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MAXIMIZING THE BENEFITS FROM WATER AND ENVIRONMENTAL SANITATION

Hygiene & sanitation strategies in Uganda How to achieve sustainable behaviour change?

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Breaking the faecal:oral disease transmission route is a vital first step towards overcoming preventable disease and, ultimately, poverty. Simple knowledge transfer, whatever methodology is employed, does not automatically result in changed or improved behaviour. There is growing consensus that to achieve behaviour change in hygiene and sanitation practices communities, both rural and high-density peri-urban, need to be supported in ways that will stimulate social cohesion and result in group decisions being taken. Such cohesion and the building of social capital can ensure that peer pressure comes to bear and poor hygiene practices can thus be challenged. This paper considers several approaches to Hygiene Promotion and Sanitation that are currently receiving attention. It attempts to tease out some of the common threads that appear to be stimulating social cohesion and peer pressure towards achieving behaviour change that will be sustained and also considers the current hopeful situation in Uganda

Background

Over the past few years, in various parts of Africa and Asia, there has been considerable debate and discussion as to which Hygiene Promotion and Sanitation (HP&S) methodologies really work and actually achieve sustainable behaviour change. This debate is especially pertinent when dealing with poor, illiterate and semi-literate rural communities who continue to bear such heavy burdens of disease, 80% of which are preventable. It is also especially pertinent at this time, when only ten years remain to achieve the Millennium Development Goals.

This paper will relate HP&S to the current situation in Uganda, being one of the poorest countries in the world with 40% of the population living below the poverty line and ranked 146 on Human Development Index. It typifies much of the rest of the continent with 85% of the total population (26 million) living in rural areas where poor domestic and personal hygiene and lack of sanitation perpetuates the vicious cycle of disease, low-productivity and relentless poverty. Recent surveys in Uganda have indicated that fewer than 4% of people wash their hands effectively with soap and water after defecating. Despite the fact that latrine coverage is estimated to be around 56%, open-defecation is widespread, even in homes with latrines. Faecal:oral disease transmission thus impacts on 96% of Ugandans, particularly infants and young children.

For several decades the crucial role that safe drinking water and sanitation play towards raising the quality of life of the world's poorest communities has been understood and emphasised. In Uganda, this has resulted in substantial investments to improve rural drinking water supplies over the past 15 years. Yet infant & maternal mortality & morbidity

rates ("verifiable indicators" for the MDGs) have continued to climb. This has stimulated the Government of Uganda to again highlight the importance of hygiene and sanitation in their latest Poverty Eradication Action Plan (2004 – 2008). Five years ago, in 1997, it launched the Kampala Declaration on Sanitation. However, despite such "high level" advocacy and concern, there is still considerable confusion as to what can practically be done to tackle the challenge. Simple common sense tells us that "prevention" is much more cost-effective than "cure", especially in a desperately poor country with such a high disease burden. Common sense also tells us that very little money is actually required in order to break out of the vicious faecal : oral disease trap: simply burying all faeces and carefully washing hands with soap and water (a minimal-cost intervention) would make a quantum leap in terms of improved health. And yet this "simple" quest appears more elusive than that of getting man to the moon!

This paper considers the following 5 methodologies that are currently being employed in various countries with the intention of 'teasing out' the common threads that appear to indicate what works in order to achieve behaviour change:-

- PHAST (in Uganda);
- Community Led Total Sanitation (in India);
- "Carrot and Stick" (also in Uganda);
- Social Marketing (in West Africa);
- Community Health Clubs (in Zimbabwe and Uganda).

Hygiene promotion strategies

PHAST in Uganda

In Uganda, during the past 10 years, the Participatory Hy-

giene and Sanitation Transformation (PHAST) approach has become well established. However, a recent Study (WSP 2004) of the Cost-Effectiveness of PHAST has yielded very disappointing results showing that minimal positive hygiene behaviour change has been sustained despite the fact that this participatory approach is excellent at transferring knowledge. Similar insignificant outcomes have been reported from other countries where the PHAST methodology has been promoted over the past decade (e.g. Zimbabwe and Tanzania). So once again it is back to the drawing board.

