required 5 or more minutes to walk to the sanitation location; 7.9% pay for use of the facility; 16.9% reported being seen using the sanitation location; 15% of facilities were not locakble from inside; 16.7% of facilities had not been functional in the past 30 days; 55% of women reported having to wait at the facility; while 16.3% of the sanitation facilities were not located in a private place (please see summary of figures).

Access to sanitation facilities in schools;

Access to toilets;

According to the Ministry of Water and Environment, the pupil: stance ratio in schools stands at 72:1 which is further away from the national standard of 40:1 (SPR 2020). According to the MoES guidelines, there should be one stance for every 40 pupils in 2 star schools and 1:25 for three star schools. Latrines should have functional walls, and doors with locks for privacy. Regarding separation of facilities, according to the MoES MHM Situation Analysis Study (2020) 86% of respondents in the 14 sampled districts indicated having separate toilet facilities for boys, girls and staff, except Bundibugyo and Kasese. Overall, according to MoES (2019), 12% (140 schools) required latrines for girls, while 171 secondary schools representing 15% required latrines for boys. Bundibugyo district reported approximately only 30% of schools having separate toilet facilities, which negatively impacts the use of toilet facilities by girls especially during menstruation due to lack of privacy. Girls in their menstruation periods are challenged

because they have to queue to access latrine services, which means loss of time and lessons for the girls. There was also a general outcry about the poor state and unhygienic conditions of the latrines.

> *In Kalusandara SDA P/s in Kasese district, there are 5 stance pit latrines; 1 for staff, 2 for girls, and 2 for boys for 400 learners, implying a stance pupil ratio of 100: 1.*
>
> *In St. Peter's Kibalya P/s, the teachers reported not having a single permanent pit latrine at school that hosts 500 learners (300 girls, 200 boys). They had 4 temporary stances; 2 stances for boys and 2 stances for girls. Teachers use the neighboring church latrine; implying a stance-pupil ratio of averagely 100:1*
>
> *In Nebbi district, the Senior Education Officer shared a pupil stance ratio of 103:1*
>
> ***Source: MHM Situation Analysis Study (2020), Ministry of Education and Sports.***

Issues were also reported about the designs of sanitation facilities that do not, in many cases, take into account disability and exclusion; heavy borehole handles that makes it difficult for the elderly, pregnant women, the sick and children to access water and long distances to water points are some of the issues that perpetuates exclusion.

Access to toilets for disabled; bathrooms

Over 70% of the respondents in the study conducted by MoES on MHM reported not having latrines for children with special needs. Washrooms/bathrooms at school enable girls to wash during menstruation; over 40% of districts visited reported having no bathrooms at school. Comprehensive facilities are expensive for some schools and as a result, they only want to construct them after registering or receiving children with disability. Overall, the general outcry was the poor state of the bathrooms-unhygienic, depilated, very limited in number; the limited bathroom coverage in schools and communities poses challenges in maintaining hygiene during menstruation. For the community women, less than 10% of those interviewed reported having bathroom shelters in good condition.

Access to changing rooms

The MoES Study established that over 70% of districts had no changing rooms for the girls and female staff. In home settings the bedrooms, latrines and bathrooms acted as changing rooms for the girls and women. School girls and teachers, while at school use mainly the latrines and bathrooms as changing rooms. According to teachers, many people including the school leaders have not yet appreciated this facility, therefore making it difficult to prioritize its funding. In cases where there are no staff latrines, the teachers compete with the learners for the same facilities (bathrooms and latrines) to change their pads. Where changing rooms exist, they were not furnished with the necessities such as lines for drying cloths, mirrors, water, emergency menstrual pad materials, etc. It was only Moroto district were the changing rooms were a bit furnished with a table, chair, bucket for disposal of used menstrual pads, water, emergency pads, mattress for resting, first aid box and some reading materials. This was due to support from C&D, KOICA and UNICEF.

Facilities for waste disposal

According to the MoES Study on MHM (2020), 80% of the girls, female teachers and community women that reported regularly using disposable pads disposed of their used menstrual pads in pit latrines. Over 80% of district respondents indicated having no incinerators in schools, hence some disposed in the rubbish pits, bushes, bathrooms, school compounds (majorly practiced at night by school girls). Some of the schools that cannot afford incinerators for disposal of hygiene facilities improvise a pit/hole for disposal of these used materials. However, in event when it rains, water accumulates in the pit and this can lead to air pollution and can become a breeding place for germs thus the outbreak of infectious diseases. Also, disposal of used menstrual pads in pit latrines contributes to latrines filling up fast and makes emptying difficult.

3.3 Policies, Strategies and Legal Frameworks that guide implementation of sanitation, hygiene and MHM – Based on literature review.

The Constitution of the Republic of Uganda (1995)

The Constitution of the Republic of Uganda (1995), national policies and other legal instruments. Article 39 of the constitution stipulates that, "Every Ugandan has a right to a clean and safe environment." The constitution further provides for equality and freedom from discrimination (Article 21(2) on the basis of sex, race, colour or social or economic standing, political opinion or disability". Again article 32(1) guarantees affirmative action in favour of the marginalized on the basis of gender, age, disability or any other reason created by history, tradition or custom, for the purpose of redressing imbalances which exist against them. Uganda is also one of the first countries to establish a Human Rights Commission in the 1990s.

However, while Uganda's constitution is widely recognised as one of the most inclusive, and while it has informed the formation of a number of policy instruments, and whereas the WASH policies have clear stipulations geared towards promoting inclusive and sustainable services, gaps still exist and the implementation of the stipulations is quite limited and needs to be addressed to ensure access to sanitation, hygiene and MHM services for all by 2030.

The National Gender Policy (2007)

The National Gender Policy (2007) seeks to promote appropriate education, sensitisation and creation of awareness on the responsibility of all concerned parties in each sector to address the specific gender inequalities within the sector. The gender and rights priority actions include enacting and eliminating gender discriminatory practices, norms and values; developing and implementing sexual and reproductive health rights programmes; and developing strategies to sensitise communities about children's rights and responsibilities so as to protect the girl-child from abuse. It is technically right to say that the NGP policy provides the policy context for menstrual programs. While it notes the sanitation improvements, it falls short of emphasing the links between WASH and women's reproductive and sexual

rights; and the need to strengthen the focus on sanitation and related issues such as knowledge and skills, facilities, materials and policies that can have implications on women's reproductive and sexual rights.

Equal Opportunities Policy (2006)

The Equal Opportunities Policy (2006) is the policy that specifically deals with concerns of marginalization, discrimination, injustice, exclusion, unfairness, inequality in access to resources, services and benefits. It mainly addresses three critical issues in relation to marginalization and exclusion and resources that are access, control and benefit. The policy also notes that the Social Development Sector Strategic Investment Plan addresses marginalization and exclusion by articulating the interventions for promoting participation, access and utilization of basic services by the different groups. The plan also focuses on strengthening coordination mechanisms. Among the policy priority areas, two are critical to exclusion and sanitation and MHM. These are:

1. promoting retention of vulnerable groups in formal education
2. a national minimum package to ensure that vulnerable groups receive services.

It is important to note that while the equal opportunities policy locates the coordination of exclusion and marginalization in the Ministry of Gender, Labour and Social Development, MHM as marginalisation and exclusion issue is currently coordinated in the Ministry of Education and Sports (MoES).

National Policy on Disability in Uganda (2006)

The policy clear notes the vulnerability of PWD; also notes that their major concerns are poverty, education and skills, employment, conflicts and emergencies, social security, health, HIV/AIDS and accessibility. According to the policy, gender and age exacerbate the situation in accessing services. The policy does not unpack each of these services. The policy notes that conflict and emergencies not only contribute to disabilities among communities but also undermine the social patterns that support PWDs and that such situations may lead to exclusion and marginalisation in accessing emergency assistance. The policy further observes that PWDs concerns in relation to health remain inability to access basic health services and assistive device to enable them lead independent and productive lives.

The policy also observes that women with disability challenges include lack of public awareness, negative community attitudes, cultural beliefs and lack of programs on specific concerns of women with disabilities. The policy also notes that PWDs lack access to most buildings and all services in general. It promoting effective friendly service delivery to PWDs and Care-givers and is to ensure that the capacity of PWDs and their Care-givers to access essential service is enhanced. On the overall, one may say that the policy has limited engagement with the concerns and specific health needs of women and girls with disabilities. There is also lack of disability-specific gender mainstreaming know-how because nothing much has been invested to increase skills in disability-specific gender analysis. Whereas guidelines, checklists and gender action plans have been developed to assist staff in programming, disability-specific gender action plans are yet to be developed.

