REPORT OF THE SECOND MEETING

WORKING GROUP ON PROMOTION OF SANITATION

WATER SUPPLY AND SANITATION COLLABORATIVE COUNCIL

3-5 OCTOBER 1994

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World Health Organization
Geneva

7 November 1994

World Health Organization

1. Introduction

Background

The Working Group on the Promotion of Sanitation was established at the Rabat meeting of the Water Supply and Sanitation Collaborative Council in September 1993. The Group has a two year mandate to develop recommendations for the next Collaborative Council global meeting, tentatively scheduled to be held in Barbados at the end of October 1995, on the best ways to promote sanitation. Membership of the Working Group is open to any interested sector professional. The audience of the Group are Collaborative Council members and any other sector professionals.

The Group has been fortunate in receiving funds from the Swiss Development Cooperation (SDC) and the Swedish International Development Agency (SIDA). These funds are used to assist experienced professionals from developing countries in attending Group meetings and in fulfilling the workplan defined by the Group.

The first meeting of the Group was held in Hilterfingen, Switzerland from 1 to 3 March 1994. This first meeting fulfilled a number of important tasks: the terms of reference of the Group were refined; the term sanitation was defined; an analysis of the problem was made and issued under the title, *The Problem of Sanitation*; and a broad workplan for the coming months was drafted[1].

At the first meeting, the Group considered that sanitation promotion is not just a question of advocacy, but also a question of understanding in some detail why the sanitation sector has not been moving forward. Professionalizing the sector and giving it better tools may be necessary before advocacy can take place. For this reason the Working Group decided to make a profound analysis of the basic problems before determining how advocacy should take place.

Meeting objectives

The objectives of this meeting were to decide what should be the output of the Group to the next Collaborative Council meeting in September 1995 and to establish a workplan to achieve that output. A date was fixed for the third and final meeting of the Group and specific activities assigned to members to be completed before this date, bearing in mind that all elements of the Working Group's final report have to be submitted to the coordinator, M. Simpson-Hebert, by June 1 1995 for final editing.

Working Method

At the first meeting of the Working Group, the group had decided to explore in more detail seven topics and responsibility had been assigned for each. Out of the seven, six topics were ready for this meeting. Between the first and second meetings, two additional topics were strongly suggested for the agenda. This resulted in eight topics being explored at this meeting. Each topic was considered to be potentially a key element in the promotion of sanitation. The Working Group was divided into two sub-groups of about 13 people and each group addressed four topics. Discussion of each topic began with a presentation by one or two resource persons of key resource literature and what is currently known about the topic.

The working method was for each sub-group to identify "what we know" and "what we still do not know" about each topic. From that basis, the sub-groups were to identify what we know enough about already to make a recommendation to the Collaborative Council. On items about which it was felt that the Group's knowledge is insufficient, the sub-group was to make a recommendation to the Working Group to undertake more work on the topic and to outline what the nature of that work should be. These recommendations would form the basis of the Group's work plan between this meeting and the next meeting, ~~which the~~ Group decided should be ~~held in March~~ 1995.

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[1] The report of the first meeting can be obtained from Mayling Simpson-Hebert, Working Group Coordinator.

2. Problems encountered

The Working Group struggled with many of the topics they addressed. Across the globe positive experiences in sanitation promotion do exist and many lessons have been learned, however it is difficult for any group, and particularly one so heterogeneous, to achieve a really global perspective or to create consensus. The problems the group encountered reflect the incoherent approach of the sector and the insufficient dissemination of research and experiences to and from field practitioners. Innovation has been insufficiently supported within the sector, and rethinking the issues can prove slow and painful. Some of the difficulties encountered by the Group are summarized in the following paragraphs.

- The issue of "willingness-to-pay" was widely debated for its applicability to promotion of sanitation, its relation to reality, and its relation to ability to pay. Some members thought that good willingness to pay studies would be integral to sanitation promotion, while others saw it as useless and did not want to waste more time on the topic.

- Promotion of sanitation as a prestigious product and social marketing became intertwined, causing much debate. Many participants felt that they had minimal experience in this area and it is hoped that as more work is undertaken in the coming months the Group will be able to achieve greater understanding and consensus on these key subjects.

- It was considered that very little good information was available for discussing the potentials, limitations and appropriate roles for different actors in the sector. This led to the generation of six complex recommendations to the Working Group for further studies or papers on the subject.

- The topic on identifying existing literature that would help countries to create or adopt simple indicators of sanitation progress proved a difficult one for participants, often becoming entwined with hygiene behaviours studies. Some of the participants felt that the subject was beyond the realms of their experience and it seems that further work will be required if the Group is to provide coherent recommendations on this topic to the Collaborative Council.

- Discussion on participatory methods, social marketing and social mobilization was particularly weak because of lack of understanding and experience within the group. The group was, however, able to identify ways forward and integrate these into the workplan.

- The topic dealing with promotion of sanitation through schools and school children was one highlight of the meeting. After lengthy discussion the Group arrived at the firm conclusion that the school environment and school children are not the primary targets, but rather the community environment as a whole and the parents of the children.

It is clear that sanitation is not developed as a sector in its own right. It seems not to have its own development literature, its own theory, its own data bank of experiences and lessons learned. Most of what is known is mixed with experiences in water supply. The primary challenge of the Working Group is to fill this gap. The group firmly realized that promotion of sanitation is not simply a question of social marketing, or a better physical product or health education but is a complex puzzle of many issues that need to be sorted out before recommendations can be made to the Council. The enormous work plan of the group between Oct 94 and March 95 will have to be supported by private consultants contracted to assist Working Group members who have volunteered to examine particular topics.

3. Ways forward

This section details the recommendations of the Group, the workplan it prepared for the period October 1994 - March 1995, and the designation of a core group. In Annex D, the findings of the Working Group are presented in detail under the eight topics around which discussions were held.

The Working Group identified 17 issues about which we do not know enough and made recommendations on how to move forward on these. These recommendations formed the basis of the Work Plan for the period October 94 to March 95. The group attempted a few recommendations that it felt it could make at this time to the Collaborative Council, but time limitations meant that these were not discussed in plenary and they will be held over for further discussion at the Group's next meeting. The Group's recommendations to the Working Group are summarized below.

Recommendations

Recommendations to the Working Group

1. *Define criteria for successful sanitation programmes.*

   The Working Group should directly carry out or commission a consultant to define criteria for successful sanitation programs with which institutional capacities can be measured. As a starting point, it is recommended that the criteria should address:
   - improving health,
   - cost-effectiveness of the sanitation solutions,
   - replicability and sustainability of the program under conditions that do not require continued external financial support,
   - effectiveness in increasing coverage.

2. *Critical review of existing water supply and sanitation sector assessment tools.*

   Existing sector assessment guidelines should be reviewed and a judgement made as to whether these guidelines sufficiently address the sanitation sector or whether a new national sanitation sector assessment guideline should be developed.

3. *Study on institutional realities and behaviours.*

   A consultant should be commissioned to study the institutional realities and behaviours of donor agencies that often lead to the imposition of supply-driven approaches to sanitation promotion. The findings of this study should then be used by the Working Group in March 1995 to come up with ideas on how to make it easier for donor agencies to financially support consumer/demand-oriented approaches.

4. *Dissemination of Working Group recommendations, through such means as holding high level conference.*

   An assessment should be made of the feasibility of the holding by some country or institution of a Global Ministerial Conference for advocacy purposes, in order to raise the awareness of Ministers, to encourage them to make a commitment to sanitation improvement and to translate this commitment into national sanitation strategies and funded plans of actions. This assessment should be reported at the March meeting in order to allow the group to make a final decision as to whether it should be recommended to the Collaborative Council.

5. *Analyze existing experiences with global and national private sector.*

   The Working Group should commission a consultant to document and analyze existing experiences with global and national private sectors in promoting sanitation.

6. *Document examples and make concrete recommendations for ways in which national policies can be influenced.*

   The Working Group should commission a consultant to document examples and make concrete recommendations for ways in which international financing institutions (IFIs), external support agencies (ESAs), and international non-governmental organizations (NGOs) can address national sanitation policies as part of their assistance to their countries. These recommendations should strongly state that when possible, policy dialogue and recommendations should build on valuable experiences of field level sanitation projects that are also being supported by the external agencies.

7. *Recommend how PROWWESS tools and trainers can be further disseminated in the sector.*
   The future dissemination of PROWESS-developed methodologies, particularly SARAR, should be explored in a brief document. The reasoning behind the development of the PROWWESS project and its current evolution should also be explained.

8. *Prepare a 2-page document on sanitation indicators.*
   A simple guideline should be prepared explaining what sanitation indicators are and how to identify and use them. The guideline should be suitable for use by field workers.

[2]9. *Document positive experiences and develop operational guidelines for social marketing for the promotion of hygiene and sanitation.*

   The Working Group should commission a consultant to develop an operational guideline for social marketing and to document positive experiences of social marketing in the context of promotion of hygiene and sanitation.

[2]10. *Prepare a short paper on social marketing to explain its potential usefulness to promoting sanitation.*

   Social marketing should be used as a tool in sanitation promotion, delivery of sanitation services and hygiene behaviour change.

[2]11. *Prepare draft guidelines on promotion of sanitation as a valued concept (to raise awareness at all levels). Include a critical review of successful and unsuccessful examples.*

   In order to raise awareness at all levels, draft guidelines should be prepared on promotion of sanitation as a valued concept, based on the current techniques used and local knowledge, behaviour, attitudes. The guideline should include promotional examples at national and community level and their results.

12. *Document examples of applying problem-based learning (PBL) or approach for promoting sanitation through channels other than schools.*

   The Working Group recommends that the possibility should be explored of using a problem-based learning approach in settings other than the school.

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[2] In order to avoid duplication of work, the guidance of the Collaborative Council IEC Working Group will be sought on the application of these recommendations

13. *Collect examples of working through children to promote sanitation (other than HESAWA PBL approach).*

    The Working Group recommends that sanitation promotion through children in all its forms, for example through schools, scouting or sports, should be explored as a potentially effective method for reaching adults, in particular parents.

14. *Prepare paper on when "willingness-to-pay (WTP)" studies are useful and not useful.*

    A paper should be prepared on when WTP studies are useful and when not, what their pitfalls and limitations are and where improvements are needed. As much as possible the paper should review how promotional activities have changed households' willingness to pay.

15. *Prepare a paper on the various additional tools (other than WTP studies) to assess community readiness for improved sanitation.*

    A paper should be commissioned on the various additional tools that exist to assess local men's, women's and community organizations' willingness to improve sanitation with local resources.

16. *Expand USAID/EHP study on small credit schemes for communities, focusing on sanitation. Include typical models of successful schemes.*

    The USAID/WASH study on household credit for water supply and sanitation should be complemented with additional cases and applied specifically to sanitation. Typical models of successful sanitation small credit schemes should be identified. A few of the most promising models of sanitation small credit schemes should be assessed in the field.

17. *Prepare a critical review of affordable and saleable sanitation technologies, starting with "dig and bury."*

    A critical review of existing low-cost and least-cost technologies should be prepared. This review should examine the appropriateness of the existing technologies from the point of view of their affordability, saleability, user friendliness and their general adaptability on a large scale. In the review, the following critical issues could be considered:

    - The design/performance principles.
    - Design and cost information on low-cost and least cost sanitation system.
    - Existing approaches and strategies.
    - Definitions of the meaning of affordability and saleability.
    - Minimum standards (design and performance).
    - Factors influencing saleable technology.
    - The efforts required to make people to use the technology.

    The review will require inputs from an interdisciplinary group including engineers, social scientists, etc. and also from all members of the Working Group. Individual responsibility may have to be assigned for this purpose.

Tentative recommendations to the Collaborative Council.

The Group felt that the Collaborative Council should recommend to its members that they launch special campaigns to promote sanitation by celebrities in their countries. Another issue on which certain members of the group felt ready to make recommendations to the Collaborative Council was the use of sanitation behaviour studies: it was felt that they should be integrated into sanitation baseline studies, project planning, implementation, monitoring, and evaluation and that strengthening of human resource capacities at national levels to carry out such studies was necessary. These issues will be discussed more fully at the next meeting, before final recommendations are made.

Work Plan (October 94 to March 95)

Based upon the 17 recommendations made to the Working Group, the following work plan was developed. In the following table the recommendations are given abbreviated names. The full title of each activity can be found in the list of recommendations above.

Activity	Responsible
1. Define criteria for successful sanitation programmes.	1. **B. Samantha** (5 pages). Input from all members of WG. First draft by 15 Jan. 95
2. Critical review of existing water supply and sanitation sector assessment tools.	2. **E. Perez**. Input from WG members. First draft ready by 15 Jan. 95.
3. Study on institutional realities and behaviours.	3. **A. Nyomba**. WG members to send inputs. May be desirable to hire consultant and WG members requested to submit possible names. First draft by 15 Jan. 95.
4. Dissemination of our recommendations, through such means as holding a high level conference.	4. To be discussed by the WG at the next meeting, March 95.
5. Analyze existing experiences with global and national private sector.	5. **M. Simpson** to hire a consultant. Core group to create TOR and find consultant.
6. Document examples and make concrete recommendations for way in which national policies can be influenced.	6. **P.K. Sivanandan, T. V. Luong** and **H. Alkhandak**. WG input requested. First draft by 15 Jan.
7. Recommend how PROWWESS tools and trainers can be further disseminated in the sector.	7. **L. Clarke** and **A. Chatterjee** to prepare 2-page document. First draft by 15 Jan. 95.
8. Prepare a 2-page document on sanitation indicators.	8. **C. Van Wijk** and **A. Almedom**. Input requested from M. Yacoob, USAID/EHP. First draft by 15 Jan. 95.
[3]9. Document positive experiences and develop operational guidelines for social marketing for the promotion of hygiene and sanitation.	9. **M. Simpson** to ask IEC Working Group if they would be willing to take on this task. End Oct. inform WG members on reply.
[3]10. Prepare a short paper on social marketing to explain its potential usefulness to promoting sanitation.	10. **D. Ikin** to prepare draft, review by USAID/EHP and by Mr Neil McKee. First draft by 15 Jan. 95.

[3] In order to avoid duplication of work, the guidance of the Collaborative Council IEC Working Group will be sought on the application of these recommendations.