The PHAST approach seeks to prevent diarrhoeal disease by improving hygiene behaviour and awareness, using participatory methods. It has a “7-step guide” to facilitate engagement and a commitment to change by communities:-

- i. Problem identification;
- ii. Problem analysis;
- iii. Planning for solutions;
- iv. Selecting options;
- v. Planning for new facilities & behaviour change;
- vi. Planning for monitoring and evaluation; and,
- vii. Participatory evaluation.

As already mentioned, the recent study in Uganda of the ‘Cost-effectiveness of PHAST’ determined that minimal behaviour change had been sustained (approx. 8%) despite 10 years of implementing the PHAST methodology in a variety of programmes involving over 4 million people at a per capita cost of \$3. A follow-up workshop (March 2005) was arranged in Kampala to consider the study findings and determine whether the PHAST approach should now be abandoned completely (for failing to deliver sustained positive behaviour change) or be modified, and if so, how?

There was consensus that despite the shortcomings the study had unearthed, PHAST should certainly not be abandoned completely but rather, the methodology should be further refined and implemented. There was agreement that the ‘7-step guide’ had not been adequately adhered to. Key ‘success factors’ like political will and policy support, integration within government programmes, access to finance and community involvement in the management of PHAST are undeveloped in Uganda and need to receive focused attention for scaling up. For PHAST to succeed, it is crucial that health extension staff be fully supported, coordinated and provided with motorcycles; there is need for properly structured programmes that entail consistency in delivery with on-going monitoring and evaluation. With so many health extension staff already well trained and familiar with PHAST tools, and on the payroll anyway, these additional refinements should not be too daunting.

Community led total sanitation (CLTS) - in India

There have been reports of dramatic changes in hygiene behaviour in India and Bangladesh where this CLTS approach has been introduced, with whole villages changing from open defecation practices (i.e. no latrines) to “total sanitation” within a matter of months. A “walk of shame” through the village by health extension staff initiates a process whereby

the villagers stand back and reflect on just how at risk from disease they and their children are as a result of their own poor (“disgusting”) hygiene and sanitation practices. The villagers decide for themselves just what they are going to do about it and set about exerting peer pressure and sanctions on those individuals who fail to comply. Numerous rural villages are now proudly displaying large signs proclaiming, “This village is 100% faecal free”!

The trick here seems to be to get consensus and decisions taken by the whole community by considering just how important it is for everyone to take action and to change their behaviour. The argument being: “If I am protecting my neighbour from my excrement, what is he doing to protect me from his?” No subsidy for latrine construction is offered as the emphasis is on safe disposal (i.e. burial of faeces) and that the householders themselves should choose from a whole menu of locally developed very low-cost options. This in turn has unleashed considerable ingenuity in latrine design and construction, using locally available materials, by the communities themselves.

“Carrot and stick approach” - Uganda

In Uganda’s Busia District, notable improvements in sanitation coverage have been achieved during the past two years by employing a “carrot and stick” approach by district authorities. The District Director of Health Services initiated a hygiene campaign following a serious cholera outbreak in the district. Householders were told to construct and use latrines and hand-washing facilities. The health extension staff gave explanations as to why this was especially urgent and necessary, in light of the cholera outbreaks. Prizes were awarded to the best parish, village and household in each of the implementing sub-counties. Fines (that ultimately raised the money to pay for the prizes!) were imposed on those householders that refused to comply after receiving several warnings.

After a slow start-up, this approach eventually gained widespread approval and support within the district, particularly after the district leaders realised that there was political mileage in it and that their district was heading to be top of the National League Table for Sanitation coverage. However, although latrine coverage figures have jumped dramatically from below 40% to over 90% in a short period, there is some doubt about just how sustainable the recently improved hygienic behaviour will turn out to be. Questions have been raised as to whether genuine “conversion” to improved behaviour change can be achieved after so much “coercion”.

One of the most notable achievements is that Busia district managed this remarkable turn-around in sanitation coverage without additional budgetary or NGO support. The district managed to mobilise resources like extension staff and transport through better coordination and integration of existing assets within the district. Perhaps this example helps indicate just how vital good leadership is and that it is not only “behaviour change” of householders that is the

challenge but, more pertinently, of senior officials within MoH and Local Government?

