

CHIPATA D-WASHE

PAPER PRESENTATION ON EVALUATION OF HYGIENE AND HEALTH
BEHAVIOUR IN CHIPATA DISTRICT
EASTERN PROVINCE

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JUNE, 2000

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ACKNOWLEDGEMENTS

A study of this nature cannot be done in isolation. Honesty, demands that I pay due appreciation to all those who made this study tenable.

Heartfelt complaints go to the Town Clerk Mr. Sipopa Mulikita for assistance with the logistics while in the field not forgetting the D-WASHE Chairman, Mr. R.M. Daka for facilitating in the release of funds. I also thank him for assurance of support in we case faced problems in the field. Of course, I thank the entire Chipata D-WASHE Committee and its executive for their endurance and sense of duty even without extra incentives.

I also wish to acknowledge Mrs. Idah Kamanga and Mrs. Elizabeth Phiri for their company and kind assistance with numerous secretarial duties. Above all, I show appreciation to all those who made this task possible, to all of you, God bless.

3. ACRONYMS

ACO	.....	Area Community Organiser
AM	.....	Area Marson
APM	.....	Area Pump Mender
CHW	.....	Community health worker
EHT	.....	Environmental Health Technologist
LWF	.....	Lutheren world federation
NGO'S	.....	Non governmental organisation
PCO	.....	Project Community Organiser
PRA	.....	Participatory Rural Appraisal
RHC	.....	Rural Health Center
SANPLAT	.....	Sanitary platform
TBA	.....	Traditional Birth Attendant
V- WASHE	.....	Village Washe Committee
WASHE	.....	Water Sanitation and Hygiene Education
WVI	.....	World vision international

c) METHODOLOGY

A questionnaire schedule, a home/facility visit status form and Focus Group Discussion guide were used to collect data. The questionnaire schedule was used to collect data from key informants, that is, from village headmen, EHTs, ACOs and other people with first hand information on specific topics. This provided quantitative data. Home/facility visit status forms had household specific questions on household bio-data; status of family latrines; water supply, collection and storage; status of water points; hand washing facilities and behavior; availability of dish racks; storage of cooking utensils and food; and solid waste disposal. Focus Group Discussion guides were used to gather qualitative information from homogenous groups, the criteria being their understanding of the issue under investigation.

The study was conducted in all villages where project activities took place in 1996, 1997 and 1998 with or without follow-ups. The selection criteria for villages were:

1. Villages that were not visited by the 1998 students' team.
2. Villages with progress on sanitation/hygienic behavior.
3. Villages with no or little progress on sanitation/hygienic behavior.
4. A convenient sample of 16 villages were picked.

A total of 128 households in the villages were randomly picked using the systematic random sampling technique. Eight households were picked per village. Two D-WASHE members trained in PRA were picked, one per student, to accompany the teams in the field, and APMs, ACOs and EHTs were involved during field visits.

6. CONSTRAINTS

- The first and major constraint was that the field team visited villages when people were out in the fields to do their harvests. As result, the first day was usually reserved for appoints, which were done with the able assistance of local headmen.
- Secondly, although the plan was that the team uses a motorbike for the study, the situation was that, there were two teams, who could not do work within the given time, if they were supposed to use a motorbike. As a result, a vehicle was allocated to the study. This was a problem to the budget of the field team, who used their personal money to ensure that they had adequate fuel to take them to all the villages.
- Thirdly, people in the village did not understand the terms of reference for the field team. As a result, discussions became protracted because issues beyond the jurisdiction of the field-team were brought up. Handling this situation took time and careful compromise.
- Fourth, inadequate information and lack of systematic record keeping capacity by V-WASHE committee constrained access to some important factors on hygiene behavior in the villages. However, the field team considered this a challenge and managed to extract the information required within the given time. Because of this, the constraint cited had not in anyway affected the validity of this report.