Uganda National Culture Policy (Reviewed 2019); Draft

The Uganda Culture Policy provides the framework to facilitate community action against practices that impinge on human dignity. However, the policy does not elaborate on how this is going to be done either as a priority area or strategic action.

The Uganda Gender in Education Sector Policy (2016)

The Gender in Education Sector Policy recognizes the high attrition rate of girls from Primary 5 to Primary 7, and that is linked to sexual violence while at school. The policy recognizes that girls with disabilities are disadvantaged by lack of information on sexual maturation and being take advantage of which aggravates their dropout rates. On the overall, the policy recognizes that inadequate sanitation facilities and infrastructure keep girls and other marginalized groups out of school. The policy provides for an objective of promoting an enabling, protective and gender responsive learning environment for all persons with a target of a learning environment that is gender responsive by 2030.

As a principle, the policy provides for gender equality and non-discrimination where education is a human right and all individuals (male and female) have equal right to education resources and opportunities. It also provides for inclusiveness. "This policy stresses paying specific attention to special needs and the disadvantaged groups including orphans, learners from poor families, single headed households, learners from hard to reach areas, learners leaving with HIV/AIDS, child mothers and learners that practice negative cultural practices and adopting affirmative action in favor of women and girls to address the existing imbalances."

i. the primary education subsector targets provide for, among others, the promotion of sexuality education programs aimed at preparing learners for puberty including a menstruation and sexual maturation
ii. budget resources to provide gender and disability responsive infrastructure and facilities under the school facilities grant
iii. ensure the learning environment is gender and disability responsive and promote safety and security at school.

The policy provides for gender in construction and infrastructure development. The specific policy objective is to promote school and institutions facilities and infrastructure that are responsive to women and girl's special needs and interests. The policy strategies include:

a) Conduct gender and social impact assessments on infrastructure development projects in order to identify related gender and social risks and impacts
b) Design and implement gender and social safe guards during construction and infrastructure development
c) Mainstream women and girls special needs and interests into facilities and infrastructure development
d) Mobilize contractors on gender responsive construction and infrastructure development
e) Promote codes of conduct on protection of women and children's rights contractors including development of policy guidelines on Grievance Redress Mechanism (GRMs).

The Gender in Education Sector Policy recognizes the following as key actors in sanitation, hygiene and MHH: Ministry of Education & Sports (The Gender Unit); District Gender Coordination Committees; Local Governments; Education Development Partners; National Curriculum Development Centre; Directorate of Education Standards; Ministry of Gender, Labor and Social Development; Ministry of Finance Planning and Economic Development; Ministry of Justice; Parliament of Uganda; Ministry of Local Government; Ministry of Health; Ministry of Internal Affairs; Schools and Institutions; Community Service Organizations; and communities/parents/guardians.

The International Menstrual Hygiene Day

Speaker Kadaga endorses Menstrual Hygiene Charter

By Fred Ouma, Plan International

The weather was perfect. The organisation was meticulous. Security was tight. The band was awesome.. And the signing of the Menstruation Hygiene Management Charter for Uganda was a priority. That's the day it was – May 28, Menstrual Hygiene Day.

It all started with an Advocacy Walk, which started at Wandegeya and ended at the Parliament of Uganda, where the MH Charter was handed to the Speaker of Parliament, Hon Rebecca Kadaga.

Speaking as a chief guest, the Speaker of Parliament, Rebecca Kadaga said that menstrual hygiene was crucial to the health, education and self-esteem of girls and women. 'Last time [in Parliament] when we were demanding for sanitary facilities for all schools in the country some people were saying it was too expensive, but you can't place a price on dignity of girls and women,' said Kadaga, amidst applause.

May 28th, is the international day declared by the United Nations as Menstrual Hygiene Management Day that started in 2014. Advocacy led to moving of a motion on MHM in the Parliament of Uganda in 2014. Uganda celebrates the MHM Day annually since 2015 which led to the signing of the Menstrual Hygiene Charter by the Speaker of Parliament. The Menstrual Hygiene Day is an annual awareness day to highlight the importance of good MHM. The day affirms the world's commitment to create conducive conditions for girls and women. In the Ugandan context the day helps to break the silence and build awareness about the fundamental role that good MHM plays in women and girls' lives to reach their full potential. It also highlights the specific needs and risks for refugee girls, displaced girls whose dignity and access to the safety and opportunity of an education are pushed aside by taboos, misconceptions, and lack of proper training and materials. However, it is observed that nothing is going on at national level since the signing of the Charter and the passing of the MHM motion in Parliament and the question would be "why"? Additionally, a question remains whether the MHM day should remain coordinated by Ministry of Education and Sports or by MoGLSD..

Motion on MHM, passed by Parliament of Uganda in November 2014

Moved by Hon. Amongin Jacqueline

Chairperson Parliamentary Forum on Water Sanitation and Hygiene

Seconded by Hon. Akello Judith France Shadow Minister of Education and Sports.

(Under Rule 43 of the rules of procedure)

WHEREAS Article 30 of the constitution of the republic of Uganda 1995 grants the right to education to all persons of Uganda and article 34 imposes the responsibility of providing children with basic education on the state and the parents.

AND WHEREAS the girl child is subject to vulnerability and increasing her access to education is an important policy priority in many developing countries, including Uganda.

AND WHEREAS the policy makers have failed to indicate poor menstrual hygiene management lack of

Water and Sanitation Gender Strategy (2018-2022)

The Strategy provides the Water and Environment Sector's commitment to the promotion of Gender Equality and Women's Empowerment in the Country. It specifically presents the commitment of the Sector to the elimination of gender inequalities among men, women, boys, girls and other vulnerable groups. The strategy makes specific reference to menstrual hygiene in relation to the following:

1. Ensuring a gender sensitive environment by making available such amenities like nursing rooms, breastfeeding rooms, menstrual hygiene pad bins and baby day-care centres.
2. That the rural water sanitation department promotes menstrual pad bins in the washrooms for girls to take care of the menstrual hygiene concerns.
3. Urban Water Supply and Sewerage Department ensures that in schools washrooms for girls are promoted to take care of the menstrual hygiene concerns.
4. The procurement Unit ensures that specification for school latrines have washrooms for girls to take care of the menstrual hygiene concerns.
5. Local government and NGOs ensure that the water supply and sanitation technology and infrastructure:
    a) in schools, ensure that washrooms for girls are promoted to take care of the menstrual hygiene concerns.
    b) Build capacity of the primary school girls to make re-usable sanitary pads.

In relation to Persons with disabilities the strategy makes the following references:

1. Ensure that new and old office facilities have convenience rooms (toilets and urinals) well labeled for men, women and access for PWDs and the elderly.
2. That rural water supply and sanitation department provide access for PWDs with a specific platform and access ramp on the water source.
3. Ensure that all facilities are gender segregated and cater for PWDs.
4. Local government and NGOs ensure that the water supply and sanitation technology and infrastructure
    a. provides access for PWDs with a platform and access ramp on the water source apron.
    b. ensure that all facilities constructed are gender-segregated and have provisions for PWDs
5. Water Entrepreneurship should encourage women, men, youths and PWDs who are caretakers of water kiosks to vend other items alongside water to maximise utilization of the water kiosks. And that technologies such as valley tanks and dams have women in leadership with the committees needing at least 30% of women in leadership positions and representation of all other vulnerable groups like youths and PWDs. Ensure that 30% gauge readers are women and other vulnerable groups.

The key issue to note is that the strategy uses advocacy rather than requirement concepts such as promote; in essence these are not mandatory requirements.

National Water Policy (1999); under review

The National Water Policy notes that in planning and allocation of public funds for agriculture water development, investment subsidies will be given to vulnerable groups: women, youth, poor farmers and disabled especially in drought prone areas. The policy also notes rehabilitation and or development of

dams and valley tanks in dry pastoral areas will be done with full community participation with priority given to vulnerable groups for example youths, women and poor farmers.

While there is limited mention of the specific sanitation health needs of women and girls, the policy clearly recognises women and their needs to have an equal opportunity as men; to participate and develop their capacity in water processes including in the design, construction, operation and management of improved water supply and sanitation facilities. The policy observes that the use of public funds for the development of aqua-culture and livestock water supply will mainly be for vulnerable groups (poor farmers, poor households, women, youth and in schools) in order to provide basic needs for food security, reduce water related health problems, increase nutritional levels, settle nomadic pastoral communities and protect the environment. The policy observes that training of women and youths will be targeted to enhance equal opportunity for their participation in management of the schemes. The policy has a strategic outlook but does not focus on the women's specific needs in relation to sanitation and MHM.