Social marketing - West Africa

Marketing consists of activities by which customers are persuaded to buy and use a product or service. Marketing works on the principle of a voluntary 'exchange' between consumer and producer where both gain. Consumers get benefits they want and producers gain profits. Social marketing uses marketing techniques to serve social objectives. The '4-Ps' of Marketing: product, price, place & promotion, go far beyond mere advertising. Whereas commercial marketers only want to sell a product (e.g. soap), social marketers want customers to use the product correctly and behave differently (e.g. wash hands with soap after defecating).

Social Marketing has already demonstrated positive results, particularly in urban and peri-urban areas of Ghana, Senegal and Burkina Faso. A media campaign (TV, radio soaps & drama) has been developed which targets specific behaviours like hand washing with soap and water and safe disposal of children's faeces. As with the CLTS approach in India, the instinctive human response to "disgust" is used to gain attention and help people to understand and realise just how at risk they are on a daily basis from fresh faecal contamination.

In Burkina Faso, after the programme had run for 3 years, 75% of the target audience in the towns had had contact with the programme activities and hand-washing with soap by mothers after cleaning a child's bottom rose from 13% to 31% (18% change). The proportion of mothers who washed their hands with soap after using the latrine increased from 1% to 17% (16% change). The conclusion reached was that hygiene promotion programmes that employ social marketing techniques can change behaviour and are more likely to be effective if they are built on local research and use locally appropriate channels of communication repeatedly and for an extended time. The importance of following up the media messages with regular home visits has been found to play an important part in moving from knowledge acquisition to behaviour change.

It is argued that sanitation matters most in high-density areas where people cannot avoid unmanaged human wastes. The rapid growth of unplanned peri-urban communities thus represents a daunting challenge for sanitation. The problem is not restricted to large cities as small towns can have many of the same problems. In Uganda, although 85% of the population is spread out in the rural areas, small towns and market growth centres are mushrooming everywhere. With local FM radio stations being established in many districts there should be ample opportunity for the social marketing approach to be promoted in support of the ongoing activities of health extension services. This is in fact already happening to some extent as the Communications Division is developed within MoH.

Community health clubs (CHC) Zimbabwe, Uganda

A programme that initiates a process of behaviour change by strengthening social cohesion and peer pressure within communities, using the Community Health Club approach, has been proven successful in Zimbabwe. A participatory course that is well structured and uses PHAST training materials and methodologies has been developed that targets, not just one or two behaviours, as in most "vertical" interventions to reduce disease; but is "horizontal" and targets a whole raft of hygiene issues.

CHC members are issued with membership cards and attend weekly sessions for 6 months to cover at least 20 health topics. These weekly sessions are facilitated by health extension staff, who are provided with motorcycles and are properly monitored and coordinated. Members are expected to carry out a whole range of "home improvements" that include constructing latrines, hand-washing facilities with soap and water, safe drinking water storage and handling, swept faecal-free yards with rubbish pits, pot racks, bathrooms, clean kitchens etc. In addition to water & sanitation, other preventative health topics include malaria, bilharzia, HIV/AIDS, ARI, nutrition, infant care (weaning foods) and many others. This approach has proven to be cost effective, at <50 US cents per person, and results in sustainable behaviour change (over 10 years to-date). Hand washing facilities increased from 20% to 74% (54% change) and sanitation (use of latrine and/or burial of faeces) went from 20% to 97% (77% change).

The social capital that develops as a result of this approach has been channelled into a whole spectrum of income generating activities like soap making, bee keeping, nutrition gardens, and various home crafts together with adult literacy and care of people living with HIV/Aids.

The CHC approach has also been introduced in 15 Internally Displace People (IDP) camps in Gulu district, northern Uganda. Here too the all-inclusive Clubs are strengthening social cohesion within these traumatised communities of IDPs. This in turn has stimulated a remarkable campaign to rapidly move away from open defecation to total sanitation similar to the CLTS approach in India (>3,500 latrines constructed within 3-months of start-up). In addition, the IDP camp communities are now adopting the same raft of positive behaviours as in Zimbabwe.