11.[4] Prepare draft guidelines on promotion of sanitation as a valued concept. Include a critical review of successful and unsuccessful examples.	11. Input from WG members to **V. Jitjaturunt**. D. Ikin also to help. **M. Simpson** to ask Mr Neil McKee for input. First draft by 15 Jan. 95.
12. Document examples of applying Problem-Based Learning (or Approach) for promoting sanitation through channels other than schools.	12. **E. Mwasha** and **B. van Bronckhorst**. Input from WG members to be sent to Mr van Bronckhorst. First draft 15 Jan. 95.
13. Collect examples of working through children to promote sanitation (other than HESAWA PBL approach).	13. **E. Mwasha** and **B. van Bronckhorst**. Input by WG members to Mr van Bronckhorst. First draft by 15 Jan. 95.
14. Prepare paper on when "willingness-to-pay" studies are useful and not useful.	14. **R. Schertenleib** to ask SDC/Aguasan if they could tack this onto their on-going review of WTP studies. WG members requested to give input.
15. Prepare a paper on the various additional tools (other than WTP studies) to assess community readiness for improved sanitation.	15. **C. Van Wijk** to identify consultant and inform **M. Simpson.**
16. Expand USAID/EHP study on small credit schemes for communities, focusing on sanitation. Include typical models of successful schemes.	16. **Mr E. Perez** to ask if USAID/EHP would be willing to do this. E. Perez to send out existing report on credit schemes to WG members. First draft by 15 Jan. 95.
17. Prepare a critical review of affordable and saleable sanitation technologies, starting with "dig and bury."	17. **H. Silva** and **J. Gough**. UNICEF/Bangladesh to provide special input on "home-made latrines" project. First draft by 15 Jan. 95.

Core Group

The Working Group requested that the Coordinator form a small core group to decide upon the agenda and definite location of the next meeting. Members of the core group will be:

Bryan Locke	Eddy Perez
Roland Schertenleib	Dennis Warner
Lucy Clarke	Mayling Simpson-Hebert

Needs and considerations for the meeting in March 1995

The next meeting of the Working Group should have participants who are particularly strong in the following areas:

- Social marketing and social mobilization
- Participatory methods for behaviour change
- Institutional behaviours and behaviour change
- Training for practitioners

[4] In order to avoid duplication of work, the guidance of the Collaborative Council IEC Working Group will be sought on the application of this recommendation.

ANNEXES

A Findings by topic

B Meeting agenda

C List of participants

D Documents consulted

E Expanded list of all Working Group members

FINDINGS BY TOPIC

TOPIC 1: AFFORDABLE AND SALEABLE SANITATION TECHNOLOGIES

We know that:

a. The technologies to be promoted should be affordable, appropriate, saleable and environmentally friendly.

b. The technologies should be gender friendly and that women can be excellent designers and builders of sanitary facilities.

c. The low-cost options promoted now are affordable largely only by communities and households which are relatively better off.

d. The involvement of the private sector, which is essential for long term sustainability, has been minimal and that so far, market mechanisms have played a very insignificant role in accelerating sanitation coverage.

e. Good product technology alone does not promote itself, and that no amount of clever marketing strategy can sell an inferior product.

f. There is a lot of relevant information on different technical options available in an unpublished form.

We do not know enough about:

a. Good examples of least cost technologies which are affordable by low income households.

b. The inter-country and intra-country variations in the range of options adopted and their replicability.

c. Good examples of location-specific technologies with the potential for adoption on a large scale.

d. How to choose technologies to suit different geo-hydrological situations and various socio-economic population segments.

e. How to link affordability with technology choice.

f. Ways to promote the use of excreta as a valuable resource (eg. soil nutrient, gas production, fish food).

g. The potential benefits of using solar energy and hydraulics to reduce cost/impacts of excreta disposal.

Recommendation to the Working Group

A critical review of low-cost and least-cost technologies should be commissioned. This review should examine the appropriateness of the existing technologies from the point of view of their affordability, saleability, user friendliness and their general adaptability on a large scale. In the review, the following critical issues could be considered:

- The design/performance principles.
- Design and cost information on low-cost and least cost sanitation system.
- Existing approaches and strategies.
- Definitions of the meaning of affordability and saleability.
- Minimum standards (design and performance).
- Factors influencing saleable technology.
- The efforts required to make people to use the technology.

The review will require inputs from an interdisciplinary group including engineers, social scientists, etc. and also from all members of the Working Group. Individual responsibility may have to be assigned for this purpose.

TOPIC 2: EXISTING TOOLS TO DETERMINE WILLINGNESS TO PAY

We know that:

a. It is generally assumed that people are not willing to improve sanitation with their own resources. Present evidence suggests the opposite.

b. Planners and decision-makers often assume that they know what local men and women want, without asking them.

c. Willingness to pay studies are useful to assess and plan technology choices, service levels and local contributions.

d. These studies are not universally applicable and have limitations in cost, methodology, range of choices given (they tend to exclude lowest cost and traditional options) and implementation of findings.

We have not:

a. Defined in which situations WTP studies are suitable and where they are better avoided.

b. Translated WTP studies into simplified planning procedures.

c. Developed a set of other practical tools for women and men in communities to choose, from a range of sanitation options, that option which matches needs with resources.

Recommendations to the Working Group

1. A paper should be prepared on when WTP studies are useful and when not, what their pitfalls and limitations are and where improvements are needed. As much as possible the paper should review how promotional activities have changed households' willingness to pay.

2. A paper should be commissioned on the various additional tools that exist to assess local men's, women's and community organizations' willingness to improve sanitation with local resources.

TOPIC 3: PROMOTING SANITATION (CONCEPT AND FACILITIES) AS A PRESTIGIOUS PRODUCT

The sub-group decided to re-word this topic to:

PROMOTION OF SANITATION AS A VALUED CONCEPT

<u>We know that:</u>

The following are the values on which sanitation should be based:

At the local level:
a. Concern about the family and children
b. Privacy, convenience and dignity
d. Prestige

At the national level:
a. Reduction of the incidence of diseases
b. Improvement of health conditions

<u>We do not know enough about:</u>

How this should be done at the community and national level.

Recommendation to the Working Group

[5]In order to raise awareness at all levels, draft guidelines should be prepared on promotion of sanitation as a valued concept, based on the current techniques used and local knowledge, behaviour, attitudes. The guidelines should include promotional examples at national and community level and their results.

Tentative recommendation to the Collaborative Council

The Collaborative Council should recommend to its members that they launch special campaigns to promote sanitation by celebrities in their countries.

TOPIC 4: SMALL CREDIT SCHEMES FOR LOW-INCOME HOUSEHOLDS

<u>We know that:</u>

a. Credit can be a powerful mechanism for increasing sanitation coverage. It can bridge the gap between people's needs and their resources.

b. Credit (to households, the private and the public sector) as a mechanism for promoting sanitation has not been well explored and utilized.

[5] In order to avoid duplication of work, the guidance of the Collaborative Council IEC Working Group will be sought on the application of this recommendation

We do not know enough about:

a. How to create an interest among the financial/credit institutions to fund (at the household level?) a non-income generating activity like sanitation.

b. How to make credit schemes accessible to households.

c. How to determine appropriate interest rates for credit schemes.

Recommendation to the Working Group

The USAID/WASH study on household credit for water supply and sanitation should be complemented with additional cases and applied specifically to sanitation. Typical models of successful sanitation small credit schemes should be identified. A few of the most promising models of sanitation small credit schemes should be assessed in the field.

TOPIC 5: POTENTIALS AND LIMITATIONS OF EXTERNAL SUPPORT AGENCIES, GOVERNMENTS AND NON-GOVERNMENT SECTORS IN SANITATION PROMOTION

We know that:

a. Raising the profile of sanitation and boosting sanitation production is a complex process that must involve many institutional actors including External Support Agencies, Government Agencies, Non-Government Agencies, and the Private Sector.

b. A major reason for the lack of progress in the promotion of sanitation is that a National Sanitation Sector, per se, is non-existent in most countries, that institutional capacity is weak and that institutional roles and responsibilities of the various institutional players are not well understood or defined.

c. Successful sanitation promotion happens when institutions are responsive to user priorities and preferences.

d. That chances of success are higher when there is a good and natural match between program needs and institutional strengths. for example ministries of health are inherently better at changing hygiene behaviours than managing a construction program to build latrines; private sector financial institutions are inherently better at managing a credit program; private sector producers are inherently better at producing materials and sanitation components (if allowed to respond to market forces); and that government institutions are inherently better at facilitating and regulating sanitation promotion.

We are concerned that:

a. The international sanitation sector does not have a clear and common definition of what is successful sanitation promotion. This makes it difficult for the sector to agree on the strengths and weaknesses of the various institutions. For example, many small-scale pilot projects have been successful at improving sanitation in a given community or regional area but many of these "successful" projects are often not replicable without significant subsidies, are not sustainable

without continued external financial support, reach a relatively small number of families, and have little institutional capacity to scale up.

b. The current conventional wisdom that sanitation programs must be largely subsidized to reach the poor is crippling to government agencies and, to a lesser degree, to NGOs in their ability to significantly boost sanitation promotion.

c. The IFIs, ESAs, and to a lesser degree the International NGOs, significantly determine and even dictate the sanitation program design, roles of the institutions and even the technology choice. This can be a significant barrier to a more consumer-oriented demand approach.

d. Donor agencies have increasingly chosen to set up a separate implementing arm for the project or to avoid the public sector altogether and work directly with non-governmental groups and the private sector. Both approaches facilitate project implementation in the short term. However, the projects are almost never sustained after donor funding dries up, and their impact on national level capacities building is often limited or even counter productive.

Recommendations to the Working Group

1. Criteria for successful sanitation programs should be defined, with which institutional capacities can be measured. As a starting point, it is recommended that the criteria should address: improving health, cost-effectiveness of the sanitation solutions, replicability and sustainability of the program under conditions that do not require continued external financial support, and that effectively increases coverage.

2. Existing sector assessment guidelines should be reviewed and a judgement made as to whether these guidelines sufficiently address the sanitation sector or whether a new national sanitation sector assessment guideline should be developed.

3. A consultant should be commissioned to study the institutional realities and behaviours of donor agencies that often lead to the imposition of supply-driven approaches to sanitation promotion. The findings of this study should then be used by the Working Group in March 1995 to come up with ideas on how to make it easier for donor agencies to financially support consumer/demand-oriented approaches.

4. An assessment should be made of the feasibility of the holding by some country or institution of a Global Ministerial Conference for advocacy purposes, in order to raise their awareness to make a commitment to sanitation improvement and translate this commitment into national sanitation strategies and funded plans of actions. This assessment should be reported at the March meeting in order to allow the group to make a final decision as to whether it should be recommended to the Collaborative Council.

5. A consultant should be commissioned to document and analyze existing experiences with global and national private sectors in promoting sanitation.

6. A consultant should be commissioned to document examples and make concrete recommendations for ways in which IFIs, ESAs, and international NGOs can address national sanitation policies as part of their assistance to their countries. These recommendations should strongly state that when possible, policy dialogue and recommendations should build on valuable experiences of field level sanitation projects that are also being supported by the external agencies.

TOPIC 6: HYGIENE/SANITATION "INDICATORS"

Indicators of change in sanitation are important for promotion because they allow programmes and projects to measure whether progress is taking place. Indicators of progress at national, provincial, district, community and household levels can be devised. If the indicators indicate that progress is not taking place or is moving too slowly, the promotion programme can be reviewed and modified at relevant levels. The sub-group decided to discuss indicators at the household and community level and to discuss them together with hygiene behaviour studies. However, some clarification of the difference between indicators and hygiene behaviour studies is required.

Indicators are easily-observed proxy measures of change (not only behavioral change). Indicators at household level could include presence or absence of soap or ash, presence and location of handwashing bowls or other facilities, or presence and intensity of faecal contamination near houses. Indicators usually do not require interviews or group discussions nor do they necessarily explain why a behaviour or situation is changing or not changing. Indicators are selected on the basis of what is already known about the community (or what the community knows about itself) and what would be a good indicator of change. Ideally, communities would select their own indicators and monitor them themselves.

Indicators at national level might be changes in staffing and staff training, changes in the sanitation budget, changes in reward and promotion procedures, or changes in legislation and promotional incentives for the private sector.

It is not clear, but very probable, that certain indicators could be universal (such as presence of faecal contamination or presence of soap or ash) while other indicators must be project-specific, based upon particular project goals and therefore specially created each time. It is clear that sanitation programmes near better guidance on how to identify indicators for various levels.

Hygiene behaviour studies can be a precursor to selecting household and community indicators and can be done either by outsiders, such as anthropologists, or by community members themselves, often with facilitation by outside trained personnel. These studies aim to describe in detail and understand the meaning behind hygiene behaviours. Techniques for gathering data may be very simple, such as using focus group discussions and observations over a few days, or more extensive using a great variety of methods. Hygiene behaviour studies can help in the design of better programmes, but they may not play any role in sanitation promotion. This issue should be further discussed at the next Working Group meeting.

We know that:

1. The PROWWESS/UNDP Project produced a guideline on indicators entitled Goals and Indicators. Other literature exists (see attached bibliography) which addresses this topic, but a guideline for the sanitation sector alone does not exist.

2. There is a growing body of knowledge and experience on how to do hygiene behaviour studies, e.g. Boot and Cairncross, 1993; Cairncross and Kochar 1994. Such studies may lead projects to identify better indicators.

We don't know enough about:

1. How effective the PROWWESS publication Goals and Indicators is in measuring changes in sanitation - it has mostly been used in water. It may be necessary to adapt Goals and Indicators for sanitation alone.

2. Whether participatory tools can be used to monitor hygiene behaviour change. Trials in Kenya, Tanzania and Ethiopia have shown them to be useful when integrated with other methods. More of this needs to be done in other parts of the world.

Recommendations to the Working Group

1. The future dissemination of PROWWESS-developed methodologies, particularly SARAR, should be explored in a brief document. The reasoning behind the development of the PROWWESS project and its current evolution should also be explained.

2. A simple guideline should be prepared explaining what sanitation indicators are and how to identify and use them. The guideline should be suitable for use by field workers.

TOPIC 7: EFFECTIVENESS OF PARTICIPATORY METHODS, SOCIAL MARKETING AND SOCIAL MOBILIZATION TECHNIQUES FOR PROMOTION OF SANITATION.

We know that:

a. Participatory methods are effective for promotional purposes at household and community level.

b. Government/leaders do not appreciate fully the value of participatory methods for sanitation promotion.

c. Applying participatory methods takes time.

d. Social marketing can be understood as: *creating and satisfying (social) demands*. It should be seen as a tool for:
   - promotion of sanitation (creating demand);
   - delivery of sanitation/facilities;
   - changing behaviours.

We don't know enough about:

a. Various experiences in using social marketing to create demand for sanitation.

b. The proper application of social marketing in the context of sanitation and hygiene.

Recommendations to the Working Group

[6]1. A consultant should be commissioned to develop an operational guideline for social marketing and to document positive experiences of social marketing in the context of promotion of hygiene and sanitation.

[6]2. A short paper should be prepared on social marketing to explain its potential usefulness to promoting sanitation.