Policy Recommendations for National MHM in Uganda Primary and Secondary Schools 2017

The recommendations problematize MHM in Uganda and locate the problem in lack of adequate infrastructure in schools due to increased enrolment in schools. The policy recommendations identify a number of issues including the following:

1. Girls missing of school due to MHM issues including lack of private changing rooms;
2. Underdeveloped MHM strategies
3. MoES being the most active actor in the last decade in cooperation with development partners and not necessarily other ministries such as the MoH, Ministry of Gender, Labour and Social Development, and Ministry of Water and Environment which poses sustainability threats.

The policy recommendations highlight the following policy options for cooperation across ministries:

1. National policy indicators included in the strategic plans such as the National Strategy for Girl's Education and a clear annual target with an overall 50% increase in MHM-Friendly facilities and availability of sanitary pads in schools by 2020.
2. Comprehensive education and training programs that engage stakeholders, such as school leaders, community leaders, parents, schoolboys and school girls.

National Environment Policy (2005)

The policy observes that environmental health encompasses a wide range of subjects and that in the Ugandan context it is primarily concerned with water supply, sanitation and hygiene promotion; solid, liquid, hazardous and health care waste management; air pollution control, food safety and hygiene, the control of insect vectors and vermin, occupation health and safety, road safety; and housing conditions.

The policy further observes that Environmental sanitation is a subset of environmental health and for the purpose of the policy, it refers to the safe management of human excreta and associated personal hygiene; the safe collection, storage and use of drinking water; solid waste management, drainage; and protection against vermin and other disease vectors.

According to the policy Environmental health activity is concerned with the control of environmental factors that affect health and the provision of infrastructure and environmental services necessary for health. The policy recognises the increased enrolment in schools due to Universal Primary Education (UPE) and the need to provide adequate water and sanitation facilities in schools. On the overall, the policy uses gender neutral language and it is hence unable to cipher the specific sanitation and health needs of PWD, women and girls.

It, however, observes that interventions should respond to the differing needs of men, women and children while recognizing that women are main users of water and sanitation facilities. The policy leans more towards a private sector driven approach but recognises geographical marganization. Specifically, it observes that "Government funding for sanitation does not include subsidies towards the hardware cost of household latrines. The case for the use of appropriate and carefully targeted subsidies will however be considered when addressing the challenge of stimulating demand for improved sanitation and hygiene amongst the more disadvantaged or marginalised sectors of society as well as those living in difficult areas…and where innovative low-cost sanitation technologies are being pioneered for future scaling" (p 16).

The policy also notes that Government is committed to establishing clear budget mechanisms for sanitation at all levels and that it will take steps to ensure that allocations for sanitation at district/town level and below are commensurate with the scale of local sanitation and hygiene promotion needs and that district guidelines on the use of central funds will be revised accordingly based on a comprehensive plan.

In relation to health care waste management, the policy observes that the legal and administrative frameworks are inadequate; there are no guidelines and appropriate equipment and technologies to handle the safe disposal of healthcare waste. The policy notes that Environmental Health Division (EHD) will play its part in addressing these issues by providing appropriate guidelines to help monitor such risks and will also undertake research to devise ways and means to overcome the environmental risks wherever they occur.

Technically, the major focus here is on the non-human risks related to the environment and not the human-based risk factors, for example those associated with menstrual hygiene. The policy provides a window for engagement in menstrual and PWD issues in environmental health through the review of the guidelines to be more specific on the software and hardware aspects of sanitation rather than the simplistic definition that is embedded in it that focuses on only toilets and latrines.

It is further important to observe that the policy also provides guidelines on households' environmental health including bathing areas, safe disposal of all wastes and notes that appropriate strategies for improved housing will be formulated. The key issue to note here is the absence of reality – policy links – in reality there is inability to afford decent housing including in relation to menstrual hygiene by many Ugandans.

In relation to monitoring, the policy observes that the EHD will support the incorporation of the environmental health indicators into the district health monitoring systems and the use of relevant

monitoring information as a tool to inform sanitation strategies. The policy highlights the key indicators for sanitation and hygiene and these include:

1. Percentage of households with access to and using hand-washing facilities with water and soap (soap substitute)
2. Percentage of households that are safely disposing children's faeces
3. Percentage of households that are maintaining safe drinking water chain
4. Percentage of households that have access to and are using improved toilets/latrines and
5. Proportion of villages with faecal-free environment.

It is important to observe that sanitation is monitored at the household and not school level while MHM is mainly monitored from the school – again a dejuncture between policy and practice. Also, important to note is the fact that the recently commissioned National Sanitation Guidelines (2017) incorporated a small sub-section on MHM and include i.e. "percentage of primary and secondary schools with facilities for washing, changing and disposal of menstrual waste". By and large the National Environmental Policy is gender neutral, it does not major on understanding the various social categories and how they should engage with the policy. It highlights the importance of the EHD. Interestingly the policy seems to be located in the Ministry of Health and yet MHM is mainly implemented in the MoES and should be sitting in the MoGLSD.

The Kampala Declaration on Sanitation (1997)

The Charter observes that sanitation is a basic right and a responsibility for every citizen of Uganda. It further observes that women and youth organizations shall be represented at all levels of the sanitation delivery system and are provided with opportunities for advancement and support in sanitation activities. The Declaration is gender neutral in its language except when it comes to community engagement, it notes that the focus of sanitation at community level should be on women and children. It also observes that due attention should be paid to persons with disabilities; behavioral change; multi-sectoral approach and that sanitation is a basic right that is context specific and can be addressed through partnerships among actors, government, donors and civil society. Lastly the Declaration recognises the need for indicators for sanitation improvement.

The Public Health Act 1935 (Cap. 281); modified in 2000

The Public Health Act uses gender neutral language. The Act focuses mainly on the management and prevention and management of diseases. The Act highlights infectious diseases, epidemic and endemic diseases, plagues, and venereal diseases. The Act also focuses on prevention of disease and here it highlights vaccination, sewerage management, sanitation and housing, drainage and latrines. It is important to note that the Act mentions nothing in relation to marginalization or exclusion and nothing in relation to menstrual hygiene.

Local Government Planning Guidelines (2014) –

The guidelines recognize gender and disability as cross cutting issues that should be considered at situational analysis and policy relevance levels.

Summary of the analysis of policies and legal frameworks

Table 5: Summary of the Analysis on Policies and Legal Frameworks

REVIEW OF POLICIES – KEY FINDINGS

1. The Equal Opportunities Policy mandates the Ministry of Gender, Labour & Social Development to coordinate MHM as an issue of exclusion and marginalization issue, and not Ministry of Health or Ministry of Education and Sports.
2. The few policies that have attempted to refer to MHM do so in relation to girls in schools more than the girls and women outside the school environment.
3. There is no policy/legal framework that focuses on Menstrual Hygiene exclusively. The existing policies (environment, water and public health policies) are not explicit on MHM.
4. There is no definition for sanitation in some of the policies. For example the Water and Sanitation Gender Strategy; the National Water Policy; and the Public Health Act. It is the National Health Policy that endeavors to define sanitation and briefly says that in "this document, it refers to the management of human excreta" (pp 1).
5. One document, the Kampala Declaration refers to Sanitation as a right. It is not clear, however, what this means in practical terms because a right is an entitlement but issues of affordability, accessibility, and availability become important in this case.
6. In relation to the National Water Policy, Water is both a Social and Economic Good. But it plays out more as an economic good that has implications to access and affordability particularly for the poor women who suffer from poor menstrual hygiene and yet need to wash frequently.
7. Sanitation in the Environment policy mainly is monitored at household point and mainly in relation to management of faecal matter. Yet MHM is not a faecal issue and by and large it is monitored at school level. In other words, levels of sanitation are at the HH level and not school level.
8. The National Water and Sanitation Gender Strategy uses the words to 'encourage', 'promote' but not 'required". In essence it is not mandatory. Ministry of Education and Sports already has MHM related policies. The question would be why is the Ministry of Water & Environment not implementing them? Why does the exclusion in sanitation, hygiene and MHM continue? It is because this is more located in the Ministry of Education and Sports not in the Ministry of Water and Environment.
9. The Public Health Act 281 mainly focuses on management of diseases such as prevention (vaccination, sewerage management, etc.) of infectious diseases. It mentions nothing in relation to marginalisation, exclusion, and disability.

KEY QUESTIONS

1. Is the concept of sanitation understood in the same way by the three Ministries of Water and Environment, Health and Education and Sports?
2. Is there a common policy on sanitation in Uganda that can govern the three Ministries?