7. RESEARCH FINDINGS

a) PROGRESS ON ACHIEVING OBJECTIVES

- There has been an increase in the proportion of people with access to an adequate supply of safe drinking water, located within convenient distances from their dwellings. Water is available at the sources at all times, and there are no long queues. All people interviewed indicated that they spent less than 30 minutes to collect water. Therefore, women who collect much of domestic water were saved time, which they said was spent on looking after children, cleaning their homes and doing other economic activities for the betterment of their families.
- The water quality is safe because the water used is free from visible suspended matter, excessive color, bad taste and odor, dissolved matter and microbes indicative of contamination. There was only one water point where people indicated that the water they got was of poor quality. As a result, people using this water point have gone back to the unprotected spring and unprotected water-wells.
- In hand washing, EHTs have been very instrumental in promoting target behavior. Both elders and children wash their hands 3 and more times per day, especially at critical times (after defaecation, after cleaning children's bottoms, before touching food and after meals), using soap in all cases.
- Most households have a garbage disposal pit, where they throw rubbish, and the few who don't have at least throw rubbish 30 meters away from their dwellings (into the bush). Children's excreta are thrown in rubbish pits and in pit latrines. No household indicated throwing waste water within proximity of 100 meters around the house or in hollow objects around the house.
- Cooking utensils and hand washing facilities are cleaned every day after use with soap, and household heads indicated that the utensils actually became clean. Food is covered in the interim between preparation and eating, and left covers are also covered. The latter are kept near a fireplace so that the food remains warm before it is eaten again.
- Water is collected in jerry cans and buckets, and is covered while in the house, so that no impurities go in. This safeguards water against microbial contamination. Some families have a cup per member to ensure hygiene, but in a majority of household, cups are used collectively. The common practice is that a cup is put at the container of drinking water which all members and visitors use when they want to draw water. Both cups and water storage facilities are cleaned daily, in some cases after use.
- Progress on pit latrines is very slow. Over half of the households visited indicated that they did not have a pit latrine. For those who have, most of them have traditional mud pit latrines with no sanitary platforms, foot rests or hole covers. Although the V-WASHE are making painstaking effort at encouraging people to dig pit-latrines, locals themselves are very negligent. Perhaps this might be consequent upon less health education promotion and campaign. D-WASHE has currently embarked upon an aggressive education promotion campaign, involving people of the community as much as possible.

b) GENDER ASPECT

The study reviewed that women do most of the work related to water and sanitation. The cleaning of the water point is a stereotyped role of women, imbedded in the culture of the area. Similarly, water collection is either done by women or girls. In addition, cleaning of cups, plates, pots and hand washing facilities is also done by women. Although latrine maintenance is done by men, day to day cleaning is in the hands of women. Cleaning of children's bottoms after defaecation and washing of their filthy cloths are all women and girls' roles. This demonstrates that there is still gender imbalance in water and sanitation in the villages. However, the V-WASHE committee has incorporated both men and women in its structure, and both sexes take part in the decision making process.

c) **COSTS RELATED TO OUTPUTS**

The cost of the project in relation to output is high. More money and effort is being committed to the project but the peoples' response has been very low. Firstly, materials like cement and sanitary platforms moulds have had very marginal coverage, because people have not been so committed to making contributions towards the acquisition of these materials and also because of less awareness about the importance of pit latrines. For water supply, the cost is still very high, but in the long run, this will be offset by the fact that projects will be sustainable.

d) **SUSTAINABILITY**

The corner stone of sustainability is acceptability of the project by community members. This means that they should exercise control, ownership and responsibility over the project. Auxiliaries this are two-fold: capacity building and community empowerment. To ensure that WASHE projects are sustainable, D-WASHE requires that;

- a. community members make some contributions towards materials.
- b. local people, resident in villages, are trained to maintain the hand pumps and to put chemicals in the bore holes, and in moulding sanplats for sale.
- c. local people are trained in keeping contributions toward the project.
- d. women and men participate fully and equitably in the project activities.
- e. Village people understand the importance of rendering assistance to the less privileged in the village, including children, old people, widows and orphans.
- f. People are enlightened about new technologies in water and sanitation, especially in bore hole technology, sanplat latrines, and the importance of hygienic behavior in hand washing.
- g. There is deliberate and vigorous health education. D-WASHE has stepped up such education in schools, at RHCs and within villages, using trained staff.

e) **SUPPLY MATERIALS**

There was evidence that tools and spares to be used in hand pump installation and in sanplat construction were readily available.

f) **RISKS**

There is a high risk of water contamination at some water point with cracked aprons and poor soak away pits. The other greater risk is that most of the boreholes do not have a fence around them, and villages have so many domestic animals, especially pigs.