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[6] In order to avoid duplication of work, the guidance of the Collaborative Council IEC Working Group will be sought on the application of these recommendations.

TOPIC 8: EFFECTIVENESS OF PROMOTING SANITATION THROUGH SCHOOLS

We know that:

a. Schools can be effective channels for promoting sanitation and hygiene in rural communities.

b. Trial and error over a long period of time has led to the discovery of problem-based-learning (PBL) as an appropriate participatory method.

c. Good health for children was a good motivator for sanitation promotion through the schools in the HESAWA/AMREF project in Tanzania.

d. Positive reinforcements/rewards are successful motivators for children (even for adults) to change behaviour.

e. Teachers should be key role models, therefore they need to be motivated to practice key sanitation and hygiene behaviours.

f. We have to target various organized groups and not just schools as channels to bring the message home.

We don't know enough about:

a. Whether working through schools is also effective in urban and peri-urban areas.

b. Which other ways of working with/through children on sanitation promotion are equally or more effective in changing sanitation behaviour of parents.

c. How to sustain sanitation promotion programs over sufficiently long periods to acquire effective lowering of pathogen loads of the environment. It took decades in Western and some Asian countries.

Tentative recommendations to the Collaborative Council

1. Sanitation promotion through children, eg in schools, scouting, sports, should be considered as an effective method for reaching adults, in particular parents.

2. Both national Ministries of Education and Ministries of Health should expand and accelerate sanitation through schools using PBL approach.

ANNEX B

AGENDA

Second Meeting of Working Group on Promotion of Sanitation
Hilterfingen, Switzerland
3-5 October 1994

Monday 3 October 1994

09:30	Welcome and introductions	M. Simpson
10:00	Aim of this Working Group Session Expectations of our outputs Key dates until Barbados	
10:15	Presentation and adoption of agenda	
10:30	Feedback on "Problem of Sanitation."	
10:45	Break into two working groups and refreshments	
		Resource persons
Group 1:	Facilitator: Mr. Mohammed Kané	
	What do we know about **affordable and saleable sanitation technologies**?	R. Schertenleib
	What do we know about **existing tools to determine willingness to pay**?	D. Ikin
	Can sanitation be promoted as a **prestigious product**?	C. Van Wijk D. Ikin
	What do we know about **small credit schemes for low-income households**?	B. Samantha
Group 2:	Facilitator: Vathinee Jitjaturunt	
	What do we know about the **potentials and limitations of government and non-government sectors** in sanitation promotion?	E. Perez
	What do we know about **existing documents on hygiene/sanitation "indicators" and methods to measure them.**	A. Chatterjee A. Almedom
	What do we know about the effectiveness of **participatory methods, social marketing and social mobilization techniques** for promotion of sanitation?	B. Ramahotswa
	What do we know about the effectiveness of promoting sanitation through **schools**?	E. Mwasha

13:00	Buffet Lunch	
14:00	Working Groups	
16:00	Refreshments	
18:00	End of working sessions and **Reception**	

Tuesday

08:30	Working groups	
13:00	Buffet lunch	
14:00	Plenary session to present outputs of group work - Findings - Recommendations to Working Group on next steps	
16:45	Refreshments	
17:00	Review of Wednesday's agenda	
18:00	End of working sessions	
20:30	Special presentations	

Wednesday

08:30	Workplan from October 1994 to June 1995 - Determination of WG outputs to Collaborative Council	R. Schertenleib
10:45	Refreshments	
11:00	- Assignment of responsibilities	
13:00	Buffet lunch	
14:00	- Determination of projects and programmes where outputs of WG can be immediately tested or applied.	
16:00	Closing remarks	B. Locke

Sanitation is the "safe interaction with human excreta."

- Working Group on Promotion of Sanitation
March 1994

ANNEX C

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Hilterfingen, Switzerland, 3-5 October 1994

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ANNEX D

DOCUMENTS CONSULTED

A. Documents presented during working group sessions

Topic 1: Affordable and saleable sanitation technologies

Latrine bibliography, IRCWD, 1994

Topic 2: Existing tools to determine willingness to pay

Willingness to pay, Derrick O. Ikin, SKAT, October 1994. Prepared for the Second Collaborative Council Working Group Meeting on Promotion of Sanitation, Hilterfingen, 3-5 October 1994.

Household Demand for Improved Sanitation Services: A Case Study of Kumasi, Ghana, Dale Whittington, Donald T. Lauria, Albert M. Wright, Kyeongae Choe, Jeffrey A. Hughes, and Venkateswarlu Swarna, Water and Sanitation Report 3, UNDP-World Bank Water and Sanitation Program.

Topic 3: Promotion of latrines as a prestigious product

Promotion of latrines as a prestigious product, Christine van Wijk, October 1994. Prepared for the Second Collaborative Council Working Group Meeting on Promotion of Sanitation, Hilterfingen, 3-5 October 1994.

Promotion of latrines as a prestigious product, Derrick O. Ikin, SKAT, October 1994. Prepared for the Second Collaborative Council Working Group Meeting on Promotion of Sanitation, Hilterfingen, 3-5 October 1994.

Demand creation and affordable sanitation and water, Derrick O. Ikin, SKAT, 20th WEDC Conference, Colombo, 22-26 August 1994.

Social mobilization and social marketing in developing communities, Neill McKee, Southbound, Penang, 1992.

Promotion of rural sanitation in Bangladesh with private sector participation, Skylark Chadha and Martin Strauss, Swiss Development Cooperation.

Topic 4: Small credit schemes for low-income households

Rural sanitary marts, B.B. Samanta, UNICEF India Country Office, New Delhi, August 1994. Prepared for the Second Collaborative Council Working Group Meeting on Promotion of Sanitation, Hilterfingen, 3-5 October 1994.

UNICEF's experience in promoting rural sanitation in India, B.B. Samanta, UNICEF India Country Office, New Delhi, August 1994. Prepared for the Second Collaborative Council Working Group Meeting on Promotion of Sanitation, Hilterfingen, 3-5 October 1994.

Topic 6: Hygiene/sanitation "indicators"

Studying hygiene behaviours, A. Cairncross and V. Kochar, Sage Publications, India, 1994.

Goals and indicators, PROWWESS/UNDP, Technical Series Involving Women in Water & Sanitation, New York, 1989.

Topic 7: Participatory methods, social marketing and social mobilization techniques for promotion of sanitation

Social mobilization and social marketing in developing communities, Neill McKee, Southbound, Penang, 1992.

Social mobilization for sanitation - Project proposal for supplementary funding, UNICEF, Bangladesh, 1993.

Tools for community participation - a manual for training trainers in participatory techniques, Lyra Srinivasan, PROWWESS/UNDP Technical Series Involving Women in Water and Sanitation, New York, 1990.

Topic 8: Promoting sanitation through schools

The HESAWA school health and sanitation package, Eben S. Mwasha, Zonal HESAWA Coordination Office, Mwanza, Tanzania, 1994.

School sanitation and hygiene education in Latin America - Summary report of a workshop on problems and options for improvement, PAHO/WHO/IRC, Cali, Colombia, 22-27 March 1993.

Hygiene education and environmental sanitation in schools in Viet Nam - the report of a project identification and formulation workshop, REH/EOS/WHO, Hanoi, 8-10 June 1993.

B. Other documents consulted

New initiatives in rural sanitation in India, P.K. Sivanandan, Rajiv Gandhi National Drinking Water Mission, Ministry of Rural Development, Government of India. Prepared for the Second Collaborative Council Working Group Meeting on Promotion of Sanitation, Hilterfingen, 3-5 October 1994.

Participatory evaluation - tools for managing change in water and sanitation, Deepa Narayan, World Bank Technical Paper Number 207, Washington, D.C., 1993.

Taking the pulse for community management in water and sanitation, PROWWESS/UNDP, September 1990.

Indicators for success - CPHE in water supply and sanitation: how to measure progress and results? (Draft), Community Participation and Hygiene Education, CPHE Series No. 4, GTZ, Eshborn, October 1989.

The CDD-WATSAN strategy, B.B. Samanta, UNICEF India Country Office, New Delhi, August 1994. Prepared for the Second Collaborative Council Working Group Meeting on Promotion of Sanitation, Hilterfingen, 3-5 October 1994.

Sanitation and latrine producers, Bangladesh, T.V. Luong, UNICEF, Dhaka, Bangladesh. Prepared for the Second Collaborative Council Working Group Meeting on Promotion of Sanitation, Hilterfingen, 3-5 October 1994.

Environmental sanitation in China, Vathinee Jitjaturunt, UNICEF, Beijing. Prepared for the Second Collaborative Council Working Group Meeting on Promotion of Sanitation, Hilterfingen, 3-5 October 1994.

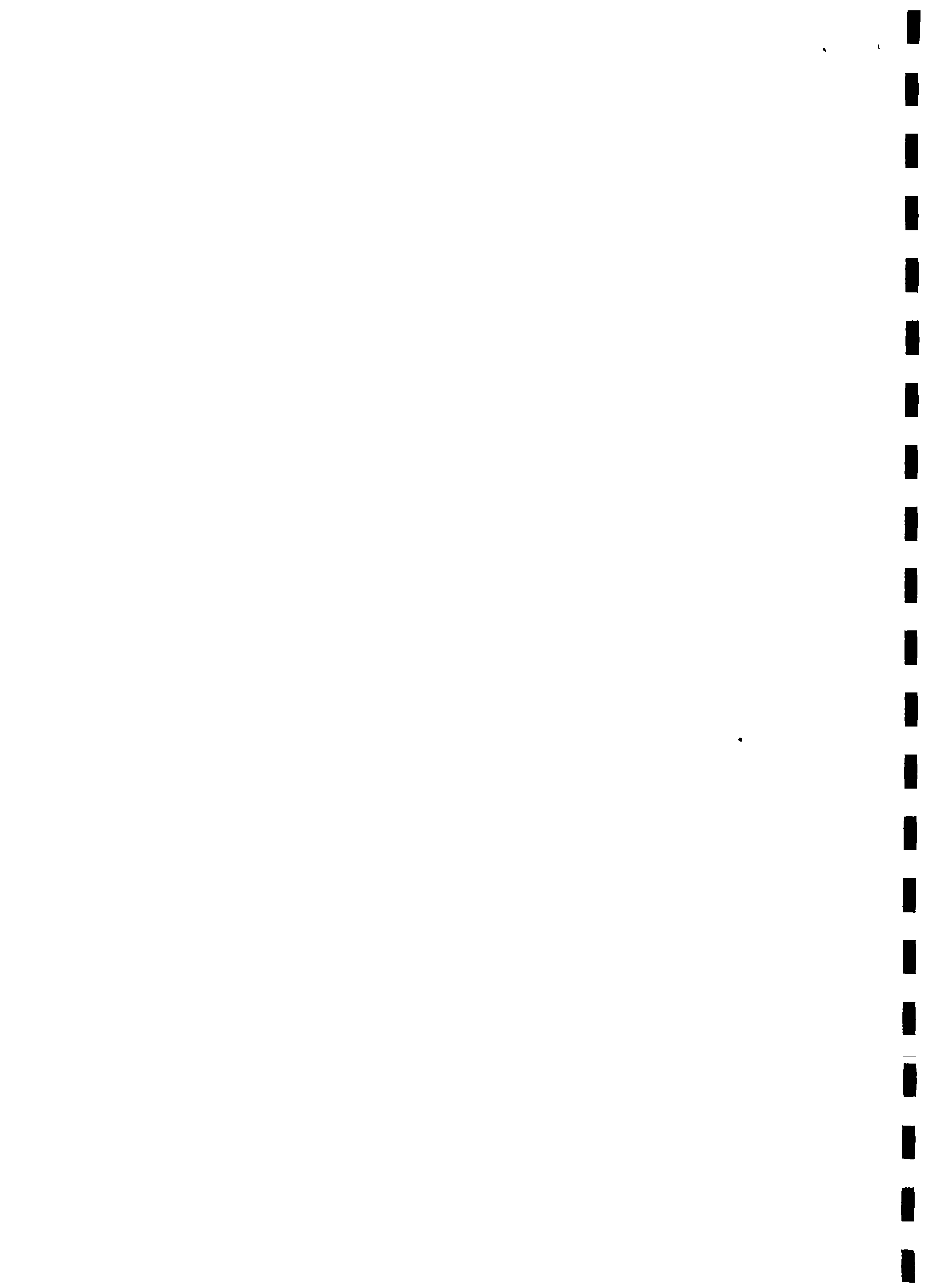
Gender aspects of sanitation, the missing slipper of Cinderella? Christine van Wijk, IRC.

Proceedings of the National Seminar on Rural Sanitation (16-17 Sept. 1992), Ministry of Rural Development, Government of India, New Delhi.

People, water and sanitation - what they know, believe and do in rural India, The National Drinking Water Mission, Government of India, New Delhi, 1990.

The Mvula Trust - supporting water and sanitation development, The Mvula Trust, Braamfontein, South Africa.

Proceedings of a Regional Urban Sanitation Workshop, Eastern and South Eastern Africa, Mukono, Uganda, 23-26 May 1994, Government of Uganda, 1994.



ANNEX E

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Working Group on Promotion of Sanitation
Water and Sanitation Collaborative Council
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New initiatives in Rural Sanitation in India

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New Initiatives in Rural Sanitation in India

*(P. K. Sivanandan *)*

Safe disposal of excreta with emphasis on poorer individual households, total sanitation of the village, campaign for creation of the felt need and involvement of NGOs in both implementation and awareness creation are the key elements in the new strategy adopted by the Government of India, in its efforts to push through the rural sanitation programme.

In evolving such a strategy Government have carefully considered the results of its earlier strategies, the views of the NGOs and other institutions and organisations engaged in rural sanitation in India. The recommendations of the National Seminar organised in September, 1992 to elicit the views of opinion leaders in the sector (representatives of federating State Governments, NGOs, etc.) were grouped under four broad areas of sociological aspects; appropriate technology and research development, institutional and intersectoral linkages; human resource development, community participation and role of women. Motivating women through reputed NGOs, integration of sanitation with other related national and State programmes, subsidy to poor, conversion of dry latrines; appropriate cost effective technology using local materials to suit local practices, initiation of large number of problem oriented research; involvement of both Governmental and non-Governmental organisations in implementation; training sufficient number of village level masons, and other functionaries at the village level, sanitation education through schools and ensuring sanitary facilities in all girl schools and creation of a cadre of women motivations were major recommendations. These recommendations were basis for the new policy.

