Assessing a VIP latrine construction training course

by Marianne Symons

Many of the problems encountered on these training courses could be solved by running community-based courses for trainees with building experience.

SINCE ITS OPENING in 1984, courses in the theory and practical building of ventilated improved pit (VIP) latrines have regularly been run at Amatikulu Primary Health Care Centre. Situated in rural KwaZulu/ Natal in South Africa, the centre provides training for primary health care workers. These include clinic nurses and Community Health Facilitators (CHF), who in turn train Community Health Workers (CHW) throughout KwaZulu.

The Amatikulu course has been in great demand. With an average of four courses per year and 15 trainees per course, over 280 trainees have already successfully completed the two-week residential course. The course has been open to anyone who is already involved in (or who wishes to become involved in) rural sanitation work and is free, although participants must pay for meals (at present less than R60). With a high proportion of hands-on practical work (the trainees are required to be personally involved at all stages of construction), it was hoped that the course would produce trainees capable of building VIP latrines for a living once they returned to their own communities.

An assessment of this course was undertaken during November and December of 1990. The purpose of this was twofold. First, to find out from the trainees how effective they felt the course had been and how it could be improved. Second, and this became the major concern as the assessment advanced, how many latrines were being built and by whom.

The assessment

The assessment took the form of a series of visits throughout KwaZulu to meet with and interview the trainees, and also to visit the projects they had worked on. The professional backup knowledge that trainees had access to from hospital staff, health inspectors, and CHFs was also investigated.

If the success of the training course is measured simply in terms of how many VIP latrines have been built, then the results are not encouraging. Only 58 of the original 176 trainees could be traced. Of the others some had found alternative employment and it appeared that others had simply lost interest. It is possible that some of these trainees are still involved in VIP latrine construction but could not be contacted because of communication difficulties, but it is not felt that the number could be significant. The number of VIPs built by the 118 'missing' trainees before they stopped work is not known, but is not expected to be high.

A total of 617 latrines had been built by the 58 trainees interviewed: an average of just 10 each. Worse still, many of the latrine projects were carried out by the trainees as part of a larger team, and most of the latrines have been built by just a few trainees. This can be seen more clearly in Table 1.

Table 1. Latrine projects carried out by trainees.

No. of projects completed	0	1-5	10-20	29	60	70	400
No. of trainees	29	12	4	1	1	1	1
Percentage of trainees (%)	50	21	7	17	<2	<2	<2

Half of the working trainees had not been involved in any VIP latrine building. If the aim is for these trainees to be actively involved in latrine construction, this approach is clearly not working. So what is going wrong?

The general opinion of the trainees about the training course itself was positive. Most trainees felt that the training they had received was adequate. Less than 20 per cent felt that there was not enough practical training, the most common complaint being that they did not receive enough bricklaying experience. Only one quarter of those interviewed said that the course had been too short, the majority being happy with the duration. One third of the trainees complained that the course had been expensive, but since the fee just covers the cost of the trainees' food, this problem is unavoidable. It was clear that the trainees saw no great need to transform the training course.

Before reviewing the problems that the trainees encountered, it is important to look first at just who has been trained. Some trainees are health inspectors or health assistants who have an interest in sanitation but do not work in this area full-time, and who cannot therefore be expected to be involved in many VIP projects (except at a general supervisory level). There is no doubt that it is valuable for these health workers to gain technical knowledge about sanitation projects, but the number of VIP latrines built as a direct result of these people having been trained is usually few.

Other trainees are interested members of the community with no previous building experience. Usually unemployed, they hope both to improve the sanitation situation in their own communities and to learn a skill that will ensure a job. For this group of people the training course was found to be unsuitable, because two weeks was not enough time to learn the building skills required to build VIP latrines, especially if the demand is for brick-built superstructures. To begin work, this trainee is likely to require a great deal of help for a disproportionately low return of projects. A clear distinction must be made between a job creation scheme and a sanitation scheme, the former requiring much more vocational training in building skills than the latter.

