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**ACCESS TO SANITATION AND SAFE WATER:
GLOBAL PARTNERSHIPS AND LOCAL ACTIONS**

**Think globally, act locally: Community action planning
critical to attaining global sanitation targets**

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The sanitation programme in Kadadaba community is part of the Federal Government of Nigeria/UNICEF/DFID programme in Zamfara state implemented by the Zamfara Rural Water and Sanitation Agency and the Maru Local Government Authority. It adopted a community-based integrated sanitation and hygiene approach with emphasis on community involvement. Kadadaba is a predominantly rural village in Northern Nigeria. Despite its socio-economic challenges, Kadadaba community in three months moved from a 48% sanitary pit latrine status to a 100% sanitation coverage and 100% borehole functionality which has been maintained. Maru LGA supported the community with development of community action plans and targets. This has resulted in amongst other things, the improvement in sanitation related status and demand in Kadadaba and environs, with the achievement of 100% sanitation coverage with attendant hygiene supportive behavior in other communities. This paper aims to share the best practices and lessons learnt from this case study.

Introduction

Nigeria is not on track to meet the MDG target for sanitation in its rural communities. In the fifteen years from the MDG baseline year of 1990, rural sanitation coverage rates have risen just 3%, from 33% in 1990 to 36% in 2004 (WHO/UNICEF JMP, 2006). While these coverage and progress rates are comparable to sub-Saharan Africa averages, Nigeria's large population means that more people are living without sanitation (72 million in 2004) than in any other country in Africa. If Nigeria does not meet the MDG target for sanitation, neither will Africa as a whole.

But more important than targets is the impact of the lack of improved sanitation on Nigerian communities. Poor sanitation causes diarrhoea, and the Nigeria diarrhoea prevalence rate, at 18.8% (NPC/ORC Macro, 2004), is very high. This leads to high child mortality rates due to direct deaths from diarrhoea (diarrhoea is the second largest killer of children in the country, behind malaria) and to other diseases linked to high diarrhoea prevalence. Poor sanitation is also a major contributing factor to low education enrolment and achievement rates, to malnutrition and to poverty as a whole.

Tackling poor sanitation and meeting MDG targets must start with communities. Local solutions, taken to scale, are the only way to ensure a rapid but sustainable rise in rural sanitation coverage rates to improve the lives of Nigerian children and their families. In the northern Nigeria state of Zamfara, the UNICEF and DFID-supported Federal Government of Nigeria (FGN) water, sanitation and hygiene programme is providing the tools to facilitate local action, with encouraging results.

Background

Zamfara is one of the Nigeria's poorest states, with a range of socio-economic challenges including sub-standard infrastructure and a lack of basic services. It is in the North West Region, which has the lowest hand-washing rates¹, the second highest diarrhoea rates and the highest under-five mortality rates in the country (NPC/ORC Macro, 2004). In rural areas the main occupation is subsistence farming and cattle rearing (the presence of a large number of cows in households and communities adds to the sanitation problem). People are predominantly Muslim and the purdah system of gender segregation is widely practiced.

The FGN/UNICEF/DFID support to Zamfara state began in 2004 with a range of water- and sanitation-related objectives including water point construction, the promotion of household latrines, and community mobilisation for hygiene promotion. The project also included a WASH in schools component and an extensive

capacity-building component for community, local government and state government partners. The main implementing partners were the Zamfara State Rural Water Supply and Sanitation Agency (RUWASSA) and the WASH units of three Local Government Authorities (LGAs): Maru, Tsafe and Bakura.

Two rural communities were selected in each of the three LGAs for community-level intervention, and by 2005 baseline surveys were completed. Specific interventions related to hygiene and sanitation in target communities included:

1. The establishment of WASHCOMs (Community Water, Sanitation and Hygiene Committees)
2. Community action planning
3. Sanitation artisan training
4. Hygiene and sanitation promotion
5. Latrine slab promotion
6. Establishment of school environmental health clubs
7. Provision of IEC materials to state, LGA, communities and schools

One of the six focus communities, Kadadaba in Maru LGA, is discussed in detail below.

The Kadadaba example Integrated community based health, hygiene and sanitation model

Kadadaba is a predominantly rural village in the Maru LGA of Zamfara state. It has a population of 1,301 people in 257 households. By July 2006, much had been accomplished in Kadadaba in the area of sanitation. Most notably, the community embraced the idea promoted through the project of upgrading existing traditional household latrines with sanplat slabs, making the latrines safer, more child-friendly and easier to maintain. However project appraisals showed that the progress rate was slow with only 48% of the community's 214 households taken advantage of the project's subsidy scheme to purchase and install the slabs and even less responding to the hygiene messages, particularly hand-washing (Figure 1).

In addition, while the slabs were popular, there was less enthusiasm in Kadadaba and other communities for purchasing them when the subsidy was phased out. Finally, it was shown that the participation of women in the WASHCOMs and planning discussions was very limited (WASHCOM membership was 100% male). As a result of these appraisals a modified approach was developed by the project team to stress both enhanced community-led planning and the integration of health and hygiene interventions. The model adopted is based on the Community Based Health and Hygiene Model (CBHHM) (Onabolu/Ndlovu/Mvula Trust, 2006).