Though resources are limited Government is committed to finance this programme to meet the demand generated. The major financial commitment is to give 80% of the cost limited to Rs.2,000/- per unit as subsidy to all the poor beneficiary households. This is indeed a big commitment, judging from the fact that there are nearly 41 million poor families (income below Rs.11,000/- per year) yet to be provided with individual sanitary latrines. The magnitude of the resources required may raise doubts about the validity of such a policy. First is the question of resource availability with the

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governments (Centre & State). Even if cost of a properly constructed two-pit pour flush latrine with permanent superstructure is taken as Rs.2,500/- the 80% subsidy for all poor households would require Rs.82,000 million which it is argued that Governments may find it difficult to mobilise from their resources within few years for this sector. Governments have already invested more than Rs.1,00,000 million in reaching safe water to all its 5,83,000 villages. Sanitation being complementary and essential for individual and societal health, governments cannot leave the sector specially the more vulnerable the poor households now to individual or societal initiative which will take a long time to develop. Governments have to continue these programme till awareness is fully created , demand is generated for all sections and the condition of the poor are better.

Parallel to this is the argument that sanitation has a low priority among the poorer households and therefore for the programme to pick up and spread, the initial target should be the rich and literate who are already aware of the benefits of sanitation. It is pleaded that at least a differential subsidy as existed earlier should be reintroduced. However, it is a fact that even when differential subsidy was in vogue as from 1986 to 92 the progress was not very substantial. The spread effect from the rich to the poor was also not much. On the other hand there are a number of instances where poorer groups have accepted the sanitary latrines fully, when these were given to them.

There is yet another argument based on Midnapur experiment that subsidy is unworkable and need not be part of the programme. According to this argument, what is required is popularisation of the programme and making available facilities like trained masons, materials and technical advice made available to the villages through 'Sanitary Marts'. They argue that the scarce resources should be utilised in creating infrastructure and awareness and people should be provided with technological options depending on their capacity to pay. Thus these argument need careful consideration. The programme was introduced on an experimental measure in the most populated district of Midnapur in West Bengal and was implemented along with the campaign for total literacy. It was taken by a very dedicated and well organised NGO with total Government and political support. In spite of all these favourable factors it took nearly four years for the programme to catch the imaginations of the people. Analysis of the acceptance shows that poorer sectors have opted mostly for a slab and pan trap set directly over a single pit costing Rs.300/- per piece while richer families have opted for regular two pit offset type pour flush latrines. The poor who acquire the pan & trap and the slab by persuasion generally don't have the wherewithal to put up a superstructure. They

manage with available material at hand like old gunny bags, clothes, leaves and palm thatch/grass which are unsatisfactory to give the privacy required for women during day time and would serve as another exhibit as to how poor the family is. A good latrine enhances the prestige of the poor family and governments can use this opportunity of the new formed enthusiasm in giving the poorer household a little more confidence by helping them to build one as the richer people do. By limiting the subsidy to the poorer among the poor the government can utilise the scarce resources to support the very needy. Given the socio-economic differences in the villages, the acquisition of good latrines by the poor will motivate their richer neighbours to go in for such facilities for themselves. Establishment of sanitary marts or other delivery system would meet these demands.

Lack of demand among the poor is again an argument not substantiated by any research or other evidence. Lack of demand is a general phenomenon and the programme should take into account the diversity and differences in societal structure accessibility to media, accepted practices and the availability of infrastructure in designing the programme for awareness creation. Use of media, greater involvement of NGOs at the grass root level, cluster approach to have spread effect, alternate delivery mechanisms including sanitary marts etc. built into the new policy reflect the flexibility required in such an approach.

Government of India have also appointed two Expert Committees, one on improving the quality of implementation through the involvement of NGOs and the other on technological options. The first committee will finalise its report soon. These recommendations are expected to help in strengthening the weak administrative set up now available at the Centre, promote voluntary organisations to help in identifying the magnitude of the problem in different parts of the country and to suggest mechanisms in involving various agencies and international groups in promoting sanitation. The Expert Committee on technological options is expected to examine the acceptance of various technologies and their variations for excreta disposal and other sanitation measures and work out the specifications using local material and the costs for such options.

Judging from the responses from various States, there is a clear indication that political will is slowly emerging in implementing sanitation programmes. Many states have substantially increased their outlays in sanitation. The outlay for the central sector

FINANCIAL PROGRESS

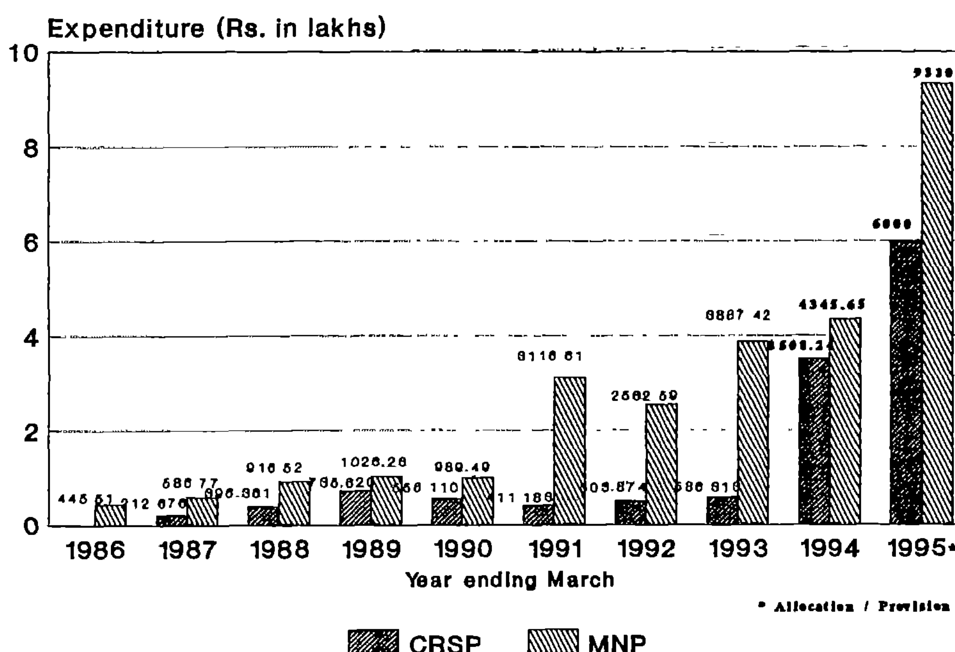

Fig. I

itself is likely to grow six-fold during the first three years of implementing the new policy (Fig. I).

The voluntary sector is also taking more interest in this sector now. The organisations who are already established in the sector are expanding their coverage in the sector. The assistance to voluntary organisations for rural sanitation through Council for Advancement of Peoples' Participation and Rural Technology, (CAPART) a nodal organisation set up by government of India to assist voluntary organisations have increased their outlay substantially in the sector.

ASSISTANCE BY CAPART TO VOLUNTARY ORGANISATIONS

(Year wise expenditure)

1986-87	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95 Aug..94	Total
28.686	38.731	321.535	257.784	161.703	260.070	451.000	953.000	316.00	2788.509

Population Coverage

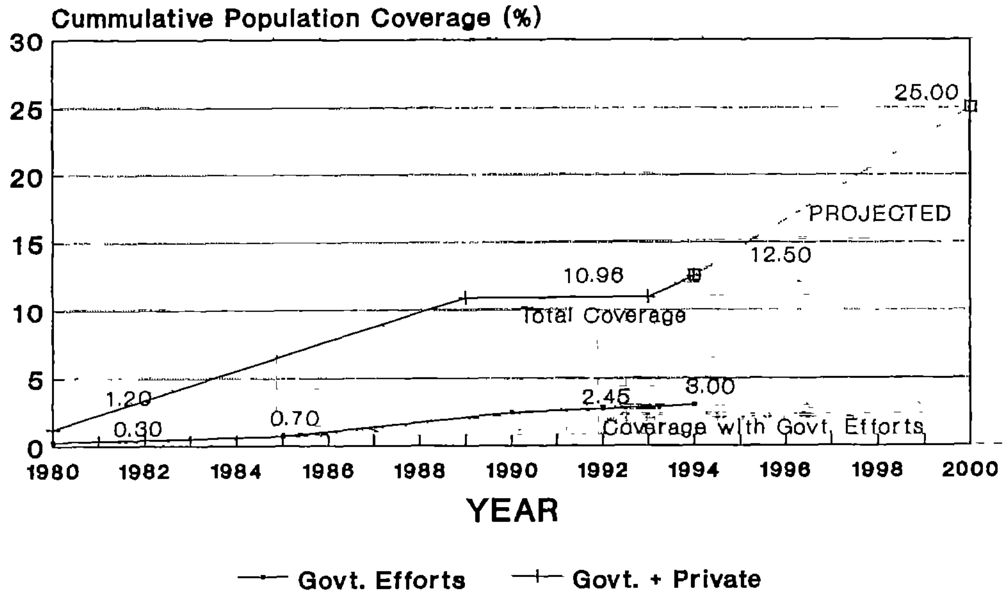

Fig. II

Recently most of the international organisations and bilateral agencies have taken initiative in combining sanitation with water supply in formulating new projects in the sector. The two projects in Maharashtra and Karnataka under implementation with the World Bank assistance have strong components of sanitation along with awareness creation involving NGOs. Other projects supported by bilateral agencies like those funded by Netherland, British and German Governments have also similar components.

The implementation of sanitation programmes is expected to receive a further fillip with the strengthening of Panchayati Raj system by transferring more powers to the village and district level administration through the latest amendment in the Constitution. The Rajiv Gandhi National Drinking Water Mission has initiated new experiments in empowering the local people in planning, preparing and implementing the rural development programmes with emphasis on water supply and sanitation. This is also proving to be effective.

Given these favourable environment, Rural Sanitation is likely to witness a sharp expansion in the coming few years. The projected coverage of rural households 2000 A.D. is 25% (Fig. II).

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SANITATION AND LATRINE PRODUCERS, BANGLADESH

by
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(for 2nd meeting of the collaborative council working group on promotion of sanitation, Thun, Switzerland, 2-5 October 1994)

BACKGROUND

Bangladesh has achieved a remarkable success in the provision of safe water supply. Almost everyone (96%) in the rural area drinks tubewell water. Yet, polluted water, insanitary environment and unhygienic habits continue to spread communicable diseases. Over the years, diarrhoeal diseases incidence and mortality remain high. More than 700 children under the age of five die of diarrhoea every day.

Village sanitation project assisted by WHO/UNICEF began in 1962. Low cost single pit waterseal latrine was introduced to the communities. Latrine slabs with waterseal pan were distributed free. Over 70% of those free latrines were not used.

Government's village sanitation programme supported by UNICEF started in 1975. Latrine parts were sold at a heavily subsidised cost. A high proportion(60%) were in used.

For wider promotion of sanitation, in 1978, the Department of Public Health (DPHE) assisted by UNICEF began to establish production centres at Thana Headquarters selling waterseal latrine parts at a subsidised price. By Mid 1985, all 460 Thanas in the country have a production centre known as Village Sanitation Centre (VSC). In order to have the production points closer to the communities, DPHE expended the VSCs to 540 selected Unions. By 1990, there are total 1000 VSCs in the country. However, for various reasons, the sale in some VSCs is low and a large stock of latrine parts are piling up. DHPE decided to gradually close these VSCs in phases. Some 100 VSCs have been closed in 1993.

Despite of the subsidised cost for the sanitary latrine parts sold in the VSCs (TK 300 (US$ 8) for a set of one slab with waterseal pan and 5 rings; and TK 120 (US$ 3) for a set of one slab with waterseal pan and one ring), the majority(80%) of the rural households still can not afford the cost. Hence, do-it-yourself home made sanitary latrine with a pit in the ground and covered with wooden and bamboo platform was introduced in 1987. This technology is accepted by the communities. Family spent about TK 100 (US$ 2.4) or less for a completed home made sanitary latrine using materials available in the homes.

The introduction of home made sanitary latrines coupling with continuous efforts of promotion have created the need for sanitary

latrines. This can be seen in the progress of sanitation coverage in rural Bangladesh. (Fig. 1) Within a period of 3 years (1990-1993) the coverage increased from 16% to 33%. Of the sanitary latrines 60% are homemade type and 40% waterseal.

Still, about 78 million people (65% of the population) defecate either in the open or use unhygienic latrines (hanging latrines). As a consequence, approximately 25,000 metric tons of fresh human excreta deposit on the public lands and waterways every day. The spread of water-born and filth-born diseases continuously threaten the communities.

The Government realised the need to link water, sanitation and hygiene for better health. In 1987, DPHE adopted an "Integrated Approach" to promote safe water, improved sanitation and good personal hygiene with the support from UNICEF. It is planned by 1995 that all 460 Thanas in the country will have adopted the Integrated Approach.

To strengthen the promotion of sanitation and hygiene, in February 1992, the Prime Minister inaugurated a national conference on Social Mobilisation for Sanitation and Hygiene. This added a new dimension to the social mobilisation initiatives taken up by DPHE and other allies in the country.

For further intensify the social mobilisation to create awareness on the need of a sustainable clean environment, improved sanitation and better personal hygiene, a three years (1993-1995) social mobilisation programmme for rural water supply, sanitation and hygiene is being implemented by DPHE with funds from the Switzerland Development Committee (SDC) and DANIDA through UNICEF. This project also aims to build up the capacities of the DPHE on social mobilization to complement their technical inputs,

In the past few years, through the involvement of change agents and the concert efforts of allies including District/Thana administration, DPHE personnel, schools and NGOs, high coverage on sanitary latrines (over 70%) and significant change of hygienic habits of washing hands with soap after defecation have been achieved within a short period (one year to 18 months) in several project areas. These successful experiences can be replicated countrywide through proper programming, planning, management and monitoring.

MEETING THE DEMAND

Over the years, the demand of sanitary latrines has simulated the growth of latrine producers. A national survey on Latrine Producers and Market Situation was conducted in early 1994. The objective is to establish a sound data base to assess the current status and the role of latrine producers and to formulate an effective strategy for extensive sanitation coverage in rural and peri-urban areas of Bangladesh. This paper presents some of the

key findings in the draft report.

Today, there are a total of 4152 latrine producers in the country compared to 119 in the 70's. (Fig-3) A growth rate of almost 35 folds in the past two decades. It is interested to observe that there are 122 potters who produce traditional burnt claywares such as pipes, rings, pans, jars/pots and toys etc. are now also latrine producers. The burnt clay rings generally used as lining for hand dug wells are also used as lining for latrine pits.

All these producers are located in 1150 of the 4400 Unions in the country. There is a need to promote the establishment of producers in those unserved Unions. Currently about 2699 (65%) latrine producers mainly private and NGOs locate in the rural while 1453(35%) are in the urban. A decade ago, the situation was much different where 437(48%) latrine producers were in the rural and 468(52%) in the urban. For private producers alone, there are now 1786 serving the rural areas while 151 supply the latrine parts to the urban and 727 are serving both rural and urban areas. This reflects the increasing demand of sanitary latrines particularly in the rural areas. These producers have a total annual production capacity of more than 2,000,000 slabs with pan and matching numbers of rings.

