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Integrating IEC for rural water and sanitation



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Introduction

The provision of infrastructure in water and sanitation programmes has been proven to have no long term health benefits when it is not supported by a programme of Information, Education and Communication.

Community participation in health education planning and execution, and in infrastructure development are the core ingredients to sustainable programmes and long term health benefits. Hygiene education has been found to be lagging behind infrastructure development, and in consequence, diarrhoea morbidity and mortality amongst underfives remain unacceptably high as compared to other health indicators for the country. This has been the case inspite of three particular Primary Health Care programmes which are the Water Hygiene Education Programme, the National Rural Sanitation Programme, and the Control of Diarrhoeal Disease Programme, all of which have diarrhoea prevention and control as their main objective.

Water Hygiene Education Programme [WHEP]

The programme aims at promoting hygienic ways of handling water from sources and at home. It encourages protection of water sources which in our case, are mainly public standpipes. It also disseminates health messages to school children at primary school levels, and encourages them to form health clubs. Children are taught about personal hygiene and handwashing before handling food and water, and, after latrine use. The clubs also encourage children to interest in other health issues and responsibility for their health needs.

National Rural Sanitation Programme [NRSP]

The programme helps rural communities to build subsidised VIP latrines. Its major components are latrine construction and hygiene education. It promotes hygienic use of latrines which involves handwashing after latrine use and keeping latrines clean. Approximately 12,000 latrine units have been built through out the country.

Control of Diarrhoeal Diseases Programme

The programme promotes both methods of reducing risks of contracting diarrhoeal diseases as well as effective ways of managing and controlling and curing diarrhoeal diseases. Emphasis is on mortality reduction and case fatality through training of health workers and promotion of oral rehydration therapies, close monitoring by parent/guardian and emphasis on when to refer.

The general objective of the above three programmes [WHEP, CDD, NRSP] therefore is to control water and excreta related diseases which are responsible for significantly high levels of morbidity and mortality especially amongst the under five age group. This is done through a series of different but complementary preventive and curative interventions.

The target groups for the three programmes are the rural population at large but especially mothers, other child minders and the underfives. These programmes which are coordinated from national level are implemented through or by the district health teams. These include cadres of district medical officers, nurses, health inspectors and health assistants, community health nurses, health education and nutrition officers, and family welfare educators.

The Knowledge Attitudes and Practices study [KAP]

Despite sharing common objectives and target groups, the three programmes have been independently implemented from each other until recently.

However, in 1990, a KAP study was commissioned by the three programmes to evaluate their respective and collective impact on community hygiene practices and health status, with regard to water hygiene, environmental sanitation and diarrhoea. A total of 4,500 questionnaires were completed from a random sample of rural households, supplemented by key informant interviews, focus group discussions and water sample analysis. The findings were both qualitative and quantitative.

Quantitative findings included the fact that whereas more than 85 % of households have access to improved water supplies in rural villages, less than 30 % have access to a toilet facility.

Qualitative findings confirmed the fact that the mere presence of a latrine or access to a safe water supply, does not have a direct bearing on diarrhoeal incidence, and that the community's attitudes and practices are still detrimental to disease reduction. Much as people have knowledge on the health aspects of water and sanitation, their attitudes and practices still indicate that a lot has to be done to change this knowledge to healthy attitudes and practices. The main finding therefore was that health education is lagging considerably behind the hardware components.

Recommendations

As a solution to the problems above, a new method or strategy of IEC implementation had to be identified. Integration of the activities of the three programmes and particularly of the IEC component was the recommended strategy, with in particular an emphasis on strengthening the quality of IEC.

Activities and achievements

The national coordinators of the three programmes organised a workshop for district health team officers, to disseminate the findings of the KAP study.

In this manner, compartmentalisation of programmes into the curative and the preventative, and between public health workers and clinic based health workers could be broken down. At national level, an action group has been set up, guided by terms of reference, to guide the formulation and implementation of integrated approaches. Specific initiatives have already been taken to ensure that all new materials are produced through the process of consultative approach. In this respect, a new integrated hygiene handbook for health workers has been produced which replaces the previously water hygiene [WHEP] specific hand book. Information posters on how to prevent and cure water and excreta related diseases have been prepared which contain the key messages of each of the three programmes, so that the linkages between the initiatives and priorities of the three programmes could easily be discerned.

Further, through regular consultative meetings, efforts are made to jointly plan field visits and workshops. In turn, the same mechanism of cooperative efforts is expected to be engendered at the district level so that both coherent messages and strategies can be developed at the community level, and maximum utility can be made of scarce human and financial resources.

Plans - a way forward

The three programmes with assistance of the donor agencies, SIDA and UNICEF will introduce or pilot a more community-based project which will include the activities of all three programmes. The pilot project will be tested in selected districts and villages. The main objective of the

project will be to involve the communities fully in programme planning and implementation in order to both enhance sustainability and reduce dependence on government subsidies. The planned outputs are as follows:

- training health teams in the planning and implementation of participatory approaches to IEC.
- sensitising communities on the benefits of the participatory approach and replicating the approach to other Primary Health Care projects and locations.
- helping communities to mobilise resources to address their environmental health and hygiene problems.
- imparting skills to village based institutions.
- Assisting the three programmes in determining strategic options for sustainable implementation.

Sanitation specific outputs include:

- improvement of overall access to basic sanitary facilities in rural areas which currently stands at under 30 %.
- increasing participation of the less privileged community members in latrine construction.

Constraints

Planning and effective coordination will still remain a problem area because the three programmes belong to two Ministries: ministry of health and ministry of local government lands and housing.

The problem encountered at implementation level is that the national programme coordinators do not have control over the district council's plans, schedules and priorities. Cooperation between district officers and district health workers still has to be encouraged and strengthened. District health teams have staff shortages and are therefore incapable of participating actively in community education.

Community based officers such as the Family Welfare Educators are still clinic oriented which leaves them with little time to work within the community. The Village Health Committees in many rural areas have been dormant, and this has made decentralisation of community education unachievable.

Top down approach vs community based approach

The experience we have in Botswana is that many projects involving provision of infrastructure have been done mainly in a top down approach. Both planning and implementation were done by councils or government. A good example is the water supply sector where many rural villages in Botswana have safe water supplies provided largely by government. The communities were not fully involved in the projects and were only glad to use the sources. The problems experienced as a result are that people do not feel responsible for the maintenance of the public standpipes but that the government that installed them, should also be responsible for their operation and maintenance.

The KAP study which was mentioned earlier in this paper, also found out that water from standpipes gets contaminated during collection, transportation and storage at home. The health benefits of safe water are therefore not fully realised.

With all the problems mentioned above, our proposed community based and demand driven project will have a main task of re-orienting the health workers and programme officers at both national and district levels. Training workshops on the community based approaches will be organised at both national, council and community levels.