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WATER AND SANITATION FOR ALL: PARTNERSHIPS AND INNOVATIONS

New challenges and innovative partnerships

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DIARRHOEA IS CONSIDERED to be the third major cause of under 5 mortality in Botswana. The 1990 Diarrhoeal and Morbidity and Mortality Survey indicated that on average, every child under 5 years in the country experiences 3.3 episodes of diarrhoea per year. Among children under one year of age, the rate rises to 4.2. The same study also highlighted the synergistic effect of proper sanitation and food and water hygiene practices in reducing diarrhoeal diseases.

Despite commendable achievements made by Botswana in key social sectors[1], the coverage of sanitation facilities remains remarkably low. Rural coverage averages 41 per cent (1991 census). Not surprisingly, those areas with poorest access have amongst the highest incidence of diarrhoeal diseases. This problem is exacerbated by poor personal hygiene practices. A KAP study conducted in 1991, indicated that despite a general understanding about sanitation and hygiene, good hygiene is not widely practised.

The National Rural Sanitation Programme (NRSP), within the Ministry of Local Government, Lands and Housing (MLGLH), constructs high cost VIP latrines on a subsidised basis. The household contribution is restricted to 30 Pula (US$8.5) down payment and full responsibility for constructing the superstructure. The fully cement block lined sub-structure, concrete slab, vent pipe and pedestal are provided by the local council. In some communities, a significant number of superstructures remain incomplete. Access to the subsidy is open to all rural households irrespective of financial status.

The GoB/UNICEF National Programme of Action (NPA) for the children of Botswana aims to increase access to sanitary means of excreta disposal in rural areas of the country to 70 per cent by the year 2003. At present, the programme is not able to keep pace with population growth. Without new initiatives, the goal is likely to remain elusive.

For this reason, a project, funded by SIDA with assistance from UNICEF, is to be piloted in three districts. It aims to introduce low cost and participatory approaches to hygiene and sanitation promotion in rural low income communities of Botswana. The following is a brief outline of the challenges to be overcome by the project and the thinking which has gone into forming a strategy to address the issue of improved access to latrines and hygienic practices.

Challenges - new and old

The NRSP itself is encountering inertia problems. A programme of this nature has been operational in Botswana, in one incarnation or another, for 17 years. It is seen at all levels as an infrastructure development project. Behind this, lies the assumption that the provision of latrines will lead to a direct improvement in public health. As we know, this defacto assumption, has been tested many times around the world and is now widely accepted to be invalid. Within the programme, hardware and software are not perceived as being essential partners. The project, therefore, faces the new challenge of changing perceptions about itself. It is time to change emphasis and image.

The fact that many superstructures go unfinished questions the assumption that people can afford to finish their own latrines or indeed that they really want a latrine. Is it the latrine that they want or do they see it as their right to be provided with a heavily subsidised costly structure? Crucially, responsibility for a safe and hygienic environment has been taken from the community. Relevant decisions are taken at Local Council or central Ministry level with virtually no community participation. Consequently, there is a poorly developed sense of ownership amongst the most important stakeholders - the community.

Another significant challenge is presented by making truly low cost latrine superstructure options available. The VIP latrine promoted under the NRSP is high cost using cement blocks as the basic construction material. An average cost for the sub-structure is P2,000 (US$568), but this varies widely between regions of the country and is dependent upon the cost of both materials and labour. The national image of an NRSP latrine is of a high cost, rendered cement block superstructure. From its beginning, the programme has promoted and been associated with this form of structure even though the responsibility for this component lies with the household. The challenge, lies with persuading people that a latrine can be made of other materials and overcome a stated resistance to "regress" to traditional construction materials. The pilot project must find ways to support innovative materials usage which will bring completion of the latrines within the range of many more households.

Botswana does not have a National Sanitation Policy[2], nor does it have minimum standards for latrine provision. Importantly in an arid country whose national currency is named after its most precious commodity, Pula (rain), there is an ongoing debate about the pollution hazard that pit latrines pose to groundwater. Because of this, gaining high level support for low cost, community based sanitation solutions remains a very serious challenge, but is, nonetheless, one that needs to be overcome if the project is

to be successful. This debate is developing into a strong challenge to the validity of promoting pit latrines within the country.

