Mobilising for sanitation: an experience in Vanuatu

RAJU DAHAL *

Introduction

For more than 40 years, UNICEF has helped provide safe drinking water and improved sanitation. It is currently supporting water and environmental sanitation (WES) activities in more than 90 countries. It also provides direct grant assistance to appropriate technology and community based water and sanitation services in rural and peri-urban areas.

The World Summit for Children in 1990 endorsed three water and sanitation related goals. These are: universal access to safe drinking water; universal access to sanitary means of waste (excreta) disposal; and eradication of drancunculiasis disease. Agenda 21 of the global action plan adopted in 1992 by the Earth Summit has endorsed these goals and specified the lower cost, community level approach to water and sanitation as a realistic strategy and urged closer coordination with bilateral organisations.

Most of the Pacific countries (PIC) endorsed the goals of International Drinking Water Supply and Sanitation Decade (1980-90) to achieve universal access to safe water supplies and safe sanitary facilities. During the decade, WES have been identified for priority action but, despite concerted efforts by all countries, the decade goals were not realized.

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There is still a need for more efforts in rural areas of PIC where 37% of the households lack access to safe and adequate water supplies and 47% of the households lack access to safe sanitary facilities. In this context, the following set of strategies looks pertinent to achieve the Summit and Decade goals:

- develop country strategies for expansion of WES facilities with government and donors;
- improve capacity to plan, build, maintain and monitor WES developments;
- undertake operational research to develop low-cost WES facilities appropriate for atolls and small islands and densely populated peri-urban areas;
- mobilise the public to construct appropriate latrines, and improve personal hygiene including the conservation, protection and beneficial use of water; and
- create capacity at village and referral level to operate, manage and maintain WES systems.

The Vanuatu Rural Sanitation Project

The Republic of Vanuatu consists of 83 islands out of which nearly 73 are inhabited. The 1989 census showed a total population of 142,000, an average annual growth rate of 2.8%, a fertility rate of 5.3, and an infant mortality rate of 45—50 per 1000 live births. The rough terrain, numerous islands, scattered population, and lack of transport and communications infrastructure are the most severe constraints to achieve and maintain a high health service coverage of the population.

Infectious and respiratory diseases are the most common causes of morbidity. The National Diarrhoeal Disease Survey conducted in 1990 found that diarrhoea was common amongst children with an average of 3.8 episodes per child per year. A National Environmental Health Survey conducted in 1988 found that sanitation for rural people was not at a satisfactory level. Only 12.6% of the rural households had adequate latrines although a further 60% used pit latrines which could be upgraded. Over one quarter (27%) did not use latrines.

The Vanuatu Rural Sanitation Project is an expansion of latrine building activities started since 1988 as a diarrhoeal disease control programme. The current phase (1990-1997) covers the entire nation and aims to provide 65% of the population with adequate sanitation through Ventilated Improved Pit (VIP) or Water Seal latrines.

* *UNV Communications Officer/Health Education Adviser, Department of Health Port Vila, Vanuatu.*

Emphasis is placed on family or household latrines and a single-pit unit is being promoted. Total project cost is US$2,524,600 of which government and participating communities are providing US$1,269,100; UNCDF - US$667 400; UNDP - US$110,000; and UNICEF – US$478,060. WHO has been assisting in funding refresher courses for village sanitarians. The project has been getting valuable contributions from all eleven Local Government Councils (LGC), community members, Rural Water Supply Section, Water and Sanitation Advisory Group, and other groups.

Project objectives and components

The project aims to contribute to the reduction of: diarrhoea associated mortality in children under 5 years old (by 50%) through coordinated efforts with the national primary health care initiatives; and the incidence of diarrhoeal diseases (by 25%) among children under 5 in villages served by the project. It has been envisaged that these objectives will be achieved through:

- national capacity building for rural sanitation systems, especially through management and supervisory support, training of local project personnel, etc.;
- communications support through health education materials development, strengthening of sanitation related education activities, etc.;
- materials and transport support for the rural sanitation programme; and
- development of a locally sustainable monitoring and evaluation system.