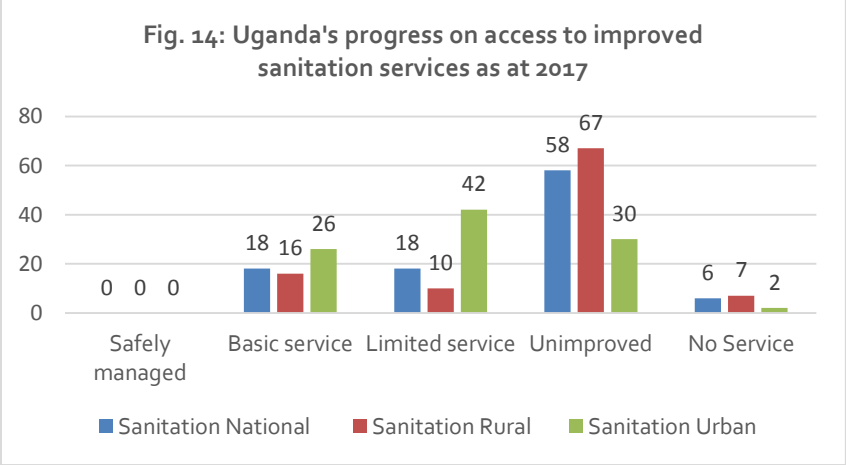
Note: Most of the policies are old, 10 years or more and may not reflect the current context.

3.4 Current level of service delivery for sanitation, hygiene and MHM (and water) in Uganda

3.4.1 Status of safely managed sanitation and hygiene services in Uganda

In the context of the 2030 Agenda for Sustainable Development, safely managed sanitation and hygiene considers achieving access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations. According to the Ministry of Water and Environment (MWE) Report (2020), sanitation coverage (population accessing any form of sanitation facility) stands at 78% in the in rural areas compared to 89.1% in urban areas. In Kampala city, 99% of the population has access to any form of sanitation facility.

While the JMP (2019) indicates that nobody in Uganda has access to safely managed sanitation[15] because estimates were not readily available, the MWE indicates that the population with access to safely managed sanitation in Uganda stands at only 7% in rural areas and 39.2% in urban areas (SPR 2020). However, it is important to note that the JMP data is of 2017, and was released only in 2019 which could explain the differences in figures (please see Figure 15). On the other hand, the percentage population accessing basic sanitation services[16] in rural and urban areas is 18% and 39.2% respectively (SPR 2020) as compared to 16% in rural areas and 26% in urban (JMP 2019). The population without any service that practices Open Defecation (OD)[17] according to JMP stands at 6% national (7%-rural; 2%-urban), as compared to 22%-rural and 12.1%-urban (SPR 2020) totaling to an estimated 8.8 million people. Although the JMP figures put Uganda in a better position with regard to OD, this points to the need for more promotion of hygiene and sanitation coupled with provision of sanitation and hygiene infrastructure if SDG 6.2 is to be attained in Uganda.

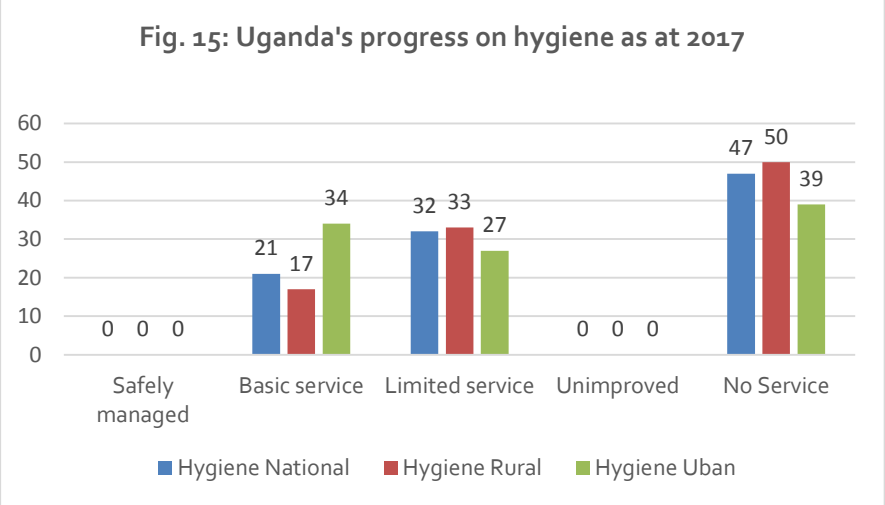


Source: WHO/UNICEF (2019)

[15] Percentage of population using improved sanitation facilities not shared where excreta is safely disposed in situ or transported and treated off-site..
[16] Percentage of population using an improved sanitation facility not shared with other households.
[17] Percentage of population practicing open defecation

3.4.2 Access to improved hygiene services (Household)

The indicator to measure hand washing with soap at household level is defined as "percentage of population with access to hand washing facilities with soap in households". Access to hand washing with soap at household level is 38% in the rural areas and in the urban areas stands at 61.1% (SPR 2020). The increase in coverage is attributed to the Covid-19 response messaging which resulted in positive behavior change amongst the population towards hand washing with soap. However, according to JMP, no Ugandan has access to safely managed hygiene; while only 21% of Ugandans have access to basic hygiene at national level (17%-rural; 34%-urban) with 47% having no hygiene service (50%-rural; 39%-urban).



Source: WHO/UNICEF (2019)

Summary of trends in WASH Coverage by Wealth Quintile (%) Uganda *(Under Development)*

The UNHS (2013) suggests that only 14.0% of households have access to improved sanitation, with the proportion of households with a shared improved facility standing at 17.3%. Clearly, most households do not have access to adequate sanitation, and when they do have access, in most cases the facilities are shared, often by too many households. A rural/urban breakdown of access to improved sanitation shows that urban households are more likely to have access to improved sanitation compared to households in rural areas. The data shows that 19.7% of households in Kampala and 18.6% in other urban areas had access to improved sanitation against 12.3% in rural areas. This is also the case for shared but improved sanitation (50.5% of households in Kampala and 36.1% in rural areas). Looking at sanitation from a gender dimension, UNHS 2013 data suggests that the share of female-headed households that have no toilet is slightly higher than the corresponding number of male-headed households (12% and 9% respectively). This finding is consistent with the evidence of a strong correlation between poverty and lack of toilet facility, and it is known that female headed households are more likely to be poor.

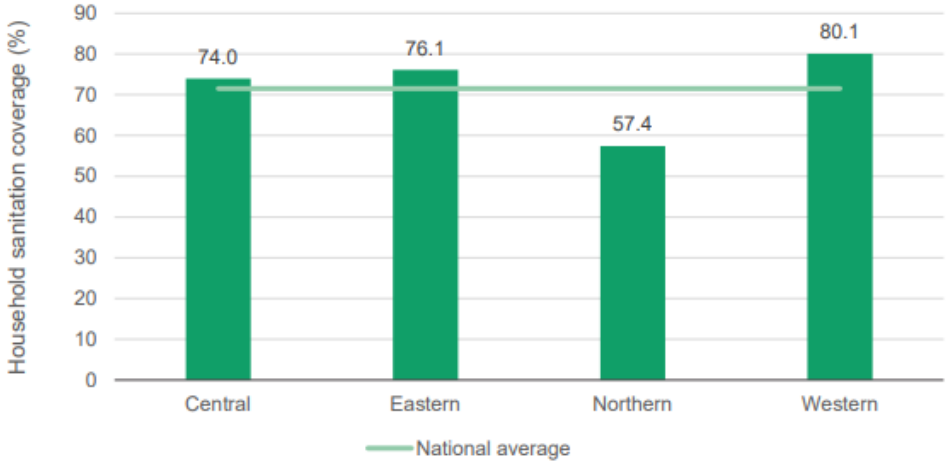
Table 6: Trends in Sanitation Coverage by Wealth Quintile (%) Uganda

Summary of trends in Sanitation Coverage by Wealth Quintile (%) Uganda				
Poorest				
	Basic sanitation	**Limited sanitation**	**Unimproved sanitation**	**Open defecation**
National	5.4	5.0	68.9	20.7
Urban	12.4	17.2	64.3	6.1
Rural	4.4	4.3	67.3	24.1
Poor				
National	10.7	6.7	79.9	2.7
Urban	23.2	36.9	39.5	0.4
Rural	10.1	6.0	81.2	2.6
Middle				
National	16.2	8.0	74.8	1.1
Urban	23.0	57.7	19.6	0.3
Rural	13.5	6.9	77.6	2.1
Rich				
National	27.2	18.1	54.6	0.1
Urban	34.1	56.9	8.9	0.1
Rural	20.2	10.9	68.4	0.5
Richest				
National	43.1	40.3	16.6	0.0
Urban	56.6	41.6	1.8	0.0
Rural	41.9	16.8	41.3	0.0

Source: WHO/UNICEF (2019)

Analysis of WASH indicators and regional poverty shows that the eastern region performed second best, and above the national average, on household sanitation coverage. Northern Uganda with the second highest poverty rates in 2016/17, performed lowest in household sanitation coverage compared to other regions (please see Figure 16).