Taking stock of policy changes in Uganda

Over the past two years the cause for Hygiene & Sanitation (H&S) in Uganda has improved significantly. There have been a number of particularly important developments to highlight as follows:-

- The revised Poverty Eradication Action Plan (PEAP 2004-8) now stresses the importance of H&S. Under the Fiscal Decentralisation Strategy, districts are gaining more autonomy and flexibility in budget allocation.

Local Gov. has instructed all districts to prioritise H&S, in line with PEAP, and utilise their Conditional Grants accordingly.

- Under the Health Sector Strategic Plan (2005–10) the vertical, ‘silo-type’ preventive health divisions within MoH, will form into a horizontal ‘cross-cutting cluster’ so as to better integrate and optimise resources in favour of preventive health. This should positively affect the Divisions of Environmental Health; Control of Diarrhoeal Diseases; School Health; Community Health; Health Education & Promotion.
- The Environmental Health Division has been increasing in capacity and national influence. It has recently completed the EH Policy. It is developing a Sanitation Strategic Investment Plan together with MIS to better capture & synthesise district H&S data.
- The new MoH preventative health strategy has potential to achieve efficiency, cost savings and synergy through far greater integration and coordination of existing resources: human (e.g. Village Health Teams and Health Assistants) and material (e.g. transport).
- GoU/Dev. Partner Joint Sector Reviews for the Health & Water Sectors have agreed Undertakings in favour of H&S: by 2005, all 56 districts should have active District Water & Sanitation Coordination Committees (DWSCCs) implementing best practices in H&S.
- The National Sanitation Working Group (est. Dec. ’04) is providing coordination for all H&S stakeholders.
- The abysmal lack of adequate school hygiene and sanitation facilities, and negative impact this has on the education of girls, is beginning to receive the urgent attention it deserves (50% of Ugandans are <15 years).
- Under Fiscal Decentralisation Strategy, all districts now have an opportunity, and obligation, to integrate, coordinate and budget for H&S. Synergistic utilisation of all existing human and material resources from within ministries of Health, Water, Education, Community Development, Local Government plus NGOs is required. Such integration can more readily be achieved at district level (as Busia has already clearly demonstrated through DWSCC), than at the centre which has proved to be more complicated.

Key factors for scaling-up in Uganda

Policy: An enabling environment now exists Under PEAP; sanitation co-ordination bodies have been established at the centre, district & sub-district levels; and successful case studies of Best Practice are emerging that help to strengthen advocacy efforts.

Leadership: As Busia has clearly demonstrated, success

occurs when Chief Administrative Officer, District Director Health Services & Council Chairman, provide the all-important leadership to promote and support the DWSSC to implement H&S. PEAP anyway requires this of leaders.

Health Extension Staff: These crucial ‘agents for change’ already exist, are well qualified and should be enabled to work more closely with ‘their’ communities (both rural and urban) in a participatory and structured way, using PHAST tools. To achieve this they need to be mobile & facilitated, well supervised, monitored and evaluated on performance (as with the above Busia, CLTS & CHC approaches).

Methodology: Several hygiene promotion methodologies have been proven to achieve sustained positive behaviour change. The five approaches discussed above can be divided into those that are ‘vertical’ and target one or two behaviours to reduce disease (Social Marketing, CLTS and ‘Carrot & Stick’); and those that are ‘horizontal’ (Community Health Clubs and PHAST) that seek to address a whole raft of hygiene and development issues. Each approach has qualities that are suited to specific situations. The trick is to adopt and implement the most appropriate options to suit local conditions & resources.

- In Uganda, PHAST is already well understood (even if it has not yet been well executed as explained above);
- Busia’s “Carrot & Stick” approach is achieving significant impact thanks to good leadership;
- Community Health Clubs are working extremely well in Gulu and this approach is now ‘ripe’ for replication;
- Social Marketing, in conjunction with the private sector (e.g. local soap companies), should be taken maximum advantage of wherever possible.

Uganda is now well positioned to build on the significant achievements of the past two years and to seriously address the enormous challenge of improving the status of Hygiene and Sanitation. Decisive action is required to ensure that every district engages & takes up the challenge of disease and poverty alleviation. The globally acknowledged success of Uganda’s fight against HIV/AIDS must surely increase the national confidence and determination to achieve the Sanitation MDGs.

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