Finally, some trainees are skilled builders (often unqualified and usually

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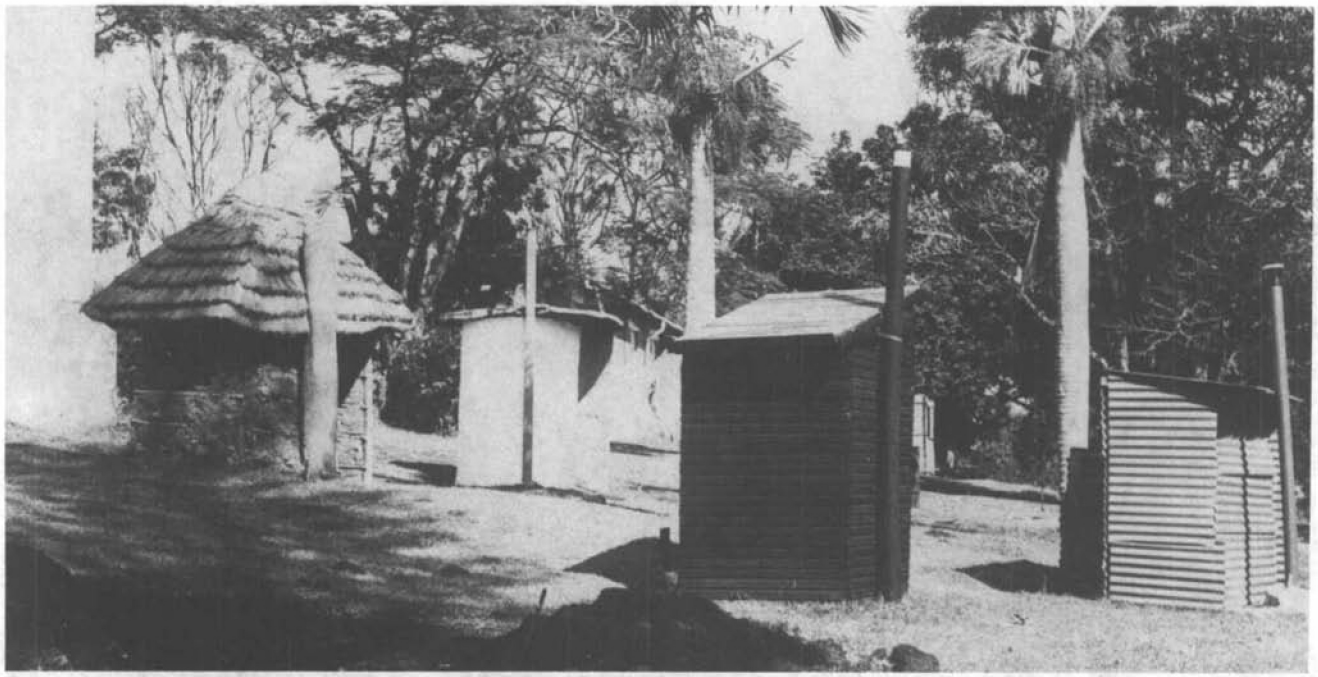


Just a few of the different variations of VIP latrines that have evolved.

unemployed), who wish to learn to build latrines as well as any other buildings. After the two-week course these trainees should be fully equipped to begin their own projects.

The problems

Even skilled builders face significant practical and organizational problems once they begin to work on VIP latrines in their rural communities:

Lack of tools Most trainees have very few tools, and many have none. Even the most basic set of tools are too expensive for many trainees. This is not usually a problem for working builders.

Lack of transportation This is a universal problem for skilled and unskilled trainees alike. Transportation is needed to bring tools and materials to the project site. Since trainees only rarely have access to a vehicle, most rely heavily on community health facilitators, health inspectors, or hospital staff to provide transportation. When no vehicle is assigned specifically to the water and sanitation projects, this lack of transportation frequently holds work up.

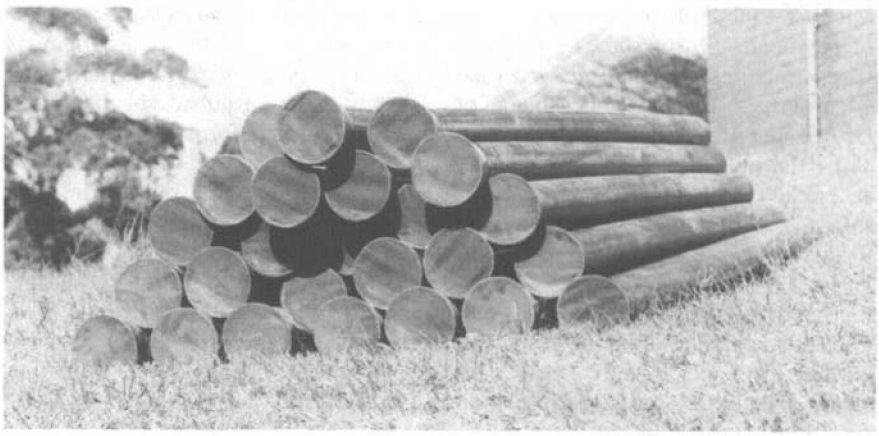
Payment problems Even the simplest well-built latrine design costs more than the poorest families can afford. At present those buying VIP latrines can be loosely labelled the 'middle classes'. The poorest people, who often have no latrines, usually cannot afford this type of latrine. In some areas of high unemployment it was reported that trainees were out of work because the community simply could not afford to employ them.