About 88% of the private producers are self-financing and 6% obtained bank loan or credit. Almost 20% and 30% of the private producers invested a total capital up to US$ 500 and US$ 1250 respectively.

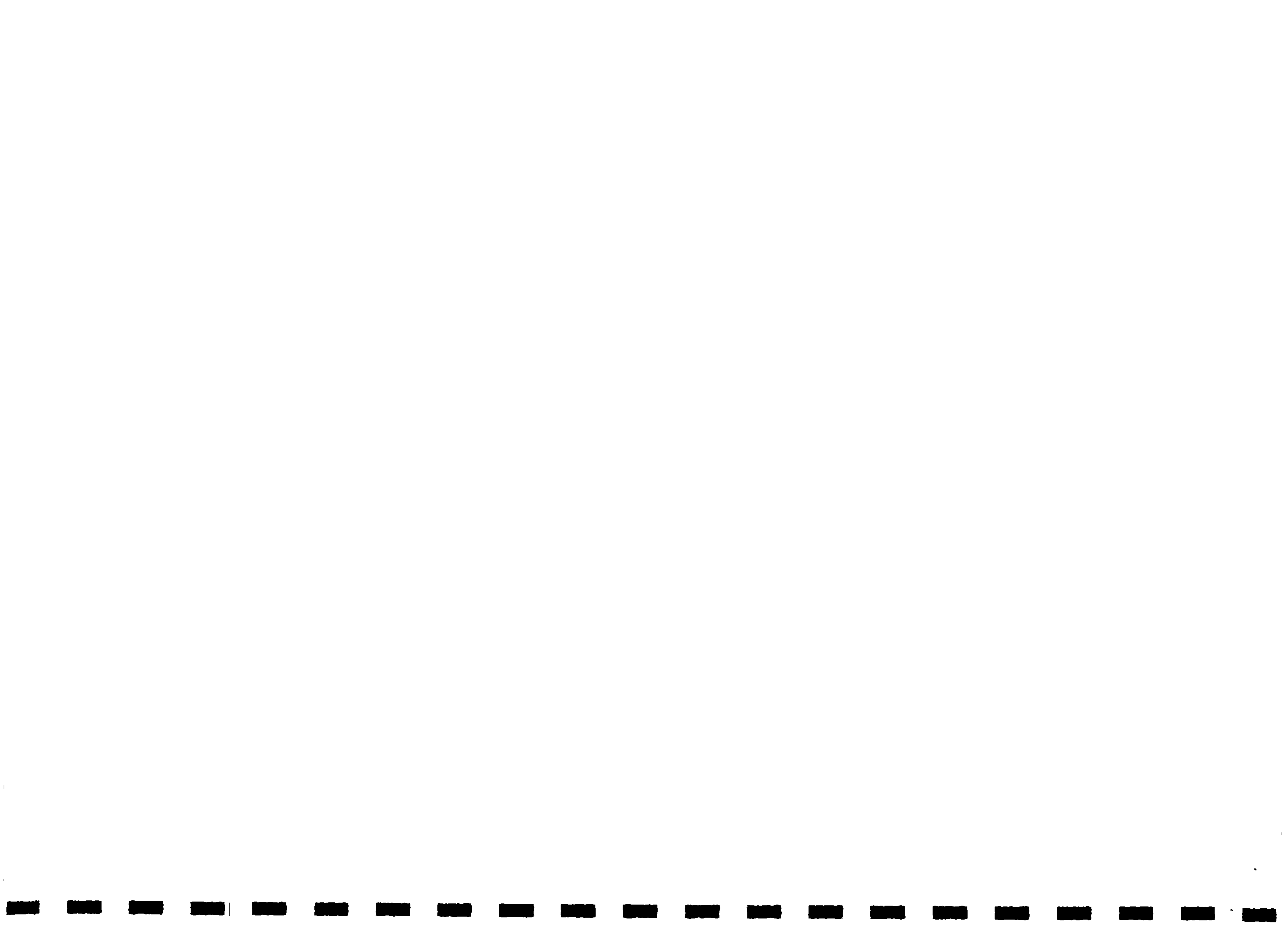
More than 50% of the private producers set up their own business with no technical assistance from any source. Over 80% of the producers manufacture and sell the latrine parts as their primary business, while the remaining produce concrete materials such as pipes, pots and ventilators as the principal products.

It was observed that quality of the products from DPHE VSCs is of the best quality, followed by those of NGOs and the private producers

PEOPLE'S CHOICE AND KNOWLEDGE

The study also covered a survey of random selected households to collect certain information which would reflect the people's practices and attitude. It reveals that families prefer to build latrines during the dry season as the producers reported that the sale of latrine parts starts picking up from November and reaches the peak during January/February and continues to March.

About 60% of the user families interviewed indicated that their latrine pits are lined. All households surveyed regardless whether



they have sanitary latrines or not are aware of the fact that using sanitary latrines would have clean environment, better hygiene and health.

For those households surveyed whom currently do not have latrine would also like to build sanitary latrine, but can not afford the cost. They, however, are willing to pay up to TK 200 (US$ 5) for a sanitary latrine. Most of these families are not aware of the homemade type sanitary latrine and the subsidised cost of latrine parts at the DPHE's VSCs. This suggests the need of wider promotion of the homemade type and creating greater publicity for DPHE's VSCs.

THE CHALLENGE

Improved sanitation is the combination of mind and technology. When people are ready to change their sanitation practices, affordable latrine technology options should be readily available to reinforce their behaviour changes for sustainability. The National Survey reveals the important role played by the latrine producers particularly the private sector and NGOs to meet the demand of the public. This is evident by the substantial increment of 1696 private and NGO producers within 3 year from 1990-1993. The intensive promotional activities in the recent years strengthened by the readily available latrine parts in both urban and rural areas could be the key factors of the doubling sanitation coverage from 16% to 33% (1990 to 1993). Currently, the average national sanitation coverage of rural and urban areas is 35%.

Bangladesh had already reached the Mid-Decade goal set by the Government, which is 35%. The task ahead is total mobilization for achieving the universal coverage by year 2000.

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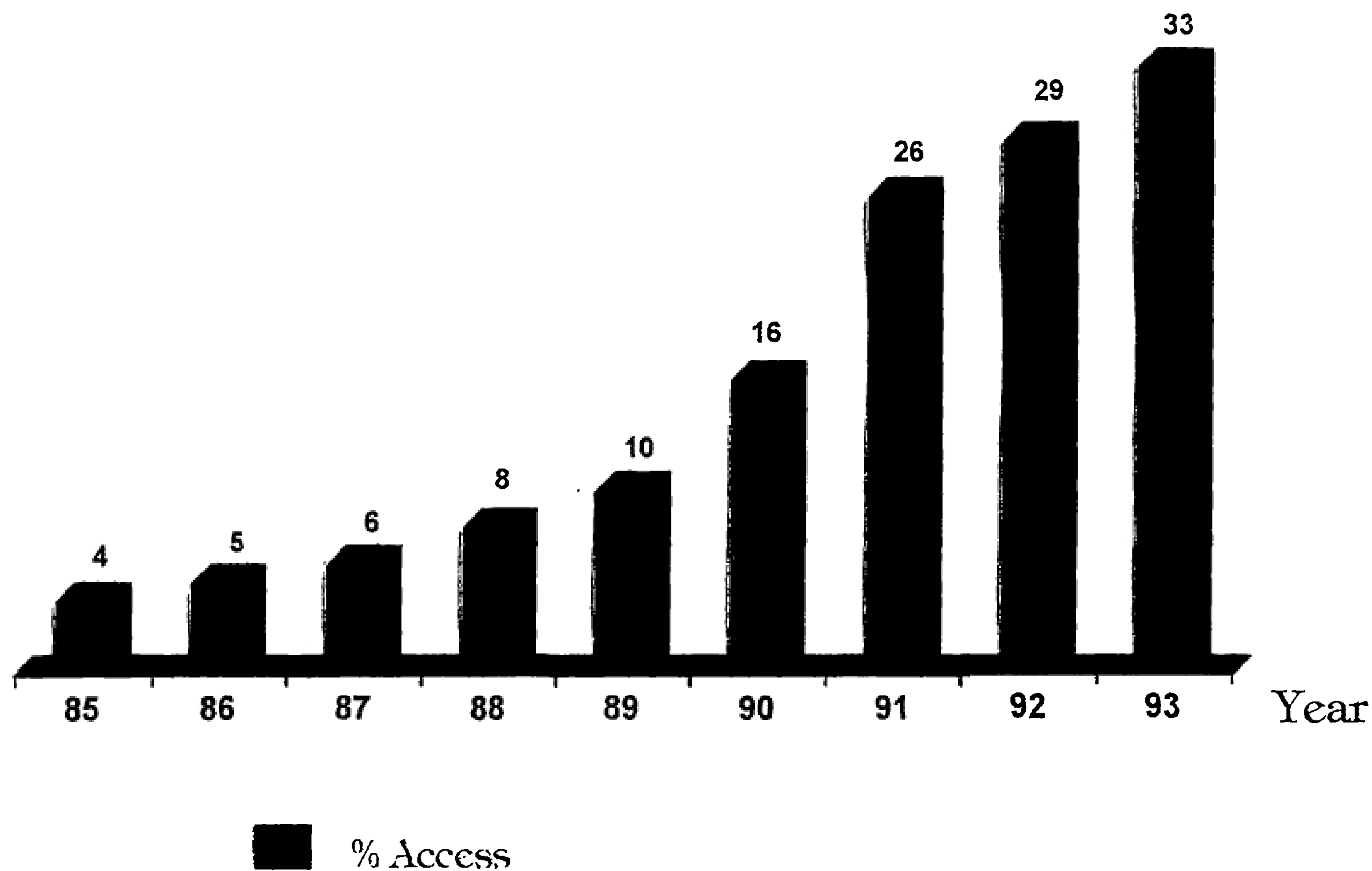
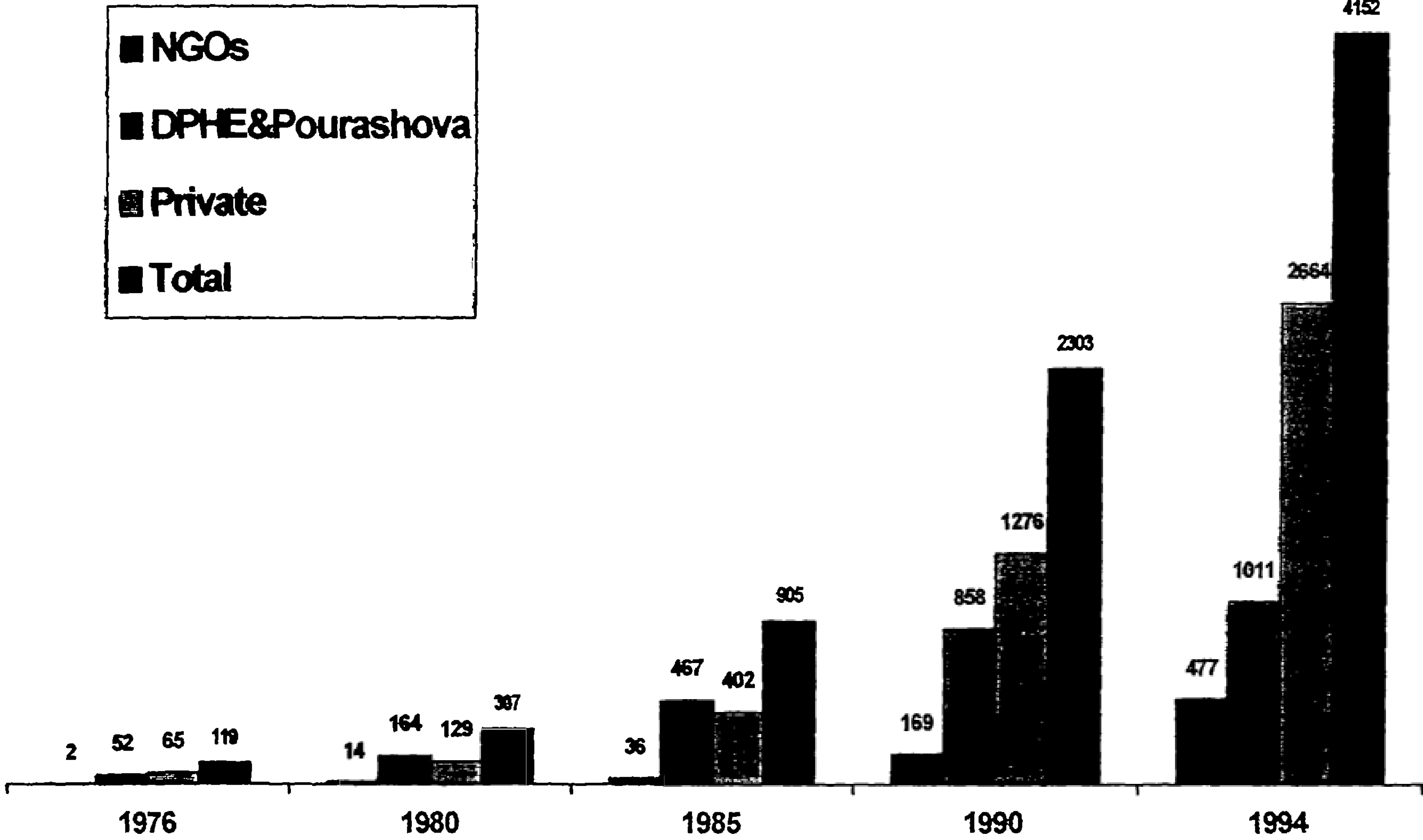


Growth of Latrine Producers



RURAL SANITARY MARTS

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August, 1994

RURAL SANITARY MARTS

WHY RURAL SANITARY MARTS (RSMs) ?

Universal access to sanitation by the year 2000 is among the goals set at the World Summit for Children. The National Sample Survey (1988-89), however, puts the total sanitation coverage in terms of household latrine at only 11% in rural India. Of this, only 3% is through the government programme and the remaining 8% through the households' own efforts. This indicates that there is a tremendous potential to promote sanitation through private initiatives in rural areas. The same is also true in an urban setting where still over 1/3rd of the households have no access to a latrine.

As of 1990, around 100 million households in rural India did not have any access to a latrine. Another 14 million had this problem in urban areas. Providing these people with latrines will call for an expenditure of over Rs.20,000 crores. It is impossible to get this magnitude of investment through government sources. Promoting sanitary facilities through private initiative seems to be a plausible solution to reach the goal of universal access.

