



The need for creating sanitation awareness

Makhosi Mpapa, South Africa



UP TO 21 million South Africans do not have access to safe and adequate sanitation facilities. Up to 60 percent of them live in rural areas. This backlog in the provision is not accidental. It is a result of years of neglect and misallocation of resources in the past. The cost in terms of the deterioration of health of rural communities can be seen in the high infant mortality rate. Economically the cost of medicine and time used in the care of those affected is enormous/incalculable. The problem has been so widespread over a very long period, that it has come to be seen to be normal.

Pillars of a sanitation project

There are three elements that we take into consideration in the planning and design of a sanitation project. They are: affordability, social acceptability and technological appropriateness. These are all of equal importance and relevance. The tendency is to stress one of these elements, which is usually technology at the expense of the other two.

Policy vision and beliefs

- Due to the way in which health has deteriorated in communities because of poor sanitation, and the potential for reversal of this situation through the provision of sanitation facilities, this has led us to regard sanitation as a health issue. People need toilets for the sake of their health.
- Every community is unique. This means that communities, like individuals, have their own ways of organising to deal with problems. They have their own perception of themselves as a group and the causes of the problems that affect them. While the communities may be identical or depend on the same or similar sources of income, they may differ in their priorities of where they want to allocate their resources.
- Sanitation projects are community based, but at the same time it demands a lot of responsibility from the owner or user. Thus the role of the project committee in mobilising the community is very vital. While sanitation projects are demand-driven, one hundred percent coverage is what we aim to achieve. Therefore a lot of effort goes into demand - creation and ascertaining the level of demand. Not through imposition, but by making community members aware of the interdependence of their health and sanitation. Making people aware would not be enough without creating opportunities and building capacity in them to access toilets or any development assistance for that matter.

Community based project management

One must try to maximise the local input and try as far as possible to reduce external content in attempting to make a sanitation project accessible to the community. This applies equally to skills, resources and the process involved in project development. The opportunities for this become apparent in a sanitation project. The project goes through a three phase construction process. First is the construction of the demonstration latrines. The purpose of doing demos is to train latrine builders and to cost the latrines. They also promote their use in communities. These are built for public institutions like schools, clinics, creches and so on. It is the community that chooses where these facilities will be, which is usually where they are needed. The builders want to be trained so that they are contracted to build in the construction of the household latrines. Then there is a pilot phase in which we try to consolidate and refine the training done at the demonstration phase. For instance, the real cost of the latrines is determined here. This is a stage where the builders do the construction on their own households and up to this stage, no one is paid for their work. At the demonstration phase, the latrine builders get trained free of charge on latrine construction. At the next phase they still do not get paid for building their own facilities at their houses, but they are given all the materials for the project. As the demonstration facilities are public facilities and are therefore owned by the community, everyone in the community is expected to participate voluntarily in their construction without expecting remuneration. This is part of the community contribution to the project.

At the end of the pilot phase, everything has to be negotiated with the community members, including the criteria for drawing up lists for the order in which construction would take place and agreement on the amount and type of local contribution. The health education aspect of the programme is launched after the completion of the demonstration phase. This is strategic as at this stage at least there are some toilets available and a user group who have access to them.

The only disadvantage in working with the community like this, at their pace, is that it slows down the rate of progress, which while it makes the project expensive in terms of time and other costs. This is far outweighed by the benefit of having the community participating to the maximum and consequently own feeling that they the project.

Health education and hygiene awareness

Methods we have applied in health education have taken different forms, both formal and informal. And we involve health personnel who work in these communities be they at the resident clinic which is based in the community, attached to mobile clinics or village health workers who are members of the community. Other health officials who are involved are the environmental health officers and the health officials from the district hospital.

In the communities, they hold a “Health Day” every year in which a particular theme is focused on and a health official is invited from the district hospital or the district health services to come and address them. When this happens in a community we are working in, we make sure that the focus is on sanitation. It is at such an event where drama in the form of role play is performed by the village health workers. They use issues people are with concerned with or gossip about and throw them into the open. It is during the health day that sanitation and health related awareness is created. Less formal events include organised workshop discussions. These are useful insofar as engagement between members of the community and health officials is concerned. People have been able to articulate the problems and/or obstacles and solutions often emerge during discussion. A good thing about this approach is that issues are raised as problems without any condemnation or judgement passed. I think this is what makes people amenable to new ideas. We have tried to use posters with relevant pictures and messages (written) on them. We are targeting school children with his type of material for fear of alienating adults we work with, a lot of whom are illiterate. Other methods we have used have been to raise issues in community meetings and during house visits.

This input takes place throughout the project cycle. Sometimes in the form of giving information about the functionality of design which takes place during the demonstration phase especially and also during household latrine construction and completion to gauge user acceptance and satisfaction.

Monitoring and evaluation

We look at monitoring from three levels:

- Usage
- Operation and maintenance
- Impact on health.

We feel that usage should be monitored as some of the people we work with do not have latrines and/or were not exposed to their habitual use. We feel operation and maintenance of latrines is important to keep them functional so that benefits of having a latrine could be realised. There is a danger that if latrines are not properly used or maintained they could impact negatively on health.

Conclusion

Sanitation is essentially a health project. Other considerations like privacy and status come secondarily. A multi-sectoral and an inter-disciplinary approach is needed to address the problems of sanitation.

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