Fig. 16: Northern Uganda is behind the rest of the country in households sanitation coverage

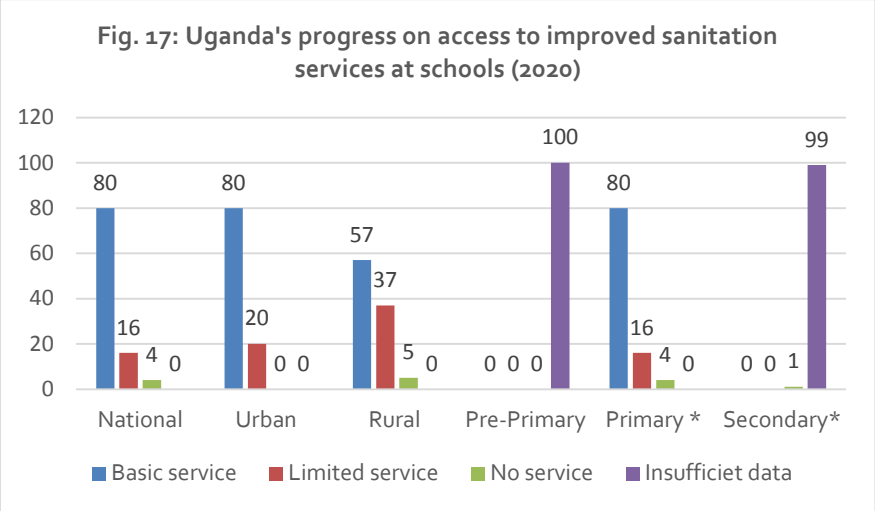


Source: Poverty in Uganda; Development Initiative; National and Regional Data Trends Factsheet (2020).

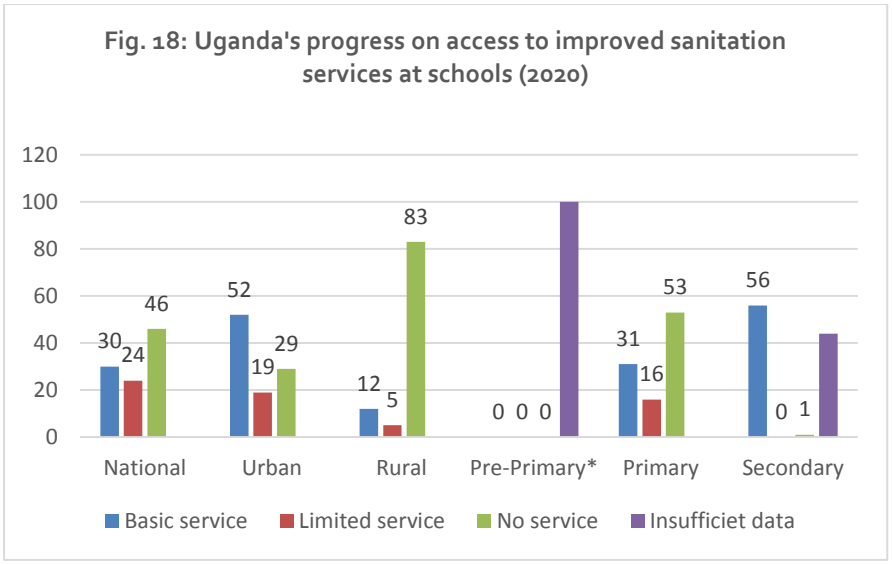
3.4.3 Access to improved WASH services in schools

Access to improved sanitation and hygiene services

Hand washing in Ugandan schools is measured by the MWE as "percentage of pupils enrolled in schools with basic hand washing facilities". Hand washing coverage in schools stood at 58% with the pupil to stance ratio of 72:1 which is further away from the national standard of 40:1. This pupil: stance ratio calls for more investment in school sanitation to make the school environment safer and more conducive for the learners.



Source: WHO/UNICEF (2020)

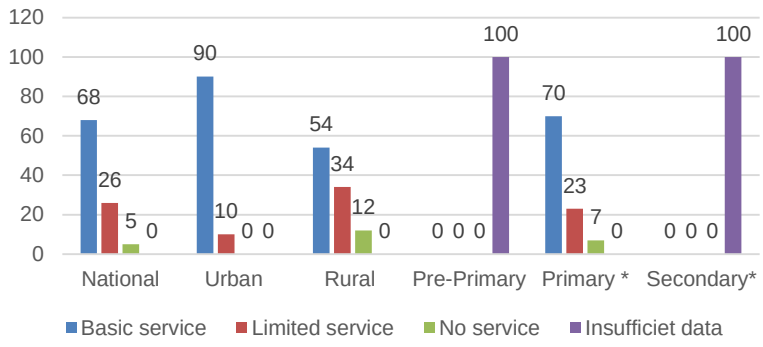


Source: WHO/UNICEF (2020)

Access to improved water services

Ministry of Water and Environment is not tracking separately the indicator on access to safe water in schools. However, the JMP (2020) puts access to basic water services in Ugandan schools at 68% (90%-urban; 54%-rural; and 70%-primary). There were no basic service estimates available for pre-primary and secondary schools (please see Figure 16).

Fig. 19: Uganda's progress on access to improved water services at schools (2020)

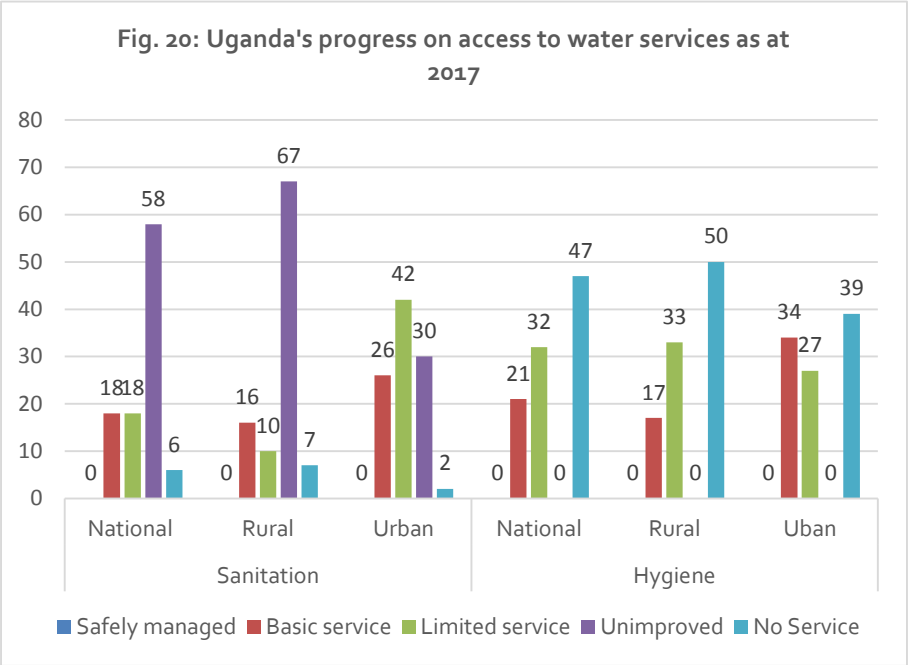


Source: WHO/UNICEF (2020)

3.4.4 Access to improved water services

Access to improved water services impacts sanitation, hygiene and MHM. According to the JMP (2019), only 7% of the population in Uganda (4% rural; 16% urban) has access to safely managed water services[18], compared to the 2020 figure of 57.11% in urban areas reported by the MWE. The Ministry was unable to report on the access to safely managed water services in the rural areas during the reporting period. While according to JMP, 42% of the population (37%-Rural; 59%-Urban) has access to basic water services[19], compared to 68%-rural and 70.5%-Urban as reported by the MWE (*please see Figure 19*).

[18] Percentage of population using safely managed drinking water services located on premises.
[19] Percentage of population using an improved drinking water source.