Supply of vent-pipes While it is possible to build a brick or ferrocement vent-pipe, a black plastic pipe with built-in flyscreen is more efficient and generally preferred. These pipes were complicated to manufacture, however, and therefore depended on central production and subsequent distribution by Amatikulu Centre. A simpler and cheaper vent-pipe is now used. The flyscreen is a flared cap that simply snaps on to a standard plastic pipe. In many areas it is possible to spot home-made vent-pipes of various diameters, lengths and colours, often with an ingenious flyscreen made out of stockings or orange bags. Although these examples of appropriate technology are to be applauded, the purpose-built plastic vent-pipe continues to be the favoured solution.

Trainee lacks support from local health authorities Since trainees must rely on these authorities (facilitators, health inspectors, hospital staff) for transportation, the collection of materials and vent-pipes, and advice and general moral support, it is extremely important that the trainee has firm structural support. Amatikulu Centre does not have the staff or resources to carry out a close follow-up of each trainee individually, so although staff at the centre are available on request to help with specific problems, it is the responsibility of the local health authorities to provide the follow-up and support that the trainee requires.

Community is not motivated This may happen for a number of reasons, but one main cause is a lack of knowledge about the VIP latrine. Once again it is the responsibility of the local health authorities to educate and motivate their communities about sanitation improvements and health in general, and about the VIP latrine in particular. This task is obviously much easier in areas with community health workers.

Lack of knowledge of the theory of the VIP latrine by the owner This can lead to strange designs being forced upon trainees. Common objections are the lack of door and the darkness inside the latrine. Many owners fear snakes or other animals may enter, and some



These purpose-made plastic vent-pipes have proved the most popular option.


Water Aid/Jeremy Hartley

The new vent-pipes are inspected by the builders, and the latrines by the rest of the community.

have been known to paint the inside white after the latrine is completed. Another unexpected fear encountered was that the use of a latrine instead of the bush could lead to the family's faeces being stolen for use as 'muthi'. It is important that the communities are well-educated about the VIP latrine, and that trainees themselves feel confident to act as educators.

NGOs or other organizations providing subsidized or even free latrines If such a scheme is already operating in an area it is very difficult to motivate people to buy their own latrine. In several areas an NGO has employed local people, in some cases Amatikulu trainees, to build subsidized latrines. These schemes are generally very productive but are necessarily limited to a small area. Nevertheless they tend to affect a wider area, since peoples' expectations are changed. In one such case the community health facilitator felt that sanitation projects were 'out of her hands'. In one area corrugated iron structures, donated to resettled communities by the Department of Development Aid, are widespread. These latrines are regarded by many as modern and therefore 'good', despite the fact that they do not conform to the recommended design of a VIP latrine because they have no ventilation pipe. In such an area it is difficult to persuade people of the need for VIP latrines (for which they must pay) while other latrines are available at no cost. Latrine building in KwaZulu is fragmented, with a variety of organizations working to improve and assist development. It is necessary to co-ordinate the efforts of all these organizations if they are to be of help to one another rather than, in some cases, actually hindering one another. At present various designs of latrines are promoted by various agencies. There is a great need for standardization and the promotion of one design to increase co-operation and decrease confusion.

Many schools have no latrines Schools provide an excellent opportunity to educate children and their families about the importance of safe hygiene practices. Yet for many children this opportunity is missed: they lack access to basic sanitary facilities at school and at home, making education impossible.

The way ahead?

The 'number of VIP projects completed' show that a few trainees were involved in highly successful programmes, but each of these programmes was in some way structured and supported by an outside agency. This support took the form of a government subsidy as part of a 'latrines for schools' programme, or the financial backing of a community co-operative. Only two trainees were known to be self-employed full-time in VIP latrine construction, and these men had great support from the local health workers, something which is not generally available in KwaZulu.

In order to motivate a community to begin building their own latrines, paying for the labour and materials themselves, and being entirely self-sufficient, a greater input than two or three members coming back from a training course is usually needed. One method of making a greater impact is to run a community-based training course which involves a far greater number of community members. The advantages of such a course are that:

- The theory of VIP latrine design can be taught.
- Health education can accompany the course.
- Trainees become skilled at working with the specific soil conditions which exist in their community.
- Good links can be set up with the local health authorities.
- The cost of transportation and living expenses for trainees is saved.
- The involvement and awareness of the whole community is increased.

The information collected through this assessment resulted in some changes to the training course. For example, several successful community-based training courses have been run, and health workers are now discouraged from recruiting trainees with no previous building experience.

There is no question that there is a demand for the course at Amatikulu Centre and that it is producing some VIP latrines, whether directly or indirectly. It cannot be said, however, that rural sanitation is being successfully tackled, and it is obvious that a training course such as this can only ever be a part of the solution. ●