8. SECTORAL PRINCIPLES

1. Enabling environment: it is not clear who owns the project. Most people think it is UNICEF. In capacity building, an environment of community ownership, responsibility and participation should be enhanced. The D-WASHE committee still lacks legal recognition and this makes it difficult for them to enforce certain legislation on water and sanitation in the district.
2. Institutional support: roles of different member organizations in the D-WASHE are still unclear and uncoordinated. There is also lack of communication among D-WASHE members in the district and between D-WASHE and villagers. As a result, people get different messages about one issue, and makes it very difficult for them to understand.
3. Felt need: people have a strong need for safe and clean water, for decent hand washing facilities and for improved latrines.

4. Financial factors: financing of WASHE projects is still donor dominated.
5. Health awareness: health education and awareness are still not effective in the district. This is mostly due to poor logistics and late funding. Because of this, people are still engulfed in risky hygiene behavior, like using the bush for defaecation.
6. Technology: the technology of India mark II hand pumps and sanitary platforms has been received well in communities. APMs are well trained to install and repair pumps and Area Marson to mould sanitary platforms. But hand pumps and tools are still issued by UNICEF, and this is not sustainable.
7. There is no risk of environmental degradation as a result of the project.
8. Supportive attitudes: D-WASHE activities are still considered part-time or extra-time activities, and not part of day to day work. However, APMs and AMs are very eager to work and they maintain bore holes/hand pumps and demonstrate (and mould) sanplats for sale, respectively.

9. DETAILS OF THE STUDY

a) HAND WASHING

In this survey, a total of 128 households were visited. Sixty-four of them reported that EHTs were vibrant in promoting hand washing, 16 that it was traditional leaders, 24 that were just aware by themselves, 8 that it was ACOs who promoted hand washing and 4 it was religious leaders. This means that EHTs are the predominant promoter of hand washing. Both elders and children regularly practice hand washing in all cases. Only two households indicated that they wash hands 2 to 3 times per day, the rest wash hands 126 over 3 times per day. While 44 households indicated that they had separate hand washing facilities at home 48 indicated that they had them at bath places, and 36 do not have them. Traditional basins are the commonly used hand washing facilities and they are used in 112 cases, while 16 cases showed that they used buckets and cups. All families use soap and water to clean hands, and they clean hands after latrine use, after cleaning children's bottoms, before cooking, before eating and before feeding children.

b) EXCRETA DISPOSAL

EHTs promoted excreta disposal in 72 cases and ACOs in 16 cases. The remaining 48 families reported that they were not taught about excreta disposal by any one (refer to the chart below)

Who promoted hand washing	ACO	EHTs	NONE	TOTAL
Frequency	8	72	48	128
Percentage	6.25	56.25	37.5	100.00

Most households indicated that they had garbage pits where they threw rubbish. For the 52 households that did not have rubbish pits, 14 heaped them in one dump, 2 burnt them and 36 threw them anyhow. Children's excreta is mainly thrown in the bush (78 households), then in refuse pits (46 households) and in pit latrines (4 households). Waste water is disposed of in the ambience of the house. All households indicated that they never threw waste water in a proximity of 100 meters.

c) WASHING UTENSILS AND DISH RACKS AND FOOD STORAGE

People are self conscious of clean cooking utensils. Most of households (118) use soap to clean their utensils, with only 10 using mealie meal. On the question of drying cooking utensils, 30 households stated that they had dish racks, 38 that they used baskets and 30 that they did not have. All households indicated that indeed utensils are clean after being washed.

Concerning food storage, EHTs have been very active in promoting the act. In all households, food is covered in the interim between preparation and consumption. Left overs are also covered and kept near the fire place most of the times.

d) **WATER SUPPLY**

Households get their water either from boreholes with hand pumps or from dug wells. In this study, 96 households reported that they got water from boreholes, while 32 got water from dug wells. The distances to water point, both protected and unprotected were 0.5 kmm, and people took less than 30 minutes. On how much time people spend on water points before they could collect their water, responses were as in the table below.