Source: WHO/UNICEF (2019)

3.4.5 Current status of MHM in Uganda

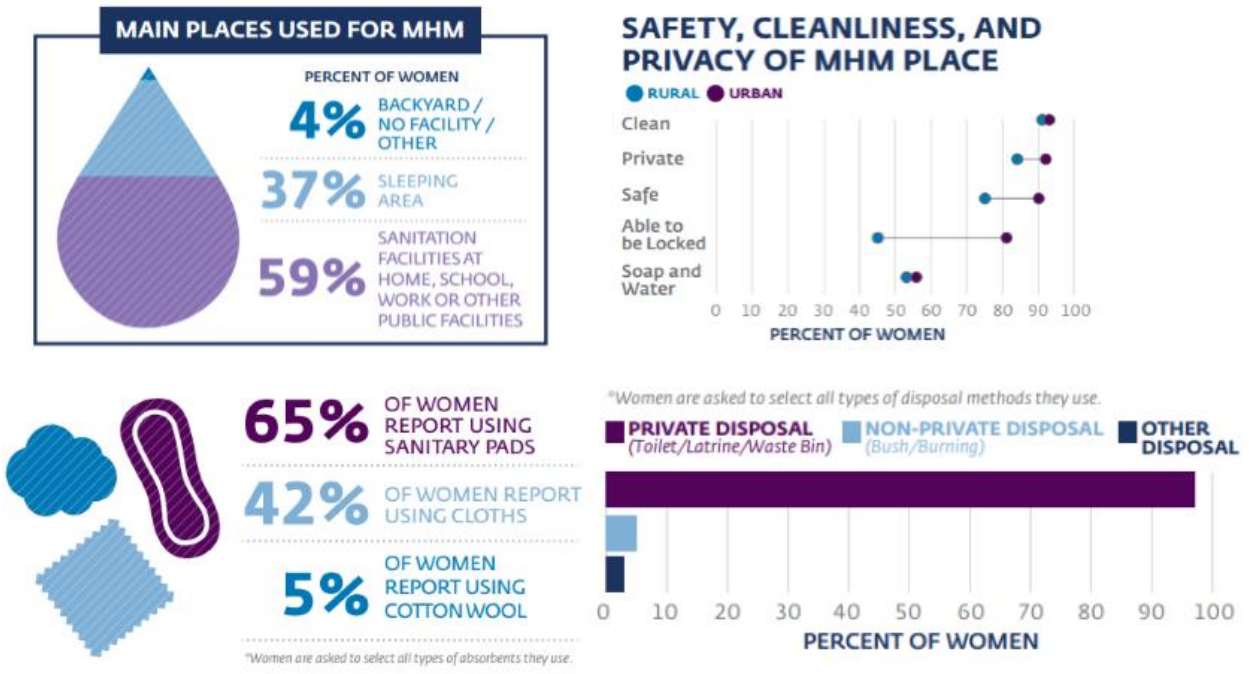
Although Uganda has committed to and taken several positive steps in achieving gender parity and empowerment for all women and girls, women continue to lag behind in many development processes due to often understated or overlooked gender challenges. One of the setbacks in this regard for women's progress in Uganda is the inadequacy of Menstrual Health & Hygiene (MHH) especially in rural areas. MHM is a multidisciplinary and inter-sectoral concern. It directly influences development outcomes through its effects on education, health and participation in the economy. It affects educational aspects such as school attendance, school retention, school performance and dropout rates.

In 2017, PMA2020 conducted a nationwide survey in Uganda of 2,762 females age 15 to 49, who reported menstruating in the past 3 months. PMA2020 looked at how menstrual hygiene is managed across age groups and wealth categories, including the types of materials used; and the safety, privacy, and cleanliness of the places where women manage their menstrual hygiene needs. Only 35% of women in Uganda reported having everything they need to manage their menstruation, and this does not vary by age, indicating that across their reproductive years, the majority of women are unable to adequately meet their MHM needs.

A total of 59% use sanitation facilities at either at home, school, work or other public facilities which shows the critical role sanitation facilities play in managing MHM. With 65% of women reporting use of sanitary pads, close to 98% of women use toilets/latrines or waste bins for disposal of used menstrual material which contributes to filling up of toilets particularly in schools.

Regarding washing, reuse and drying menstrual materials, 42% of women reported that they wash and reuse their MHM materials. Of those who wash and reuse, 97% of women reported that their materials were completely dried before reuse. Figure 20 provides a snapshot by PMA2020 of the results of the survey regarding main places used for MHM; and the issues around safety, cleanliness and privacy of MHM place (for both rural and urban locations), among others.

Fig. 21: A snapshot of select MHM indicators for the PMA2020 Survey on MHM (2017)



3.5 Extent of Exclusion among Marginalised Groups and Factors Responsible for Exclusion – Based on findings from the field

3.5.1 Who are the marginalised and excluded?

The findings of the assessment indicate that marginalisation is a relative concept that connotes exclusion, discrimination, and negligence in relation to access to and utilization of a service. It is also about non-participation in processes that provide a service; or denial of an opportunity. The study found out that women, people living with disability, the poor, elderly and girls are groups of people that are socially excluded from access to sanitation and hygiene.

Table 7: Summary of the most Socially Excluded Groups and Reasons for Exclusion

Socially excluded group	Reasons for exclusion in sanitation, hygiene and MHM
Categorization by people	• Women, girls – especially in their periods, youth, children especially those in early children development, elderly, refugees, pygmies
Based on geographical/natural factors	• Hard to reach areas; low lying areas, locations with frequent floods, natural disasters; slums; urban poor – share services – survival for the fittest. • Examples include Rakai which has a lot of iron; Kapchorwa and Bugisu, and Sebei that have rocks/water logging and hence there is lack of appropriate and affordable technology to develop the latrines.
Lack of services/Poverty *(irrespective of district of location)*	• No health centers; locations with poor roads; areas with poor service delivery; locations without access to water sources
Level of development	• Those with traditional ways of doing things e.g. those who till the land for survival; modern families leading to lack of support systems for the elderly
Level of well-being	• The sick; those with physical disabilities
Age	• Children; the Elderly
Gender	• Women and girls
Disability	• Deaf, Lame, Blind, Dumb, those with special needs
Covid-19	• Those who loose income due to Conid-19
Political exclusion	• Political interference that creates marginalization due to inability of government to provide services; those that do not have a voice
Indigenous Communities/Culture	• For example, the Batwa and the Karamojong have been left out

3.5.2 Extent and factors that are responsible for Marginalisation or Exclusion of Communities in relation to issues of Sanitation, Hygiene ad Menstrual Hygiene in Uganda

A number of factors were identified during KIIs and FGDs as responsible for exclusion and aligned to the

Policies and legal frameworks – lack of clear legal framework or Standard Operating Procedures (SOPs) on MHM. The absence of guidance on the subject matter means that leaders at various levels lack enough knowledge on the subject matter of menstruation and hence MHH does not make it to the decision-making and planning table. Respondents also observed that government has relevant policies but these policies usually end up on papers and in theory, with very little put in practice or implemented at the lower levels. Policies on MHM are available but do not trickle down to the grassroots hence communities are not aware about some of the existing policies related to sanitation, hygiene and MHM.

Culture - Menstruation is taken as an abomination where women in some communities are isolated until the end of blood flow, for example among the Karimojong and Sudanese refugees. In some cultures, menstruation is taken as a disease. "If asked in any Luo language, it is seen as disease – the disease of the month". It is seen as a disease that has not killed anybody but yet affects girls including loosing their education. In some cultures, women are not allowed to talk to their husbands during menstruation because it is taboo. It is a non-discussed issue that has no budget yet it has financial implications" (KI 1, October 2020). In other cultures, for example among the Karamojong, a woman that may be in her menstruation period is considered to be dirty and should not cross a junction. Hence if the water source location involves crossing a junction, the women will not be able to access it for self-care. The Study established that in the refugee settlements in West Nile region (Obongi and Adjumani districts), menstruating women and girls among the Sudanese are made to sit on the sand in the compound until when the menstruation period is over. During this time, girls do not go to school and women do not bathe and are isolated at home. For the boys, it is disgusting which affects the self-esteem of girls. To the parents, particularly men, once a girl starts to menstruate it is a sign of maturity and so they think of marrying her off, leading to early child-marriages.

> *"In some communities, particularly among the Karamojongs, a woman is prohibited from bathing daily, and if she does, she is perceived to be a prostitute (sex worker) who cleans up every time. She is only to bath once a week and that is on Sundays when going to attend a church service." (From a KII)*

Religious beliefs – restrictions still exist for particular denominations, such as the Orthodox Christians who continue to believe in menstrual taboos. Menstruating women must be secluded during menstruation and are not allowed to attend church services or have contact with men. According to the Old Testament of the Bible, a menstruating women is impure and that most things she touches become unclean. In Islam, for the entire duration of menstruation, a woman is considered ritually impure. She is supposed to stop certain forms of worship, e.g. the five daily prayers, fasting during the month of Ramadan) she fasts for an equivalent number of days later) or sitting in a mosque. She is not allowed to touch the Qur'an (recitation is allowed as long as she does not physically touch the Qur'an and recites it from memory or, a recent adaptation, reads it from a computer)[20].