In order to achieve the above objectives, the project plans to construct a total of 15,000 latrines and upgrade some of the existing ones throughout Vanuatu. The unit cost per latrine is approximately US$65, of which the family contributes about 50%.

A total of 30 village sanitarians are employed by the LGC. They are the on-site supervisors and impart technical know-how through community organisation. They conduct awareness sessions giving choices of alternate designs, collecting project requests from the community with the participation of the Chiefs and Area Council Secretaries. Once the request is received for the project, Environmental Health Officers ensure the proposed sites are safe in consultation with the village sanitarians.

The project provides support by supplying the reinforced concrete squat plate, PVC vent pipe and fly screen together with construction supervision. Each family is responsible for pit construction, provision of materials for and construction of the super structure and overall installation. Once complete, the village sanitarians provide health education on use and maintenance aspects of the toilets. Its impact on health is monitored through assessing the incidence of diseases before and after the availability, and the use of the latrines. The assessment is carried out by the village sanitarians.

Strategies

The communication intervention started partially around June, 1991 and in full scale from the beginning of 1992. The communication objectives were: to create an educated demand for behavioral change; empower communities with the composite benefits of uses of sanitation, water, and personal hygiene; and provide project support services through developing and disseminating educational materials.

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The approaches used were a mix of social communication, social marketing and social mobilisation. These approaches empowered the communities and provided project support. The aims of social mobilisation were to:

- increase awareness, knowledge and ability to organise for self-reliance;
- help to motivate and to know about their rights and duties, and to begin to demand satisfaction of their needs;
- understand and modify people's ideas and beliefs; and
- mobilise all available community resources.

The strategies included: concentrating on areas where water supply services were available and complement ongoing project activities; using mass media on a national scale and reinforce by empowerment through inter-personal support around critical areas; equipping on-site supervisors with communications skills to conduct awareness, demonstrations and discussion sessions (particularly on health benefits and maintenance aspects of latrines); developing communication support materials with the involvement of specialist agencies within the country; organising the activities in a campaign approach; and the gradual inclusion of messages in the school curriculum.

A mix of different media delivered the messages to the community. The messages were integrated amongst water, sanitation and personal hygiene. The information thrusts are separated for demand creation and motivation. The main messages were:

- Proper disposal of stools of young children;
- Hand washing before eating and after using a toilet;
- Use of latrines; and
- Use plenty of clean water.

The same messages were used in all the media mix. All messages were appealing to different people and aspects of

their lives. These included: health benefits and improvements in the health of families and communities; privacy; convenience; and comfort.

Current achievements

Out of a total of 22,772 households in rural Vanuatu (Census 1989) the total served each year is shown on Table 1.

Table 1. Number of household with toilets, by year

Year	Household served
1988–1991	3 963
1992	2 378
1993	3 076

Lessons learned

In summary, the following lessons were learned from the project:

- this project is promoting an appropriate technology at the current level of development;
- enough time must be allocated to prepare the community for the acceptance of the project;
- local elites e.g. chiefs, church leaders and school teachers must be amply mobilised beforehand and only then the project starts;
- communities must provided informed choices in terms of designs. Thus, the arguments over design are minimised;
- effective use of social mobilisation in motivating people to use the services and change personal hygiene behavior; and
- patience, and a lot of it, must be maintained during the community organisation phase. This leads to better community participation.

Conclusion

The emphasis of the Vanuatu Rural Sanitation Project is on eventually getting the unit cost to the level where virtually every family can meet the full cost of its latrine. Learning from the experiences in social communication, Vanuatu Rural Sanitation Project is keen on multi-sectoral and multi-level mobilisation. It is still not too late to shift our focus to provide '*some for all rather than more for some*'. The 'mobilisation of broad based alliance', if taken as an essential strategy within national plans, will help a lot to achieve global and national goals for children. WES services will not remain the exception. This project can serve as a model in the Pacific.

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