Time spent	<15 minutes	15-30 minutes	30-60 minutes	>60minutes
Frequency	60	16	0	52
Percentage	48.9	10.5	0	40.6

There is gender bias in water collection. In this study, it was found that women collected all domestic water, and 48 households that the critical times for water collection was in the morning. Only water in one village was turbid, this was in Dingeni area in Lwangeni constituency. Water in the rest of the villages is safe and clean. Most of the households collect water 3-4 times per day in containers of over 20 liter capacity. Water collected is covered well in the household. Sixty households use individual cups to get water from containers, while 68 use cups collectively. Both cups and water storage facilities are cleaned every time after use and every day.

10. CONCLUSIONS

The project has been successful in improving living conditions not only for women and children but also for men. Water improvement has been very instrumental to the reduction of diarrhea and other water-borne diseases, and in reducing the distance that women have to take to collect water. Reduced time has availed them time to spare for home up keep and for looking after children. There has been a progressive improvement in hygiene behavior change. In the water sector, water point have been improving from 1996 through to 1998. Newer ones are better constructed, with less risk of contamination.

There is need to enhance health and hygiene education, and increase follow-up activities. People in villages showed willingness to change their hygiene behavior, but lack of contact and health/hygiene promotion usually pilots them back into their risk behaviors. Donors should fund the D-WASHE well in time for them to carry-out their duties, than the current system where funds are disbursed late. Within the D-WASHE, people should be cooperative, well coordinated and task oriented. The current system is that very few are committed. Others, who do not even have precise knowlegdge about the activities end up misleading villagers, and this creates mistrust.

11. RECOMMENDATIONS

1. Rural schools and RHCs should be directly involved in teaching good hygiene practices and behaviors. They should also be involved in the monitoring of WASHE activities, as this would invoke the participation of teachers, EHTs, clinical officers, and would improve both decent sanitation and safe hygiene both in schools and in the villages.
2. Traditional and religious leaders should be incorporated in V-WASHE committee because these are very influential people who can play a central role in ensuring that hygiene and health are enhanced.

Apart from this, ACOs, APMs and Area Marson should be members of the D-WASHE committee so that they can have the opportunity to directly air their grievances on project operations in villages. In addition, although borehole drillers work on contract, it can be a good idea to involve them in D-WASHE activities especially on hygiene promotion. This is because, they may have some idea on how to improve water point hygiene, even where people would mistake local contamination of water for poor borehole quality.

3. Hygiene education should be boosted to achieve a sensitized environment and also to make people be aware of its importance. For this reason, all local leaders and teachers should take a leading role in community mobilization and sensitization on all WASHE activities, by working in close alliance with the V-WASHE and the community at large.
4. There should be peer education approach to the promotion of V-WASHE activities. From a sustainability point of view, young people become adults, and if they grow up conscious of WASHE, they will sustain these projects.
5. Players in WASHE activities at village level should have more access to workshops, so that they amass knowledge to impart to other community members. This will increase local knowledge about WASHE activities and prevent communication breakdown in the community.
6. There is need for good quality pit-latrines in villages. Standard latrines with sanitary platforms, foot rests and hole covers are a very acceptable technology in the villages. For the purpose of enhancing sustainability, there must be an aggressive campaign to induce people to make contributions for the acquisition of Sanplats.
7. Encourage D-WASHE/PCO that as far as excreta disposal is concerned, every good and strong pit-latrines (traditional) for those who cannot afford standard latrines (latrines with SanPlats) are ideal and that this should not be discouraged at all by health promoters. What is essential to know is that there should be not be excreta lying any how.
8. Ensure that there is effective communication and seriousness between stakeholders when it comes to implementing of WASHE programs. This is in a bid to harmonize principles in the MPO among government, UNICEF and other co-partners, so that they are effectively implemented. The target achievement should be a reduction in infant mortality and early childhood deaths, a reduction in maternal mortality and an improvement in the health and well being of women and children.
9. UNICEF WASHE's approach to community capacity building and community mobilization have been a milestone achievement in the route to sustainable water, health and sanitation management. However, more effort and resources should be invested in ensuring that the structure for sustainability is representative of all beneficiaries from the project. In particular women's involvement is commendable because they are the custodians of village hygiene.
10. Develop and support children in need and strengthen families and community capacity to protect and care for children in especially difficult circumstances (CEDC).
11. Monitor child and human development and increase investment in projects aimed at supporting the well being of women and children.