



A community based health and hygiene model

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THE FIRST DEMOCRATIC government in 1994 inherited an estimated backlog of 12 million South Africans mainly rural without access to safe water and another 21 million without sanitation. By 1999, 5.6 million rural people and 4 million urban people had improved water and sanitation access. Despite these achievements, the current Minister of Water Affairs and Forestry noted that at the current rate of delivery it could take the sector 20 years to attain the sector's goals of providing potable water to the rural populace. The government has embarked on a programme of accelerating the provision of adequate sanitation for all by 2010.

Problem statement

There are many challenges mitigating against the attainment of these goals some of which are: the huge unserved back log, paucity of sector skills, an immature water service authority, abject poverty of the target group, non standardised delivery methods, inefficient institutional arrangements for procurement, planning and management procedures. In addition to these challenges, the successes of health and hygiene programmes is compromised by unrealistic time frames, non-involvement of health practitioners in planning and management of water and sanitation projects, an inability to measure and thus demonstrate impact. Government health workers are incapacitated in terms of inadequate staffing, transport and other facilities, whilst the whole hygiene programme when carried out by private consultants consists of one or two exposures through community workshops.

In recognition of these realities, the Mvula Trust has developed a community based health and hygiene model which addresses these challenges by inculcating the principles of local economic empowerment, community participation, peer education, partnerships, skills transfer and cost effectiveness, review of PHAST utilisation in health and hygiene, training, promotion and monitoring and evaluation. Table 2

The model has been used in a number of EU, Ausaid and DWAF funded projects in the Eastern Cape. This paper attempts to examine the model using the AUSAID Pambili Water and Sanitation Project as a case study.

Methodology

The Pambili Water and Sanitation project is a World Vision initiative with water and sanitation expertise provided by the Mvula Trust. The project area spans 15 villages of the

Mooiplaas area of East London, the poorest state in the country. The project is an integrated water and sanitation intervention with the aim of improving community health through raised health and hygiene awareness, coupled with infrastructure improvements i.e. the provision of 500 rainwater tanks and 500 toilets. In keeping with The Trust's belief in community based management; rainwater tank, toilet construction and health and hygiene promotion was carried out by the community members. 2 village health workers per village were selected by the community to carry out health and hygiene promotion in close integration with the tank and toilet construction. Health workers were trained in water, sanitation and health related risks using PHAST tools as relevant. The health workers were equipped and validated for health promotion by:

- providing them with first aid boxes,
- linking them up with the police station and the ambulance services in the nearest town
- Providing them with the PHAST tools that had been used during their training.
- Provision of support through weekly visits by the local co-ordinating team and evaluation meetings held every six weeks.

Table 1. Practices of respondents in relation to water treatment methods

Treatment Method	2000		2001	
	#	%	#	%
Boil	248	68.9	246	68.3
Solar Disinfection	1	0.3	1	0.3
Filter	52	14.5	19	5.3
Chlorine (Jik/Bleach)	-	-	69	19.2
Nothing	66	18.3	23	6.4
No Response	3	0.8	5	1.4
Note: Multiple Responses Obtained				

Table 2. Observations of some water storage practices

		yes		no		no response	
		#	%	#	%	#	%
Whether water container has a spout	2000	83	23.1	267	74.2	10	2.8
	2001	44	12.2	304	84.4	12	3.3
Whether water container has a cover	2000	323	89.7	37	10.3	-	-
	2001	346	96.1	10	2.8	4	1.1

Table 3. Excretal disposal methods practises by respondents

Disposal Facility	2000		2001	
	#	%	#	%
Veldt	289	80.3	275	76.4
Household's Pit Latrine	61	16.9	72	20.0
Neighbour Pit Latrine	5	1.4	8	2.2
Household Water Closet	1	0.3	1	0.3
Neighbour Water Closet	3	0.8	1	0.3
No Response	1	0.3	3	0.9
Total	360	100	360	100

Community entry and identification of VHWs

- a) SC familiarize themselves with community (transect walk community mapping etc), meet leaders, administer mini – **pre-intervention observational checklist**.
- b) With assistance from existing structures (PSC, VWC, WSP) VHWs are identified. Usually 2 per village (250 Households) with guiding criteria.

VHWs training – output action plan

- a) Training of VHWs in water and sanitation using **relevant** PHAST tools. Identification and prioritisation of problems and feasible solutions &
- b) **Establishment of M&E framework** by communicating reporting systems, coverage area/VHW etc, finalising contractual arrangements etc.
- c) Development of time bound Health Action Plans which identify problems, and feasible solutions within the project parameters e.g. toilets as a barrier to contamination e.g. 6 months
- d) Pre and post training evaluation.

Promotion VHWs implement action plan
(HH visits)

- a) VHWs carry out promotion according to time bound action plan
- b) They act as water and sanitation promotion agents by giving house to house information on material & financial contributions, pit dimensions, operation and maintenance etc
- c) filling reporting sheets of H/H visits and submit to VWC.
- d) VHWs get paid for health and hygiene intervention period (approx. R250/month).
- e) Development practitioner mentors VHWs and meets with them once in six weeks as part of input into M&E

M & E

- a) Weekly reports feed into monthly visits by DP (see above)
- b) Spot checks e.g. quarterly visits by health promoting team (MT, local government , VWC/ PSC/ ward committee & DP)
- c) Quarterly visits, check H/H health & hygiene practices

Table 4 .Lessons learnt

Gaps in current model	Community based model
1. Paucity in skills transfer to community	Increased skills transfer as village health workers carry out all H&H promotion, whilst development practitioners trained and mentor.
2. Reduced impact as H & H promotion carried out by consultants at community level through 1-3 workshops.	Maximal impact as H&H carried out by dedicated VHWs on a household level through out the period of intervention.
3. Reduced cost efficiency and impact on local economic empowerment	Improved cost efficiency and improved impact on local economic empowerment . (H&H promotion budget utilised as VHW stipends)
4. Non demand responsive as health and hygiene promotion plan developed by social consultants	Development of action plan by village health workers fostered ownership and empowered village health workers to develop linked initiatives in their villages
5. Government official participation difficult (coverage of large areas, no transport, under stocked clinic etc)	Partnerships and linkages were formed (Government EHOs, Clinics and VHW), e.g. local clinics ask village health workers to carry out a cholera prevention campaign.
6. Measurement of impact of health and hygiene intervention a concern	Simple monitoring and evaluation system built into model to facilitate measurement of impact
7. Separate process from water or sanitation implementation e.g. VHWs usually said to be behaviour change agents without much involvement in sanitation training, construction etc	Health workers were water or sanitation related promotion agents . Involved in sanitation training, sanitation construction e.g. communication of pit dimensions , subsidy and household commitments etc
8. Non demand responsive	Action plan an output from community (village health workers)
9. Training of social consultants of village health workers on all PHAST tools rather than on water and sanitation does not foster the needed clarity to enable the community identify and prioritise their problems and solutions.	Training of village health workers on water and sanitation using PHAST tools as relevant. This method, saved time and cost.
10. Inadequate mentoring of village health workers	Village health workers were mentored through the Provision of tool kit and regular evaluation meetings.

Conclusion

The sector repeatedly emphasises the need to utilise local resources, employment of the bottom up demand responsive approach, encouragement of community participation and where possible community management. The community based health and hygiene model utilises the most important community resource i.e. the people, in a manner that encourages ownership and sustainability of the water and sanitation projects. Gender mainstreaming, income generation , partnerships and support to overstretched, understaffed government facilities are additional spin offs of this method.

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