A final challenge is posed by the existing relationships between communities and village based extension workers. It is not clear why, but these have deteriorated over recent years. There is an apparent lack of understanding between the two parties. This may be due to the communication strategies used or possibly to the communities perception of newly introduced ideas. Whatever the reason, this factor has significant implications for the project. This cadre of workers form the frontline of communication between the communities and the project. Without empathy between the two groups, communication and understanding will be extremely difficult.

The approach

To tackle these and other challenges, the project has chosen a strategy which will focus on the three following areas:

- Communication for behaviour change and Social Marketing.
- Participatory hygiene education methods.
- Low cost VIP latrine technology transfer.

To be successful, each of these is dependent upon the other must find ways of integrating effort through the formation of strong and active alliances or "strategic partnerships".

Community partnerships

The first, and most important partnership , will be with the communities in the pilot areas. The project needs to work with the communities to reinstate a sense of ownership and responsibility for personal and environmental hygiene. As a fundamental premise, the project will work with communities to understand their attitudes to latrines. As part of this process, the project must understand traditional hygiene beliefs and current practices and place them within its context. Positive traditional practices need to be understood and advantageously used by the project.

To begin this process, the project is conducting a qualitative, formative hygiene behaviour study. This understanding will then form the basis of a communication strategy which will use those traditional beliefs and values which conform to current scientific knowledge to its own advantage. Known high risk behaviours can then be targeted for change and where possible, positive traditional cultural practices will form the basis of the messages to be communicated.

In this way, the project will be stimulating partnerships between tradition and contemporary knowledge. It will work with deeply held values to help achieve the objective of improved hygiene practices.

An early example of a traditional practice which has been revealed by the study and which is of relevance for the project is that of "Botsetse". Essentially by placing a log in front of the household to which a new baby has been born , entrance for anyone other than the mother and grandmother is barred. "Jumping the log" is not permitted. For a period of up to 4 months, the baby is isolated from environmental infection by being kept in the clean house. The mother is said to be "Motsetse"; her food is prepared separately and all utensils used for cooking and eating are kept separate from other family members. The basis of this belief and practice, clean environment to prevent infection, is directly relevant to the project.

Traditional and spiritual healers enjoy a highly trusted and respected position within the communities they serve. Children suffering from what are considered to be traditional causes of diarrhoea i.e. other then poor hygiene, are frequently taken by their mothers or caretakers to the traditional or spiritual healers in preference to the clinics. Interaction between these community institutions and clinic staff is limited. As part of its communication strategy, the project will look at ways of improving relationships and hopefully forming productive partnerships between these two sectors by targeting both the healers and clinic staff. Traditional cures which support scientific knowledge can also be beneficially used. For example, traditional and spiritual healers administer water based remedies using boiled water which has been safely stored prior to use. The implications of this practice for supporting messages related to hygienic water storage and handling are very positive.

Innovative private sector partnerships

Discussion in the previous paragraphs supports the notion of marketing the concept of latrine use and improved hygiene practices. The project aims to learn lessons from the private sector which will help to achieve its objectives. A commercial company wanting to launch a new product would, through its market research, aim to identify influences within the target market that can be used to positive advantage. In other words, it will strive to identify the motivators behind peoples choice to consume or buy their product.

This approach can be applied to the pilot project as it not only builds on the positive and beneficial aspects of the product of more latrines and improved hygiene behaviours, but also uses the values of the community to achieve this goal. A real advantage of this approach is that it relates to the whole community by identifying itself with collective beliefs and values. This is important as experience has shown that the highest rates of latrine coverage have been achieved when the decision to build has been taken collectively.

Cross learning partnerships are being actively sought with the private sector in support of the social marketing component of the project. The behaviour study has benefited from voluntary private sector input into the design of the market research elements. The soap producing industry in Botswana is also a target for the pilot project. There is a mutuality of interest between increased soap use and hygiene messages specifically targeted at encouraging

more frequent hand washing with soap. The issue of sustained behaviour change is partly addressed by encouraging the private sector to develop a long term stake in the process.