The subsidy - linked government sanitation programme which is confined to selected areas in a state, leaves a large chunk of the population out of its purview. In most villages, there are always some households who are willing to have their own latrines and other sanitary facilities without waiting for government subsidy. What they need is the know how and easy availability of construction materials at a reasonable price and within close proximity. This calls for developing an alternate to the existing subsidy linked system for promoting sanitation. Establishment of Rural Sanitary Mart is one of the options in this regard.

The Central Rural Sanitation Programme (CRSP) guidelines now considers sanitation as a package of facilities meant to bring about a behavioral change among the people. The concept of sanitation as a package can be well demonstrated through the RSM which provides all the materials and services needed for construction of latrines, soakage pits and other facilities under the package. Over a period of time, the RSM can be a nodal point for dissemination of knowledge on sanitation and other health related issues.

In areas where community-based handpump maintenance is introduced, the RSM could be used to stock essential handpump parts to facilitate a better programme delivery. It can also keep a list of local handpump mechanics with their addresses. Similarly, RSMs can keep ORS packets and serve as an information dissemination centre on prevention and management of diarrhoea.

The RSM can also meet the needs of the peri-urban areas as they are likely to be located in a market town.

Establishment of RSM is a step towards commercializing the provision of sanitary facilities to meet the special requirements of rural and peri-urban areas. It will also facilitate private initiative for accelerating sanitation coverage.

WHAT IS A RURAL SANITARY MART

The RSM is an outlet dealing with the materials required for the construction of not only sanitary latrines and other sanitary facilities in rural and peri-urban areas but also those items which are required as a part of the sanitation package. It is a commercial enterprise with a social objective.

Besides being a sales outlet, the RSM also serves as a counselling center for those interested to have not only latrines but also other sanitary facilities. Thus, it makes available the designs for various low cost sanitation facilities, showing the estimated costs and a list of trained masons with their addresses in the area so that a household can approach them when required. In this way the RSM is a service center too.

In short, the RSM can be considered as a one stop shop to meet all the requirements of the community pertaining to sanitation.

WHAT SELLS AT THE RSM

The main aim of having a sanitary mart is to provide materials and guidance needed for constructing different types of latrines, technologically and financially suitable to the area, and other sanitary facilities like cattle trough, fuel efficient chulah etc. The RSM should,therefore, be something exclusive and different from other outlets existing in the area.

The RSM is expected to sell the following categories of materials -

Category I - This includes materials for the **construction of latrines of different types and other sanitary facilities such as** pans,traps and footrests of different types, pit covers, pipes, doors, window frames etc. and even other construction materials like cement, sand, chips and bricks.

The RSM can keep handpumps of different types and, in areas where the community-based handpump maintenance system has been set up, it can also sell the fast moving spare parts like washers. Keeping ORS packets (with WHO formula) should also be encouraged.

Category II - This includes items **relating to home sanitation** - food safe, ladle, long necked surai, water filters, materials for cleaning the latrines like brush, broomstick etc. and phenyl for cleaning house and drain.

Category III - This includes items **relating to personal hygiene** like popular soaps, nail cutters, footwear etc.

An illustrative list of items recommended for an RSM can be seen from the Annexure.

While keeping the stock of materials it must be kept in mind that the number of latrines constructed through the RSM is a generic indicator of its effectiveness in accelerating

sanitation coverage in the area. This primary objective must be remembered while determining the product mix to be stocked at the RSM.

WHERE TO SET UP THE RSM

Since the RSM is a commercial outlet with a social objective, economic viability should not be ignored.

The location of the RSM should be such that the venture is economically workable and eventually supports itself.

The RSM should always be located in a market town with a relatively rich hinterland expressed in terms of high irrigation/cropping intensity and a large marketable surplus of agricultural produce so that the people frequenting the area can afford to buy sanitation facilities, given the delivery system. The need for latrines is also greater in these areas as less land is available for open defecation. Certain other factors like high population density and higher literacy levels among the people strengthen the choice of a particular market town for establishing the RSM.

If the market town has other facilities like a Tahsil Office, Block office, PHC, sub-registrar's office, bus/railway junction etc. it is better.

WHO SHOULD RUN THE RSM

The success of the RSM is very much dependent on selecting the right type of agency to run it. The agency should have adequate experience in manufacturing and/or trading products for the rural market. Dealing in some of the items listed for RSM will be an advantage.

The cooperative marketing outlets, the Agro-service centers, outlets of the Khadi and Village industries, Rural Industries Projects etc are examples of the agencies in Government/Social Sectors. Well established and interested non-governmental organizations (NGOs) can also be involved in undertaking the task of setting up the RSM. Selected DWCRA groups could also be considered for this purpose.

HOW TO RAISE FINANCE FOR THE RSM

The financial requirements to run the RSM are of two types :

i. To meet the one time non-recurring costs (this includes cost of making shelves, sales counter and other arrangements to keep stock at the RSM as well as the cost incurred in making the sign board and other displays).

ii. To meet the working capital requirements which is of recurring nature. This includes the funds required for purchasing various items to be stocked in the RSM, sales promotion cost, rent and electricity, salary paid to the manager/sales person etc.

It is important to correctly estimate and properly manage the working capital of the RSM. The efforts should be to sell the stock of materials as quickly as possible so as to optimize the return on the capital invested.

An RSM like any other commercial outlet should raise funds either from the agency's own resources or through a bank loan. In addition, assistance from UNICEF and the Government of India could also be sought.

RSM COULD BE A PRODUCTION CENTER TOO

An RSM could either manufacture some of the items it proposes to sell and/or can have a link with other production centers in the area for supply of required materials. In areas where a few RSMs are already functional it would help them to have a network, where each RSM could produce a few items to be sold through others. This will facilitate economy of scale in production and enhance economic viability of the RSMs in addition to effective utilization of local materials and employment generation. RSMs interested in production will require additional financial support for meeting their fixed capital and working capital requirements. Besides bank loan, assistance from UNICEF and Govt of India could be sought. Also, in areas where the entry point to promoting alternate delivery system is through the creation of a revolving Fund, establishment of RSM would facilitate more effective use of this Fund. The three possible scenarios of linking RSM with other alternate delivery systems can be seen from the Annex-II.

ANNEXURE-I

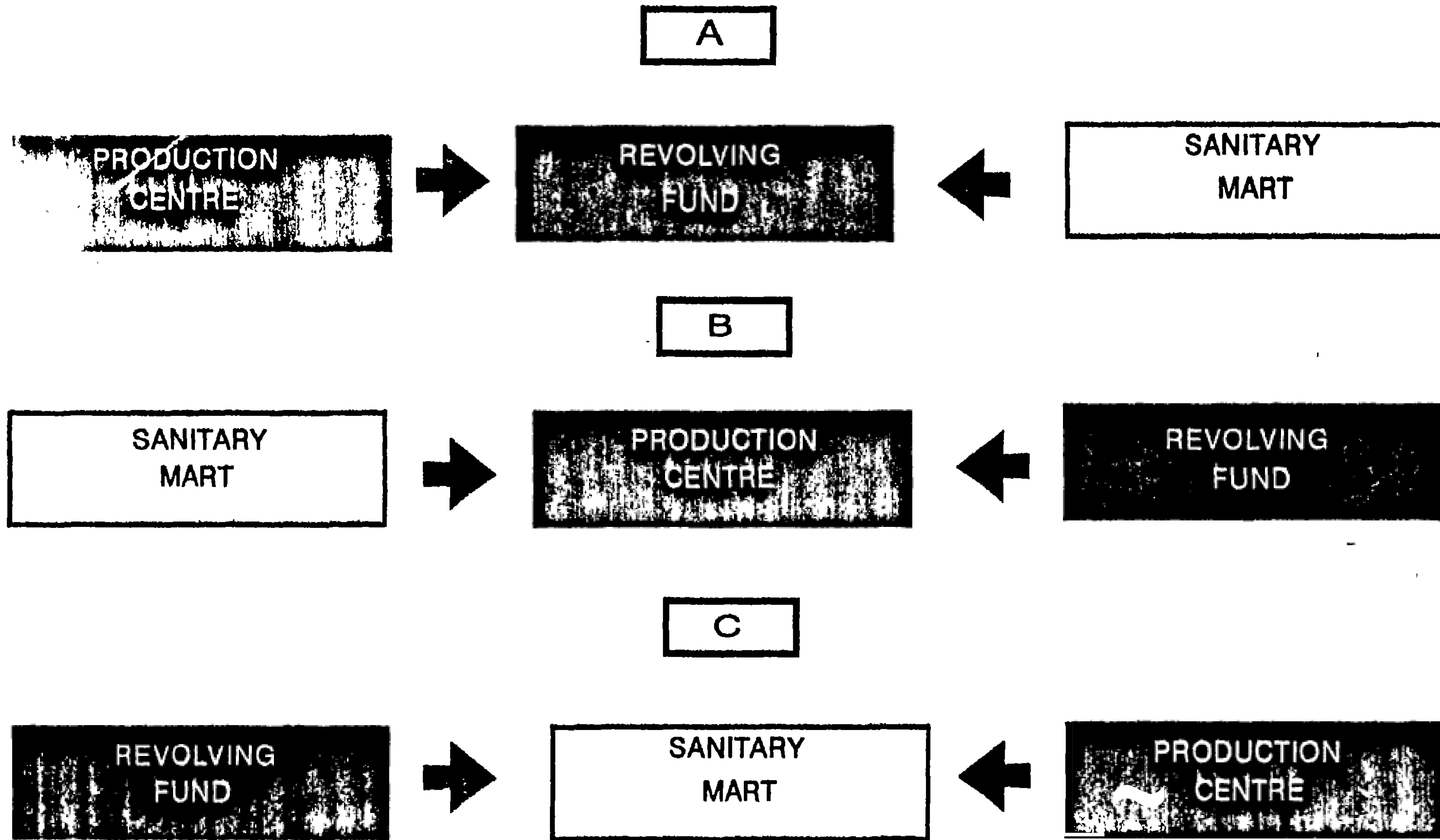
A SUGGESTIVE LIST OF ITEMS TO BE KEPT IN A TYPICAL RSM

1. PAN AND TRAP (FIBRE GLASS)
2. PAN AND TRAP (CERAMIC)
3. PAN AND TRAP (MOSAIC/CEMENT)
4. PRE-FABRICATED RCC/FC SQUATTING PLATE WITH BUILT-IN WATER SEAL PAN/TRAP AND FOOT REST (FOR DIRECT PIT WATERSEAL LATRINE)
5. 75 MM DIA PIPES (CEMENT, PVC, HDPE)
6. PIT COVER (BOTH CIRCULAR & RECTANGULAR)
7. DOOR FOR LATRINE (USING LOCALLY AVAILABLE MATERIAL)
8. CEMENT
9. BRICK
10. SAND
11. IRON RODS
12. BRICK/STONE CHIPS
13. GI PIPES FOR WATER CONNECTION/TAP
14. SHOVEL
15. CROWBAR
16. MATERIALS FOR DOOR FITTING (DOOR HANDLE, HINGES, BOLTS, FASTENERS ETC.)
17. WIRE MESH (DIFFERENT SIZES)
18. ROOFING MATERIALS
19. HAND TROLLEY
20. DUSTBIN
21. SURAI (LONG NECK WATER POT)/LADLE
22. CATTLE TROUGH
23. FOOD SAFE (WOOD, STEEL, ALUMINUM ETC)
24. FOOTWEAR (AS PER LOCAL DEMAND)
25. POPULAR SOAP (FOR BATHING & HAND WASHING)
26. TOOTH POWDER/TOOTH PASTE/TOOTH BRUSH (BRAND AS PER LOCAL DEMAND)
27. NAIL CUTTER
28. ALUM/CHLORINE TABLETS
29. BRUSH FOR CLEANING TOILET (DIFF TYPES)
30. BLEACHING POWDER/PHENYL
31. FUEL EFFICIENT CHULHA
32. WATER FILTER OF DIFFERENT MATERIALS (EARTHEN, PLASTIC, STAINLESS STEEL ETC)
33. SCRUBBER/SWAB (CLOTH FOR WET-CLEANING OF FLOOR)
34. WATER TAP
35. COMB
36. BROOM STICK
37. MUGS (DIFFERENT TYPES)
38. BUCKET (DIFFERENT TYPES)
39. BABY TOILETS
40. HANDPUMPS (DIFFERENT TYPES)
41. HANDPUMP SPARES (FAST MOVING ONLY)

42. ORS PACKETS (WHO FORMULA)
43. DELIVERY KIT
44. MATERIALS FOR MAKING SMOKELESS CHULHA
45. MOSQUITO NET (FOR ADULTS & FOR CHILDREN)
46. MOSQUITO REPELLENT

am/rsm
30/8/94)

ALT DELV SYSTEM TO ACCELERATE SANITATION COVERAGE



THE CDD-WATSAN STRATEGY

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*THE CDD-WATSAN STRATEGY**

BACKGROUND

Diarrhoea continues to be a major killer of children below 5 years and is also one of the main causes of their illness. It is estimated that around one million children in India die of dehydration due to diarrhoeal attack. Diarrhoea cases account for as much as 40% of paediatric beds and one third or more of paediatric out-patient visits in peak seasons of the year. On an average, a child is found to suffer three attacks per year before the age of five and there are approximately three hundred million episodes of diarrhoea in India in a year. The close association between diarrhoea and malnutrition is only too well known.

In the past, adequate attention had not been paid to the preventive aspects of diarrhoeal disease. Provision of safe drinking water and sanitation facilities was seen more as a social welfare measure, to be included under the Minimum Needs Programme (MNP), than as a part of the overall primary health care. This is, in spite of the fact that more than three-fourths of diseases (which include diarrhoea) are water and sanitation related. According to a recent KAP survey in the country, while majority of the people believed that contaminated drinking water caused health problems, they were unaware or not clear as to how it happened. Only less than one-fifth were aware of the links between contaminated water and diarrhoeal disease. Around 40% did not know/believe that exposed excreta could harm health. Out door defecation was not generally seen as a problem except in terms of inconvenience during rain/night/winter and privacy for women. Similarly, although oral rehydration therapy (ORT) has been identified as an important component of diarrhoea case management, it continues to get a low priority in the treatment from practitioners as well as mothers. A recent nation wide study of mothers and practitioners reveals that the first response to diarrhoea by 80% of the doctors was to give medicine or an injection. Only 11% prescribed ORS (Oral Rehydration Salts) as the first response while 3% recommended SSS (Sugar Salt Solution). Similarly, ORS was not widely known to rural mothers. In spite of the fact that over a quarter of mothers had used ORS at sometime before the recent episode, only 6% had used it in the last episode. The same study also shows that mothers consider diarrhoea a common, non serious health problem that occurs frequently enough to be deemed almost inevitable and hence have a very casual approach.

