The Last Mile: Why Building Toilets Isn't Enough Without Changing Behavior

A woman shows her newly constructed pit latrine with a functional handwashing facility

By Water For People

The Illusion of “Improved” Sanitation

A family builds a new latrine with a washable slab, a sturdy door, and even a handwashing stand. By all technical measures, the facility is “improved.” Yet months later, the latrine is used, but the handwashing stand remains dry. Family members still prefer the bush when away from home. This scenario is not hypothetical; it is a reality that plays out across Uganda and many developing countries. Our baseline assessment for the Water For People Results-Based Financing (RBF) program funded by the United Nations’ (UN) Sanitation and Hygiene Fund (SHF) — in Buikwe, Kabarole, Kamuli, and Kayunga districts reveals a persistent gap between sanitation infrastructure and

sanitation behavior. The greatest challenge facing the program may not be construction, but behavior change.[1]

Access Does Not Equal Use

Global experience shows a clear pattern: building toilets does not automatically lead to their consistent use or to improved hygiene practices. Across many countries in Asia and Africa, large-scale sanitation campaigns have expanded access, yet open defecation often persists because behavior and social norms take longer to change than infrastructure. Closer to home, countries in East Africa, including Kenya and Tanzania, have faced similar challenges: high latrine coverage alongside low rates of handwashing with soap and continued open defecation in some communities.

Uganda is no exception. Despite decades of sanitation promotion by government and development partners, many households still rely on unimproved facilities or practice open defecation in certain situations, while essential behaviors like handwashing with soap remain limited. This pattern is widely documented in global and regional sanitation research (e.g., Garn et al., 2017; Schlegelmilch et al., 2016; Mwakitalima et al., 2018; Mshida et al., 2020; Seth & Jain, 2024; Kwami et al., 2025).

What the Baseline Reveals

Our field observations paint a stark picture of this behavioral deficit. Only 12% of households (one in eight) had a handwashing station, and among those, only a minority (39%) had soap, meaning that fewer than 5% of households practice proper hand hygiene. Nearly half (48%) of all latrines lacked doors, which severely compromises privacy and discourages consistent use, especially for women and girls. And despite 82% of households having access to a latrine, 18% still rely on neighbors' facilities or practice open defecation in certain situations. As one village health team member in Kamuli noted, "We tell them to use the latrine, but when they are working in the garden far from home, they just go behind the bushes. It's hard to change that habit."

The baseline also highlights opportunities. **Community leaders political, technical, and religious are present in some of the target communities, though they represent only 6% of respondents. Engaging these leaders as champions can amplify behavior change messages.** The high home ownership rate (93% across all districts) suggests that households have long-term stakes in their properties, which can be leveraged to promote investment in both infrastructure and behavior. Moreover, the

[1] *Behavior change refers to the process of shifting habitual actions and social norms related to sanitation and hygiene, such as consistent latrine use, handwashing with soap, and safe faecal sludge management, through communication, education, and community engagement. For a detailed framework, see the WHO WASH Behavior Change Toolkit.*

prevalence of household-led construction in some districts (e.g., Kamuli) indicates that messaging can be tailored to the construction process itself, for example, reinforcing that a door is not a luxury but a necessity for privacy and dignity, and that a handwashing station is as essential as the latrine itself.

What Effective Behavior Change Looks Like

1. To close the gap, behavior change strategies must be intentional and sustained. Short campaigns are rarely enough to shift deeply ingrained habits.
2. Second, it should use multiple channels: radio, given that nearly two-thirds of households own radios; village health team home visits; community meetings; and leveraging local leaders and masons as trusted messengers.
3. Third, it must link behavior directly to the program's incentives, helping households understand that to qualify for results-based payments, the handwashing station must have water and soap.
4. Fourth, the program should adopt "triggering" methodologies that tap into emotional drivers- pride, disgust, social status- to motivate change, similar to approaches that have shown success in parts of Uganda and across East Africa.

Left: a community education meeting. Right: a woman cleans her new pit latrine.

From Infrastructure to Impact

The baseline provides a clear message: infrastructure alone is not enough.

By positioning behavior change as a core pillar of the RBF program with dedicated resources, consistent messaging, and community engagement, we can ensure that sanitation facilities are not just built but used.

Because ultimately, a toilet that sits unused delivers no health benefit. The real success of sanitation programs lies not in what is constructed but in what is practiced.

The United Nations Sanitation and Hygiene Fund (SHF) provided US$6.3 million in catalytic financing and technical assistance to implement the “Accelerating Access to Improved Sanitation and Hygiene Services using Market-Based Approaches in Uganda” Project from April 2023 to 30 September 2026.

The Project was implemented by Water For People Uganda, working with the Ministry of Health as the Government lead institution, providing policy direction, oversight, coordination, and stewardship throughout implementation. Other implementing partners included the Ministry of Water and Environment, Ministry of Education and Sports, IRC, Uganda Water and Sanitation NGO Network (UWASNET), Kampala Capital City Authority (KCCA), Finnish Mondial, and participating District Local Governments.

The Project reached approximately 2.4 million people across seven districts: Buikwe, Kabarole, Kamuli, Kayunga, Luuka, Buyende and Kole, and five urban areas: Fort Portal City, Kamuli Municipality, Kayunga Town Council, Kampala Capital City and Kole Town Council. It focused on scaling household sanitation and hygiene services, strengthening sustainable WASH and menstrual health and hygiene services in schools and healthcare facilities, and promoting innovation for safely managed sanitation and hygiene.

For more information

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