CBHHM is based on the premise that the most sustainable manner of delivering services is to ensure that the community is involved at all stages of the process. The CBHHM provides structured guidance at each stage of sanitation, health and hygiene programming; clarifies roles and responsibilities for optimal utiliza-

Previous Intervention	Steps Taken
The establishment of WASHCOMs	Women became WASHCOM members through a mechanism in which women and men hold separate meetings but integrate their reports and actions through the committee Secretary.
Community action planning	State, LGA and community plans were integrated. Each level was made aware of the linkages between all plans and targets. The roles and responsibilities of each level in the partnership were clearly defined and agreed on.
Sanitation artisan training	The number of trained artisans in the community was increased by RUWASSA to ensure that there was local capacity to meet community demand for slab fabrication and construction.
Hygiene and sanitation promotion in the communities	Women representation in the WASHCOM resulted in more women being involved in hygiene promotion as village hygiene promoters. Their brief included encouraging households to build toilets with hand-washing facilities and the proper disposal of animal dung. Village health workers were also trained as hygiene and sanitation promoters, and environmental sanitation events were held every two weeks.
Slab promotion	The slab promotion was timed to ensure that demand was created by the various sanitation promotion efforts, that the financial contribution mechanisms was clearly explained, and that enough slabs were constructed.
Establishment of school environmental health clubs	Linking the school and community components of the larger FGN/UNICEF/DFID project, school environmental health club members were encouraged to carry out community outreach on the importance of hand-washing facilities.
Provision of IEC materials	IEC materials were specifically designed to accommodate the low literacy rates in the region, especially amongst women.

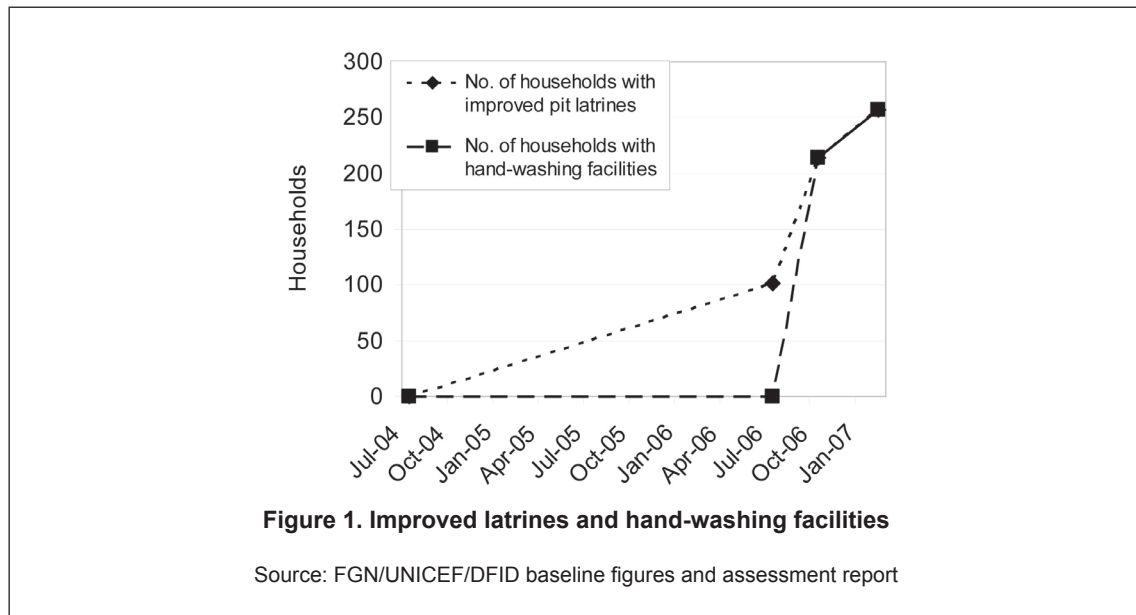
tion of human and scarce financial resources, and optimizes socio-economic development through skills transfer and remuneration for work done.

Each project component was assessed and modified using the CBHHM model, as detailed in Table 1. Key changes included the re-design of the WASHCOMs to ensure the participation of women in purdah, improved integration of planning at all levels, better timing of interventions, and the involvement of school children as agents of change for hygiene promotion.

Results

The re-designed project interventions have helped the community of Kadadaba achieve several important results, listed below:

1. A coverage level of 100% for improved household latrines and hand-washing facilities (Figure 1).
2. Beyond the initial subsidy period (involving the contribution of cement and gravel for 40 slabs, plus technical support and training), the community achieved the sanitation and hygiene targets without any external technical or financial support.
3. The community has also ensured that the 43 new households that moved into the community after October 2006 have safe sanitation facilities by making it a rule that no one can live in the community without an improved pit latrine. The WASHCOM provides support to new householders, while monitoring and enforcing compliance with this rule.
4. The success of Kadadaba has influenced neighbouring communities. With the support of the Kadadaba WASHCOM for training and the latrine artisans (who fabricate and install slabs at a fee of N300 - \$2.4) coverage is now increasing in these communities: Ungwar Tofa (103 households) and Kura Mota (138 households) have achieved 100% sanitation coverage while Jabaka has achieved 88% sanitation coverage, all with attendant hygiene promotion activities.
5. Kadadaba has been able to build a three-compartment latrine communal latrine (for visitors) and a community health centre solely with community contributions and labour.
6. The Ministry of Planning has identified the approach used in Kadadaba as a good approach and selected ten communities for replication



Conclusion and recommendation

The key factors that contributed to the success of the project in Kadadaba are the integrated planning approach, the participation of women through a mechanism that recognizes the community’s purdah system and the involvement of children as hygiene promoters. The Kadadaba experience illustrates the potential of the CBHHM model in the Nigeria context. The model should be replicated elsewhere to contribute towards the achievement of the MDG sanitation target in Zamfara, in Nigeria and in Africa as a whole.

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Note

¹ As indicated by the proxy indicator of availability water, soap or ash, and a basin in households in DHS surveys.

Keywords

integration; local planning; sanitation; hygiene; felt need

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