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* CDD stands for Control of diarrhoeal diseases and WATSAN for Water and Sanitation

THE CDD-WATSAN STRATEGY

The need for an integrated CDD-WATSAN strategy emerges from the inherent association between the two. Thus, diarrhoea which has a direct link with water and sanitation should not be looked at as merely a medical problem. A reduction in the diarrhoeal incidence can be a generic indicator of an improved water supply situation and better personal hygiene.

The recently announced Government of India Policy on Management of Diarrhoeal Disease amongst children under five through promotion of ORT has called for undertaking preventive measures in terms of providing safe drinking water and promoting improved sanitation and better personal hygienic practices together with correct case management for reducing diarrhoeal morbidity and mortality.

GOALS

The CDD-WATSAN Strategy has the following goals :

i) Reduce the incidence of diarrhoeal cases among children under five years by 25% over a three to four year period.

ii) Provide universal access to safe drinking water and improved sanitation coverage during the same period.

OBJECTIVES

In order to achieve these goals, three broad objectives have been envisaged. These are :

IMPROVING ACCESS TO SERVICES

These will create conditions for adoption of various practices:

i) To ensure availability of 40 litres per capita per day of clean water to all households.

ii) To install one source of drinking water per 150 persons within a distance of half a kilometer.

iii) To have at least one handpump mechanic, preferably female, trained by PHED for a cluster of deepwell handpumps.

iv) To have one information source in every village/ urban slum for :

- low-cost sanitation information, advice, know-how and liaison with agencies for construction.
- proper case management of diarrhoeal diseases.

v) To have one sanitary mart in every block and every village in the block to be aware of its location.

vi) To have at least 10 trained masons per block for providing guidance to households constructing sanitation facilities.

vii) To have at least one source with ORS packet available 24 hours in every village/urban slum.

viii) To have ORT corners in every primary health centre, community health centre and hospital in the district.

ix) To have clean water and facilities for sanitary disposal of excreta in every school, anganwadi centre, hospital, community health centre, primary health centre and sub-centre.

x) To ensure universal coverage of all children under one with measles vaccine (along with other vaccines being given under the Immunization Programme).

PROMOTING KEY PRACTICES FOR PREVENTION OF DIARRHOEA

These will contribute to prevention of diarrhoeal morbidity :

i) To ensure use of safe water for drinking among families.

ii) To promote use of adequate quantity of water for personal and domestic hygiene.

iii) To promote hygienic way of handling and storage of drinking water and food.

iv) To promote safe disposal of excreta, especially that of infants and young children.

v) To promote hand washing with soap before eating, before breast feeding, feeding and cooking food, after defecation/ disposal of child's stool.

vi) To promote exclusive breast-feeding among infants up to 4-6 months of age.

vii) To improve infant feeding practices, especially breast-feeding and hygiene.

viii) To promote provision of additional food for children 6 months to 5 years for one week after illness.

ix) To promote use of sanitary latrines.

PROMOTING KEY PRACTICES FOR MANAGEMENT OF DIARRHOEA

These will contribute to prevention of mortality and lower future morbidity :

i) To promote timely administration of ORT using correctly prepared fluids in increased volume in children 0-5 years having diarrhoea.

ii) To promote ORT usage rate to 80% level.

iii) To promote continued feeding in adequate quantity with appropriate foods in children 0-5 years having diarrhoea.

iv) To promote seeking of timely and correct referral outside the home when the condition of child with diarrhoea deteriorates. This involves :

- recognition by mother/care giver of signs of dehydration.
- recognition by mother/caregiver of other danger signs (fever, blood, vomiting etc.)
- knowledge of where to seek correct referral.

COVERAGE

The CDD-WATSAN strategy covers 15 districts of India in as many states including the Union Territory of Delhi.

These districts are as follows :

Sr. No.	State	District
1.	Andhra Pradesh	Ananthapur
2.	Assam	Kamrup
3.	Bihar	Ranchi
4.	Delhi (UT)	Delhi
5.	Gujarat	Panchmahals
6.	Haryana	Ambala
7.	Karnataka	Mysore
8.	Kerala	Alappuzha
9.	Madhya Pradesh	Dhar
10.	Maharashtra	Nasik
11.	Orissa	Phulbani
12.	Rajasthan	Alwar
13.	Tamil Nadu	Periyar
14.	Uttar Pradesh	Allahabad
15.	West Bengal	Medinipur.

The strategy covers both rural and urban areas of these districts.

APPROACH

The CDD-WATSAN initiative is not a programme but a strategy and has the following approach to planning and implementation so as to achieve the desired goals and objectives.

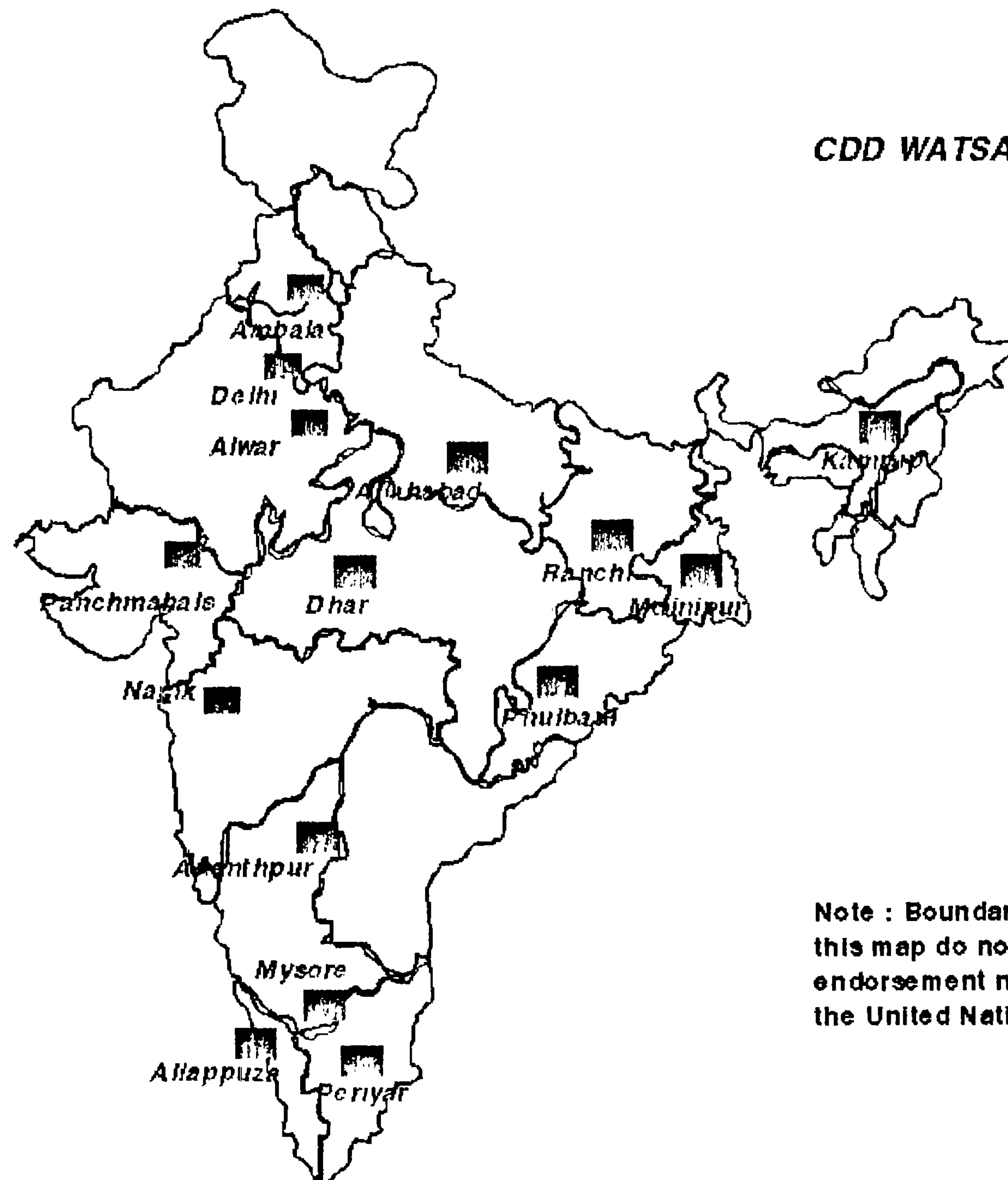
- The district is the unit of planning and implementation for the strategy. Initially, the interventions are being implemented within a limited geographic area of the district and will be gradually expanded. Both urban and rural areas of the district are being included.
- The existing infrastructure developed for the management of programmes like water, sanitation, health etc. are being used to implement this strategy.
- All the district resources, including those developed/supported by agencies, other than government sources, are being taken into account for planning and implementation of the strategy. The inputs in the district will be incremental, using available district resources with minimal additional outside resources (funds/personnel).
- The collaboration between water supply/sanitation and health sector is essential to achieve the primary objectives. Apart from this, the involvement of ICDS, Education, Nutrition and DWCRA is necessary for an integrated approach.
- Non government organizations are to be involved to create awareness, motivation and community participation. NGOs are also being encouraged to implement and manage micro projects on a turn-key basis.
- The strategy involves user participation in planning, implementation, monitoring and evaluating interventions in the project with a focus on women's empowerment.
- As a part of the planning for activities, the seven major WHO recommended interventions for reducing cases of diarrhoea are being given priority attention. These are:

- use of clean water.
- proper disposal of stools of young children.
- promotion of hand washing.
- use of latrines.
- promotion of breast feeding.
- improved weaning practices.
- measles immunization.

BASELINE SURVEY

Baseline survey has been completed in all the 15 districts to create a benchmark for studying the impact of the strategy at a future date.

CDD WATSAN DISTRICTS



Note : Boundaries and names on this map do not imply official endorsement nor acceptance by the United Nations.

UNICEF'S EXPERIENCE IN PROMOTING RURAL SANITATION IN INDIA

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UNICEF'S EXPERIENCE IN PROMOTING RURAL SANITATION IN INDIA

Overview :

The Rural Sanitation Programme (RSP) in India, has been a late starter. Unlike the Rural Water Supply Programme, which has its history spread over three decades, Government intervention in Rural Sanitation came almost 20 years later. It was only in 1986 that the Government of India (GOI) formulated the Central Rural Sanitation Programme (CRSP) and in 1987 Rural Sanitation came under the State Minimum Needs Programme (MNP). Thus, the RSP is virtually a seven year old child. Nevertheless, the programme seems to have gathered momentum in the recent past. Besides the efforts made by the Government, private initiative appears to be catching up in this sector. It is, therefore, not surprising that while the Government reported a 3 % sanitation coverage through its own programme (in terms of households having access to latrines), results of the National Sample Survey, now available, indicated that around 11 % households had access to latrines in 1989. This 8 % difference is attributed to households going for latrines on their own without any government subsidy. The present coverage is estimated at 14 %. Results of a baseline survey carried out recently indicate that in 49 % of the villages in India at least some households had access to a latrine. As regards adoption of improved sanitary practices, while more than 90 % of households covered their drinking water, over 60 % washed their hands before meals. More than one third of the households reported washing hands with soap or ash after defecation.

Advocacy :

UNICEF has been playing a catalytic role in promoting rural sanitation through advocacy and supporting innovative interventions which could be replicated. These efforts, to a large extent, could influence policy changes at national and state levels creating a much more favorable climate for accelerating sanitation coverage both in terms of physical facilities and also behavioral change. There has been a perceptible shift in the policy in several areas as described below :

From Hardware to software :

Sanitation is no more identified with latrines alone. The Eighth Five Year Plan (1992-97) and the CRSP Guidelines now consider sanitation as a package of interventions consisting of both hardware and software. A mandatory 10 % of the CRSP allocation has now been earmarked for IEC. The seven components of sanitation which are now being advocated include, i) handling of drinking water, ii) disposal of waste water, iii) disposal of human excreta, iv) garbage disposal, v) home sanitation and food hygiene, vi) personal hygiene and vii) village sanitation (as a part of primary environmental care). UNICEF has produced two films viz, Why Sanitation and Components of Sanitation for advocacy, awareness creation and motivation to promote these concepts. In addition, all the IEC materials brought out by UNICEF in the past are undergoing a revision to reflect the sanitation package encompassing the seven themes.

From Single design to a range of technological options :

A more flexible approach has now been adopted in the choice of a design. The present thinking is to encourage a range of options to suit the different socio-economic status of the people and also the varying geo-hydrological considerations as successfully demonstrated in some area - based projects like the Medinipur intensive Rural Sanitation Project. As a follow up to the strategies envisaged under the CRSP for encouraging locally suitable and acceptable models of latrines, the Ministry of Rural Development (MRD), GOI has constituted a Technical Committee to examine the designs already available, their suitability to the varying prevailing conditions in the country and suggest a range of options for their adoption. UNICEF is a member of this committee. The report of this committee is expected to be ready before the end of this year. It will form an addendum to the CRSP guidelines and facilitate demand generation by bringing in the affordability and acceptability criteria for those in the not-so-well-off group.

From Full subsidy to low/no subsidy :

In the earlier years, 80 % of household latrines were expected to be given free to the Scheduled Caste/Scheduled Tribe (SC/ST) and those below the poverty level. There has been a significant change in this approach reflected in the CRSP guidelines issued by

the GOI from time to time. In the present strategy, no subsidy is envisaged for those above the poverty level (irrespective of the caste consideration) and even those below the poverty level have to contribute 20% of the total cost. This is a major step towards under playing the role of subsidy and making the programme more need-based.

From Single delivery system to alternate delivery system:

It has been realized that the subsidy linked sanitation programme is not adequate to improve the sanitation situation in the country to any significant level. Inspite of the fact that the Eighth Plan Outlay of Rs.6740 million is eleven times more than that of the expenditure on rural sanitation during the previous plan (1985-90), it may at best cover only 10 % of even the households below the poverty level at the present rate of subsidy. The impact of this increase is insignificant at the national level. Also the withdrawal of subsidy for those above the poverty level calls for creating a suitable channel to meet their specific requirements which the present market mechanism does not provide. The thrust is, therefore, to adopt alternate delivery systems with no visible subsidy. The concept of promoting sanitation through a revolving fund as adopted in Medinipur three years back has now been replicated not only in the entire West Bengal State but also in Assam, Karnataka and Delhi (rural). Establishment of Rural Sanitary Mart (RSM) which was initiated in Uttar Pradesh is now adopted in other States as an alternate delivery system. More than 100 RSMs have now been established in 7 states. Problems noticed at the initial stage are being sorted out and the activities of RSMs are closely monitored to make them an effective delivery system. The fact that some of them have not only reached the break-even point but have started making a profit even during the first year of their operation, indicate that the concept is replicable.