Learning from the private sector by applying commercial techniques to achieve project objectives can be positive, but the limitations need to be recognised. Generally, the commercial world aims to sell a product and move on to sell more. However, persuading people to "buy" the idea of changing their hygiene practices is merely the start. More important to the project, is the concept of sustained behaviour change. This can only be achieved with a clear end-user understanding of the health benefits to be derived from the changed practice. We need to appreciate that there is an opportunity cost associated with changing behaviour. For example, by asking people to wash their hands more frequently than they currently do, a household will have to collect more water, which means more time and energy dedicated to this activity and a corresponding reduction in time available for others. This represents a cost to the household. The cost can also be social. If, for example, a household adopts new practices which are different from the norm in the community, they may be held up to question and ridicule.

Revitalising existing partnerships

The 1991 KAP study revealed that people construct latrines primarily for reasons of convenience, privacy, prestige and health. Each of these motivators can be used to help accelerate the rate of latrine construction. This, however, is only the start and the project must address the issue of sustained beneficial behaviour change associated with the use of the latrines and hygienic practices associated with the disposal of faecal matter. Participatory Hygiene Education Methods (PHEM) based on the SARAR methodology is being applied to the this purpose.

PHEM uses participatory tools to help communities Assess their hygiene and sanitation status; to Analyse this situation and to plan Action directed at improving their circumstances. The "Triple A cycle" is an iterative process providing tools which help communities take an active responsibility for their own well being. Extension workers have a very important role to play in facilitating this process. If this is well implemented, re-energised partnerships can be formed between themselves and the communities they are serving.

The project will also attempt to improve partnerships with other national programmes which share mutual objectives. The Water Hygiene Education Programme (WHEP) and the Control of Diarrhoeal Diseases (CDD) programmes share a common objective of reducing diarrhoeal diseases. However, these two programmes are based in the Ministry of Health whilst the NRSP is in the MLGLH. Coordination problems between the three programmes are rooted in the fact that they are housed in different Ministries. Mechanisms need to be established which institutionalise coordination and collaboration and make it less personality dependent. One such early initiative has been to involve both of these programmes in the hygiene behaviour study. All three programmes can gain relevant and valuable programme specific information from the study. CDD for example will benefit from information gathered about traditional cures for diarrhoea and the role of traditional and spiritual healers in this process.

Profitable partnerships

Low cost technology transfer is to be achieved through training village based builders in latrine construction. The training will focus on the functional design principles of the VIP Latrine and the importance of the different latrine components ; on maintenance requirements necessary to meet expected performance; and also on the health benefits to be derived from latrine use and improved hygiene practices. In this way the project will be forming partnerships with individuals who will directly benefit from the skills they will acquire; they will have a financial stake in promoting latrine construction. Village based builders will thus become agents for the project. This approach is new for Botswana, but has worked successfully elsewhere in the region in countries such as Zimbabwe and Lesotho.

There are no NGO's working in the sanitation sector in Botswana, and there is no existing research institute involved or expressly interested in furthering low cost sanitation solutions within the country. To address this, the project has worked with and encouraged a local rural industrial research organisation to develop new latrine designs. The emphasis has been on community acceptance, reducing costs by using locally available materials and prolonged latrine life. This has been a partially successful process. The designs developed have not significantly reduced costs, but the organisation has now incorporated rural low cost sanitation into its long term research programme, using its own core funds to finance the work. This is a very positive development

The superstructure designs developed, however, are generic and if followed accurately can be constructed of almost any material and perform as a VIP latrine. By training village based builders in the principles of latrine design and construction, the scope for innovative materials use, based on truly locally available construction materials , at an affordable cost to households, will be much greater than is currently the case.

[1] For example, >85 per cent of the population has easy access to health service; adult literacy rate exceeds 75 per cent; primary school enrolment rate is over 83 per cent and access to safe water, close to 90 per cent.

[2] At the time of writing, there is good reason to believe that this will change in the future.

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