> *"A woman is not supposed to receive the Holy Communion in the Catholic Church when she is menstruating, or during this period; she is considered dirty and therefore should not access holy sacrament". (Quote By a KII)*

Limited scope given to the relationship between Sanitation, Disability and MHM – there is non-consideration of the different forms of disability and their sanitation needs including in latrine construction and use**.** There is limited understanding of the different forms of disability. One respondent observed that NUDIPU has done limited advocacy on sanitation rights for the different categories of disabilities. There is observation that sometimes the PWDs are not considered as a special group; there is no representation on committees by PWDs and hence their needs may not be prioritized as a special

[20] Sarah house et al (2012): Menstrual hygiene matters – A resource for improving menstrual hygiene around the world.

group. Another respondent observed that the PWDs may not be able to fight for their rights and demand for sanitation services.

Discrimination against the PWDs – It was also reported that some communities still associate disability with a curse, and that when one leave home in the morning and the first person s/he meets is a disabled/an albino, his/her day will not be a good one". If a person is disabled, s/he is not meant to live and he/she is better dead than alive". Consequently, in planning, people with disabilities are looked at as the minority groups and very limited attention is given to them. This is why many institutions and households don't have comprehensive sanitation facilities including appropriate designs that suits their needs.

> *In Maracha a girl-child, physically impaired (disabled), lived in a cage around their home compound while the doors were locked. She would be given food to keep her inside the cage. Her parents did it because they did not feel comfortable living and associating with her as part of the family whenever visitors came home. The parents were later arrested when police noticed the case". (Quote from West Nile Region)*

Lack of empathy towards MHM as a reproductive health issue – most respondents observed that there is a sense in which menstruation is something that should not be talked about in or out of school**.** It is a taken as a sign of womanhood. Once girls start their menstruation, they view them as "marriage material - tortured – their bodies are presumed to be ready for motherhood, seen as a source of income" (KII 3, October 2020). In other words, they are women – and a woman applies to an adult and to this effect "they are not given support right from home to school" (KI 5, October 2020). Findings also indicated that generally MHM is considered a woman/girls' private issue that should not be talked about in the public and is not even considered as an issue for discussion either as a sanitation or reproductive health issue.

Knowledge, attitude and practices – the levels of knowledge and attitudes on MHM vary across the board. However, one respondent observed that the challenge is not lack of awareness but rather action. There is a gap between awareness and actions. The study findings indicate that local leaders and teachers are not aware of their roles in MHM due to lack of orientation and the presumption that they know their roles. There is a sense of feeling that MHM is an issue that needs to be discussed privately with the girls by the senior women teachers.

Other than roles, districts are embroiled in bureaucracy and corruption to ensure action. One respondent said that "the snag in implementation is due to bureaucracy at the district level – if one needed an MOU to work on menstrual hygiene – some district officials may start asking 'Ffe tufuniramuwa' [literally translated as: "how do we benefit"] which hinders implementation.

It was also observed that the districts have limited disaggregated data on PWDs and women and girls' health needs in relation to sanitation, hygiene and MHM to inform the planning processes. At times there is limited awareness of the needs of the different categories of people irrespective of the special needs of these different groups of people. Even where available, the focus is on numbers and not the level of suffering due to lack of services especially for PWDs. "We may need to measure the level of suffering

caused due to the lack of sanitation and services – what exclusion is causing these categories of persons and the potential and missed opportunities denied…we need to have empathy and it would inform attitude change and start creating awareness based on missed opportunities, suffering, potential, pain…focus beyond numbers and focus on the need to change…the Chief Administrative Officers (CAO), for example…do not know the magnitude of these issues…there is need to emphasize the effects than the numbers – and the impact even if one out of a thousand people …the effect of exclusion may mean a lot than a thousand persons" (KI 7, October, 2020).

There was an observation that the levels of awareness on MHM at the national level among development partners are high. This is demonstrated at the level of government by the availability of gender strategies in the ministries of education, water and health. There is a full ministry in Uganda that is responsible for gender work coupled with policies on affirmative action, together with presence of senior female teachers in schools. It was also observed that it is mandatory for sanitation facilities to have provisions for PWDs. Development partners urge government to meet their commitments in relation to their SDG commitments to sanitation and health and hygiene.

It was also observed, however, that the financial and human resources are limited and if available, may be diverted to other presumptively priority activities. This is especially compounded by the limited empathy towards the issues of sanitation, and exclusion due to the limited women and PWDs' voice in committees and community processes. Some of the respondents observed that, if not deliberate, some women and PWDs may not be party to decision-making processes and hence their issues will not feature in the plans and budgets.

The study also established that the ongoing programs by government and NGOs on MHM are piece meal, short term (most of them a year or two) and with limited geographical coverage. One respondent observed that probably only 30% of the country is reached with MH programs. Another respondent also observed that development partners are trying to address MHM but that it is more of theory than practice and lacks sustainability due to non-ownership of the programs by the communities. The MHM programs, according to the respondents, have focused on school-going children, with no focus by Ministry of Health on girls that do not go to school. "The non-school going children/girls; the community and market women do not know much about MHM" (KI 6, October 2020). The limited levels of knowledge at the community levels were linked by several respondents to the non-engagement of the Ministry of Gender, Labor and Social Development (MoGLSD) with MHM.

Sanitation facilities

The public infrastructure becomes inadequate as one moves away from the big cities. The public toilets in Kampala have improved due to private management that may not be the case of districts such and Kyegegwa, Sironko, among others. On the overall, the public sanitation facilities lack facilities for the disposal of pads and in indigenous communities, it is even worse because one cannot even talk about the absence of sanitary facilities. It was noted that hospital facilities need discussion because the patients in hospitals are temporarily disabled and would need facilities that can accommodate this disability.

However in reality, the facilities are generally poor without sitting facilities. Another respondent observed that the available facilities for persons with disability "are artistic and may not be efficient and if available, may not necessarily be used by the PWD; they get spoilt and are a threat to the health of the PWDs.

Refugee toilets is another issue, they lack facilities due to the emergency nature of their contexts that may compromise the state of their sanitation facilities. A multi-sectoral analysis of the dynamics of supply and access to basic services in nine vulnerable urban settlements (2018) by KCCA and partners showed that Kampala city has approximately 100,000 refugees who put pressure on the already overburdened basic services. The report captured access to sanitation as reported by refugees and host communities in nine vulnerable urban neigborhoods in Kampala. A total of 75% of households reported having no private access to toilets; 10% average number of households sharing one toilets; and 29% of households reported being satisfied with the quality of toilets. The most common issues reported being dissatisfied with the quality of toilets was too ditry (77%); congestion (42%); no gender seperation (33%), and Doors do not lock (21%).

The findings in relation to school sanitation facilities notes that the latrines are generally not enough in comparison to the student/toilet ratio. Most often girls have to line up, the standrd ratio is one stance to 40 learners. One respondent noted that the maintenance of these facilities is poor. Most often the school facilities lack locks and the storage of the pads is poor. Gutters get spoilt and girls resolve to stay at home where it is more favorable. The toilets especially in public schools lack hygiene materials such as soap, abd pad disposal buckets. Some of them lack the changing rooms. The location, operation and maintenance of the incinerator is also another issue. Sometimes the incinerator is located across the compound. Some schools lack incinerators and improvise by digging a small hole and where unavailable they are thrown into the latrine that fills up quickly.

Menstrual materials

> "Sanitary pads prices are so high if one calculates the monthly cost…it is prohibitive …if using 3 packs per a month…the more you move out of the city, the more expensive …if it is 3000/= in Kampala, it may cost 4000 in Arua and that is about 12000 per a month…it is exclusionary by the cost of the service… Kindly note that at household level, it is not talked about and hence it is not included in the budget "
> *(KI 8, October 2020)*

Affordability of pads was identified as a major issue as one respondent observed as captioned in the box. Indeed another respondent observed that most girls use reusable pads and to illustrate the gravity of the issue at hand she said that out of 3000 girls in a school, only 10 may be using disposable pads and that even mean that some of these pads are of poor quality. In Obongi district, ot was reported that girls in refugee camps would use one pad the entire day which compromises hygiene.

The reusable pads are not necessarily any better because the cost of the materials that make the pads are expensive and even their maintenance is complicated because most times they are dried under beds and not out under the sun due to the issue of

privacy. Some of the MHM products are not available on the local market for example the reusable menstrual cup. Two key informants noted that although the MoES has not come out to openly say it, it is against reusable pads due to hygiene concerns but yet most school children both boys and girls are being trained to make reusable sanitary pads.

In essence, the findings on menstrual materials indicate that there is no choice for women and girls when it comes to MHM. Also, it is a question of attiude towards of modern menstrual materials by women and girls. One respondent narrated the dilemma of women and girls as quoted in the text boxes below:

> " Some of them are made out materials that irritate... reusable ...issue of hygiene...storage...it is not realistic to expose them to the sun...where will it be put in the sun...women an girls do not want to hang the pad in the sun...they are hidden materials...limited choice and expensive" *(Quote By a KI 6, October 2020)*

> " At household level, if not use old pieces of cloth, MHM materials are not readily available, and hence inaccessible as they have to be bought. Secondly, there is still stigma around MHM and hence not easily talked about and therefore the concerned persons to provide are unaware of the situation...schools cannot afford to provide for the students and therefore, MHM materials are not easily accessed. On the overall, MHM materials are still very expensive for very many... can be affordable in urban communities but as you go into rural areas, they start using leaves and banana fibers."

> "The pygmies just moved from their residents (in the forests) to live with people in an organized setting (community). While in the forests, they used local materials such as leaves. They did not see or used pads before settling in the communities. Getting them to accept some of the recommended materials now is a challenge, they try to resist them" *(KII, October 2020)*

Institutional Arrangments for Exclusion and Marginalisation in relation to Menstrual Health

The respondents had mixed feelings in relation whether sanitation policies and guidelines in Uganda adequately address issues of Menstrual hygiene particularly for excluded groups. These are presented in the table below.

Table 8: Instituional arrangments for MHM

YES	NO
There is a policy on MHM in schools	• The focus is on school going children and not girls and women out of school. The MHM school guidelines are neither with the Chief Administrative Officers (CAOs) nor with the District Engineers, nor the Chairpersons LC V. • There are neither mechanisms for for policy implementation nor its follow up.The guidelines are not comprehensive enough to accommodate counseling and enforcement mechanisms – For example the Directive from ministry of Education to all Schools on MHM was just a circular or a

	letter and cannot be supported with resource allocation. It is at the discretion of the district to allocate resources for MHM.
USAID has checklist that it uses to support work on MH in schools	There are no indicators on MHM – and hence the various sectors do not have what to look out for.
	The multi-sectoral approach is lacking due to lack of policy guidance – not well integrated in policy documents. It is currently under the Ministry of Education yet it is really a Ministry of Gender issue, with MoES, MoH, and MWE, Parliament and URA all as important actors.
	Sanitation is equated to Latrines and toilets, a more inclusive definition and guidance on the subject matter is is needed that also incorporates issues of MHM and exclusion and marganalization
Service Providers	
Institution	**Activity**
MoES	The Ministry of Education started focusing on this issue since 2012. Ministry of Education Strategic plan has incorporated MHM; analyzed MHM products for URA; developed a manual for women and girls out of school; training in making of reusable pads is on-going; district dialogues on safe learning environment are held; construction of gender responsive school facilities; engaging culture and religious leaders is also on-going.
NRM Party	MHM was included in the NRM Manifesto; is provided for in NDP 2 & NDP 3 for women and girls to live a s conducive learning environment.
MH Coalition	A loose arrangement advocating for MH under the MoES.
Development Actors (PLAN, UNICEF, World Vision; Schools of Life; INTERAID)	Provide funding support, both at policy and implementation levels; they also implement short-term projects on MHM.
Private sector – Afripads; MAC pads	Are responsble for producing pads

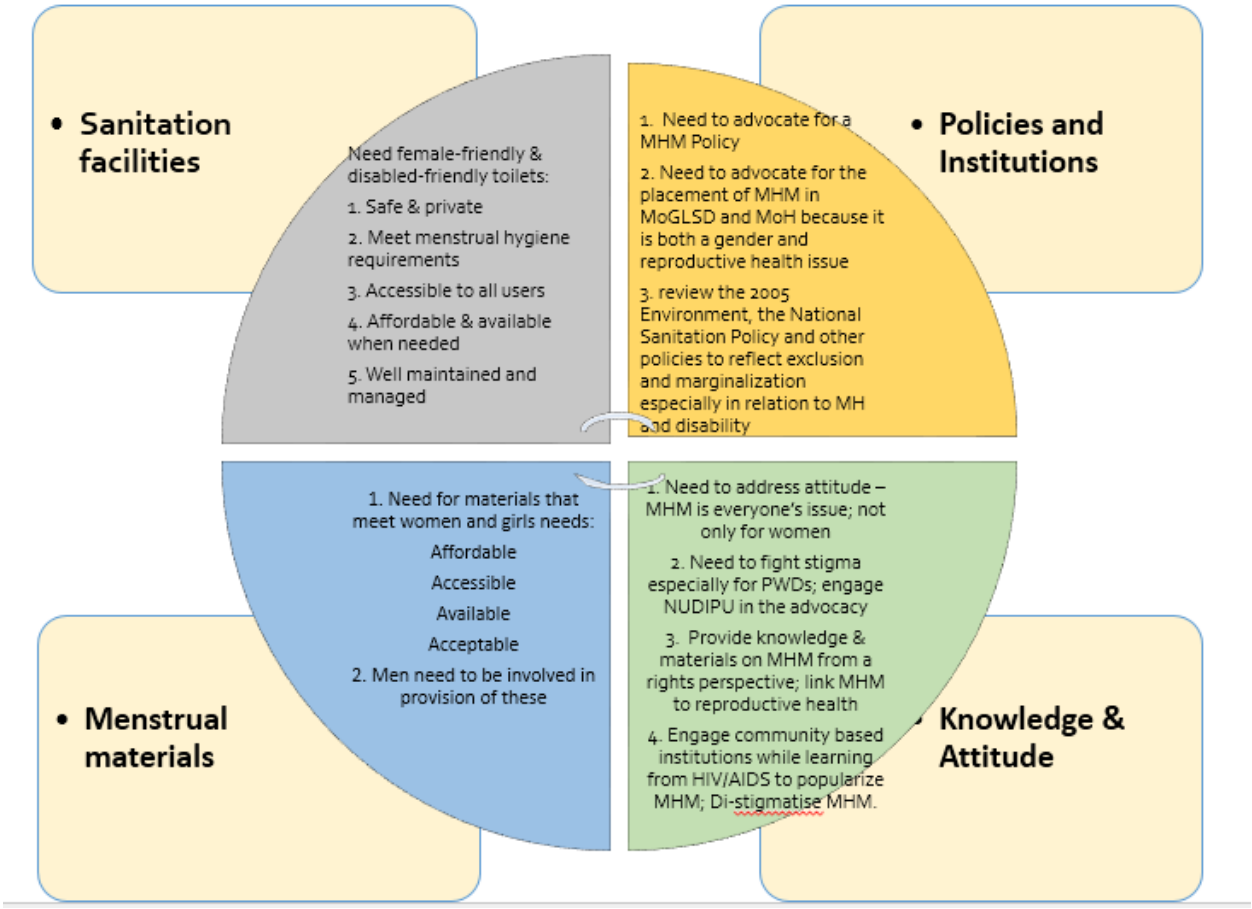
4 CONCLUSIONS AND RECOMMENDATIONS OF THE STUDY

(Still under Development)

4.1 Conclusions

1. A Menstrual Hygiene policy is not available in Uganda. Also, there is discripancy between policy and practice. Current policies do not accomodate changes in the context; they are archaic.
2. Coordination of MHM is a big issue – who takes lead – MoH, MoES or MoGLSD? Continued coordination of MHM by MoES has made MHM to be viewed as a school issue. Hence MHM is in schools, and not in communities. There is need to ignite community action, and to incorporate MHM as a concern in the District Water and Sanitation Coordination Committees.
3. Related to coordination, is the need to apply a multi-sectoral approach to MHM and ensure that resources are allocated by the different actors to address the needs of women and girls (Functionality of a multi-sectoral apporach from planning – budgeting – to action).
4. Women's Organisations and Reproductive Health and Rights Organisations have not jumped on the bandwagon because they do not see MHM as a gender or exclusion issue. This may explain why the issue of MHM has not been picked up though it has been around for over 15 years.
5. The definition os sanitation is very narrow; sanitation is reduced to faecal disposal and is not linked to the general well-being of a person. The narrow understanding of sanitation which is linked to management of faecal matter has affected how MHM is engaged with by government and other actors. The definition of sanitation needs to be unpacked to accomodate the current context and the various sanitation needs of women, girls and PWDs.
6. projects and programs are picemeal and short-term, yet MHM is an issue to do with behaviour ; a generational issue. Therfore, short term projects and interventions cannot resolve it. The least project should be at least 3 years.
7. Poverty affects policy implementation. One respondent wondered how you can get rural areas to have incinerators when even some girls have no nickers – how do you get the parents to appreciate girls needs because the government cannot provide the pads?
8. Hygiene concerns in relation to reusable pads; how can these be addressed?
9. There is a glaring limited involvement of the MGLSD in Menstrual Hygiene work
10. Lack of MHM indicators in the sector monitoring system
11. Deep rooted cultural norms and practices.

4.2 Recommendations



REFERENCES *(TO BE INSERTED)*