From Government managed to NGO managed :

There has been a growing feeling that the NGOs should be involved in a more extensive way for promoting sanitation. The Council for Advancement of People's Action and Rural Technology (CAPART), which is the apex

organization for supporting and coordinating the activities of NGOs in the field of rural development is planning to have a new strategy to involve the NGOs in a more effective way. At present CAPART supports around 7000 NGOs throughout the country. Over one thousand are currently engaged in the WATSAN sector.UNICEFis in touch with CAPART for motivating the other NGOs in this sector which has a vast scope. The Ministry of Rural Development, GOI in the meantime, has set up a National Committee to suggest ways and means of involving NGOs in promoting rural sanitation. UNICEF is a member of this Committee. In addition to the funds made available to CAPART (Rs.100 - 120 million per year), 10 % of the CRSP funds allocated to the states are expected to be channelized through NGOs. This will amount to over Rs. 600 million rupees during the present plan period. In a state like Gujarat, the entire sanitation programme is implemented through a network of NGOs. The successful implementation of RSP through Rama Krishna Mission (RKM) an NGO in West Bengal has made the state government to think of implementing rural sanitation through NGOs and village panchayats. The link between government and NGOs in promoting sanitation has become more pronounced now, than ever before.

From Single sector intervention to Multi-sector intervention:

The single sector approach in promoting sanitation has now given place to a multi-sector intervention involving not only water but also other sectors like Health & Nutrition, Education, Women & Child Development (ICDS & DWCRA) etc. There has been greater realization among the policy makers, planners, implementors and community in general, with regard to the inherent linkage between sanitation and health.

The CDD-WATSAN strategy (where CDD stands for control of diarrhoeal diseases and WATSAN for Water and Sanitation) which aims at bringing about an integrated approach to addressing diarrhoea prevention through water and sanitation interventions is an example of WATSAN-health linkage through a multi-sectoral approach. The strategy is now operational in 15 districts (see map). More requests have come from some state governments to extend the strategy to other districts thereby indicating the acceptance of the concept. A quick survey of some of the districts and discussion with functionaries (PHED,

Health, ICDS and Dist Administration) at various levels do indicate that the strategy seems to be paying dividends in reducing the diarrhoeal morbidity among the eople in general and the children in particular.

Involving the educational institutions in promoting sanitation has been another component of the multi-sector intervention. Several activities have been initiated in this regard. An approach paper along with detailed guidelines on school sanitation has been prepared and shared with the state governments. Training school teachers, motivating the children to adopt sanitary practices within the school and also in their homes, carrying the sanitation concept from school to the community as a part of the Primary Environmental Care are some of the thrust areas of the School Sanitation Programme. The response has been quite encouraging even during the first year. In some states, like Haryana prizes are awarded to schools at different levels by the Education Department to create a sense of competition among them in maintaining certain minimum standards of sanitation in the schools and among the children. In Periyar (Tamil Nadu) the initial success of the School Sanitation Programme has motivated the district administration to extend the intervention to all the schools of the district.

Functionaires of Integrated Child Development Services (ICDS) and Development of Women & Children in Rural Areas (DWCRA) along with the beneficiary families are actively involved in creating demand for sanitary facilities and also promoting domestic and personal hygiene. Specific communication materials have been developed for the Anganwadis (under ICDS) and preparation of similar materials for the DWCRA functionaires is underway. With 258,000 Anganwadi Centres (covering more than 3 million mothers and 16 million children) and about 80,000 DWCRA groups (with over 1.7 million women members), the outreach for involving women in rural sanitation is tremendous.

Skill transfer as a step towards women's empowerment :

It is now well recoganised that transfer of low-cost sanitation technology to the village level is a must for accelerating sanitation coverage. Towards this end attempts have been made to create a net work of trainers at block level so that every village panchayat should

have at least one trained mason on low-cost sanitation technology by 1995. In a few states like Andhra Pradesh and Karnataka, the government intends to have the skill available at every village. Another development, in this regard, is to give the local masons training on three "Ms" namely, Masonry, Motivation and Monitoring. This has called for training ofthe local masons on the construction of a range of sanitary facilities and use them asmotivators to create demand and also monitor usage of the sanitary facilities byhouseholds. It is also intended to empower women with the masonry skills which hitherto was the domain of men. A beginning was made in Rajasthan where **48 women masons** were imparted training on masonry. These women have now formed a cooperative society and havestarted taking contracts from the block administration in constructing latrines and othersanitary facilities. Similar reports have also been received from Madhya Pradesh and Uttar Pradesh.

Area-based Innovative Projects :

Considering the vastness of India and the variation in the socio-economic status of its people, it was felt that no single strategy could be applicable to the entire country. Beginning 1987, UNICEF in collaboration with the Govt. of India, therefore, initiated several area-based innovative projects on experimental basis, with a view to demonstrate replicable models in promoting rural sanitation. These were : i) the Alwar model on community motivation to adopt sanitation as a package (1987), ii) the concept of 'cleanliness' in Periyar (1989), iii) self-financing rural sanitation through community in Medinipur (1990), iv) a three-pronged approach to subsidizing rural sanitation in Allahabad (1991) and v) Nirmal Gram Yojna through Zilla Parishad in Mysore (1991). All these projects have made further inroads in achieving their objectives and have also influenced the strategy for sanitation promotion at both national and state level.

Alwar :

This is one of UNICEF's earliest interventions to have sanitation as a package of facilities to be promoted together. The project has made rapid strides since its inception when measured through different parameters. The percentage of households having their own latrines

(as per a survey conducted in 1992) is estimated at 15 % as compared to less than 7 % reported by 1991 census for the state of Rajasthan. Another survey, undertaken in 1993, indicates the extent to which households having latrine have also gone for other sanitary facilities like washing/bathing platforms (98%), soakage pit (63%) and smokeless chulha (57%). This signifies that the strategy is working well. As regards behavioral change among households, the 1992 survey presents some very interesting findings. While 95 % of households kept the drinking water on a raised platform, almost cent percent covered the stored water. Nearly 60 % did not dip their fingers into the container to take out the water for drinking. Similarly, around 80 % of the family members used footwear while going to the field either for open defecation or for other activities. A large majority of households (60 %) reported hand washing with soap or ash after defecation. The strategy successfully introduced in Alwar now forms a part of the national strategy for sanitation. The Eighth Five Year Plan, as well as the CRSP guidelines consider sanitation as a total package and not just confined to construction of latrines alone.

Periyar :

While Periyar adopted the concept of sanitation as a package as practised in Alwar, it went a step further to promote the general cleanliness of the house and its environment as an indicator of improved sanitation. Besides having their own latrine, a bathing cubicle, and an outlet to drain waste water into a village drain, many households were motivated to have bio-gas plants too, as a part of convergence with the activities of the Department of Non-Conventional Energy. The women's groups (DWCRA & Mahila Mandals) were actively associated with the sanitation programme, both for demand generation and for bringing about change in the household behavior. An important feature of the Periyar Project is school sanitation taken on a large scale by mobilizing funds from the community with UNICEF bearing only a part of the entire investment. Of the 1662 primary schools existing in this district, 1372 have already been covered under the School Sanitation Programme and the remaining are proposed to be covered during 1994-95. UNICEF supported construction of sanitary facilities in 713 schools in 1993-94. Another 290 are to be covered during 1994-95 to have a hundred percent coverage of schools. A study made in 1992 (end) indicated that 19 % of households in Periyar had access to latrines which was much higher than

the average (6 %) reported for the state of Tamil Nadu. The base-line study undertaken under the CDD-WATSAN strategy in 15 districts indicated the diarrhoea point prevalence rate (77 per 1000) to be one of the lowest in Periyar.

Medinipur :

The Intensive Sanitation Project (ISP) in Medinipur district of West Bengal has been inoperation since 1990. This project, implemented through the Rama Krishna Mission Lokshiksha Parishad (RKMLP), an NGO of national repute, has the distinction of being the first of its kind to have adopted a full cost-recovery approach in providing sanitary facilities to the households. Starting with one community development block, the project has now been extended to 46 of the 54 development blocks of the district. The project runs through a three tier structure with the village youth club at the bottom, the cluster organization in the middle and the RKMLP at the top. It has now more than 800 youth clubs covering nearly 3,000 villages with 14 cluster organisations providing guidance. The project has provided access to sanitary latrines for over 48,000 households. Based on the logistics now established and the substantial increase in the demand, the project now feels confident to cover an additional 40 - 50 thousand households annually.

As already indicated, this project is the first of its kind in the country where a full cost recovery approach was experimented and found to be feasible on a sizeable scale. The strategy has been widely appreciated by agencies both inside and outside the country. It has also influenced the Government policy on providing subsidy for Rural Sanitation Programme.

By giving a range of different designs to suit people with different socio-economic conditions, the project has proved that owning sanitary latrines in rural areas need not be the privilege of a few rich. A quick survey of the beneficiaries indicated that more than 60 % of the families covered under the ISP for household latrines belonged to the lowersocio-economic strata. Thus the project has brought certain social equity in the distribution of benefits.

While the project had anticipated that 25 % of beneficiary households might opt for outright payment, in

actual practice around 40 % of the families made the down payment towards full cost for constructing the latrines. The other 60 %, of course, opted for deferred payment on instalment basis. This is mainly due to a strong IEC back up and effective promotional efforts by the local youth clubs for demand generation. The project has several ramifications which need to be highlighted.

The full-cost-recovery approach has now been extended to Assam, Karnataka and rural Delhi. The Govt of West Bengal has taken a very conscious decision to replicate the Medinipur model in 10 other districts of West Bengal during 1994. All these indicate that the project has a good potential for replication, not only in West Bengal but also in other states of India.

The project has made significant contribution in creating wage employment and facilitating income generation in rural areas. A sum of Rs. 4.5. million has been disbursed towards wages so far, thereby creating around 1.50 lakh man days. This does not include other activities associated with production of sanitary components and installation of the facilities.

The contribution of this project to capacity building in rural areas is very significant. Organizing over 800 youth clubs with nearly 80,000 members and exposing them to the concept of community participation in general and water and sanitation in particular, is going to have a long term impact on the overall development of rural areas. This trained manpower could be very profitably used for other developmental activities in future.

It is reported that a few production centres have come up in the district through private initiative producing pan/trap similar to that of RKMLP's.

Allahabad :

The Allahabad project has a three-pronged approach to subsidising household sanitary facilities. Besides the government-run programme, with a high subsidy, the Institute of Engineering and Rural Technology (IERT) has extended its area of operation with a subsidy of only 40 % of what was available from the government; the target is to cover 12,000 households with beneficiary contributing nearly 80 % of the total cost (as against

only 20 % in the case of the government-run programme). The Rural Sanitary Marts (RSMs) where no visible subsidy was envisaged, has also made an impressive progress. Started with only 3 in 1991, Allahabad and its adjoining districts have now 16 such marts of which 11 have already started earning some profits. This cluster of RSMs is serving as a demonstration centre for other States to understand the RSM concept as used in the field and adopt the same in their respective areas. The number of households provided with sanitary latrines through these three approaches has exceeded 30,000. One important lesson from Allahabad experience has been that even in a limited area like a district, one can try out alternate delivery systems to promote sanitation. The IERT approach of having a very low subsidy component is now in vogue in selected areas of Gujarat, Maharashtra, Tamil Nadu and Bihar and is implemented by local NGOs.

Mysore :

The Nirmal Gram Yojna (Clean Village Scheme) not only promotesthe sanitary facilities but also createsawareness among people with regard to linking sanitation with health. After having completed more than 20,000 household latrines, this project has now decided to adopt the Medinipur Model for sustaining rural sanitation. A beginning has been made inthis regard by involving an NGO (MYRADA). Two production centres for manufacturing pans, traps and other construction materials on Medinipur lines have been established and the initial response fromthe community has been very encouraging. In arecently concluded state level workshop which was attended by the senior state level officials, there was unanimity in endorsing this change in approach by the Mysore Zilla Parishad for accelerating the sanitation coverage. The government is also seriously considering the suggestion of the seminar either to do away with the direct subsidy or make it invisible in the form of providing material support. Another significant feature of the Mysore Project is linking sanitation with literacy campaign. Called "Akshara Arogya" this approach aims at creating demand for sanitary facilitates throughpromoting health education as a part of literacy promotion. The Mysore experience can create an opening to extend the "Akshara Arogya" approach to the 300 and odd districts covered under the Literacy Mission.

Human Resources Development :

Institutionalizing the training on sanitation has been considered as an important step towards development of human resources for an effective and sustainable Rural Sanitation Programme. A break through was achieved in Haryana where low-cost sanitation now forms a part of the agenda of training the government fuctionaires at various levels. State level institutes, namely, the Haryana Institute of Rural Development and the State Community Development Training Centre together are going to convey some basic concepts on low-cost sanitation to over 5,000 functionaries during 1994-95 as a part of their over-all training schedule. In addition, they will also be organizing separate training courses on low-cost sanitation for a variety of officials. In Rajasthan, the Indian Institute of Rural Management continues to provide all the training support to the state government on low-cost sanitation. The Haryana experience is being advocated in other states. As regards technical training, the themes to be included in the existing curriculum of the engineering schools/polytechnics have been identified through a series of regional workshops participated by senior officials of the Ministry of Human Resource Development (MHRD), Ministry of Rural Development (MRD), State Directorates of Technical Education (SDTE), Technical Teachers' Training Institutes (TTTI) and selected Community Polytechnics. This is at present under discussion with the MHRD and the feedback has been very positive. As regards training of masons, the objective is to have at least one trained mason in every Gram Panchayat by 1995. The TTTIs and the Community Polytechnics have agreed to take the responsibility of training the core trainers at State, District and Block level. The possibility of involving other local agencies in this regard is also being explored. The GOI has made considerable headway in institutionalizing training of trainers on WATSAN as a part of the International Training Network in which 8 institutes have been identified. A national consultant is now working with the MRD to work out further details for this purpose.

Research And Development :

A pilot project has been taken up by the All India Institute of Hygiene and Public Health on developing an integrated and ecologically balanced approach for water supply and sanitation. Besides introducing certain appropriate and replicable technology at the village level such as different models of pour-flush latrines, vermi-culture, upgradation of traditional water sources by providing horizontal roughing and slow-sand filters, simple field kits for water quality 'monitoring and surveillance through anganwadi workers, the project has also made efforts to strategise the concept of community based approach in planning and handling these facilities. Studies on pollution travel and sludge accumulation rate are underway. The IERT continued its effort to develop various components of a latrine (including the superstructure) using locally available materials.

Collaboration of Other UN Agencies:

UNICEF maintains its collaborative efforts with other UN agencies specially in the areas of common interest for sanitation promotion.

The Integrated Parasite Control and Family Welfare Project undertaken jointly with UNFPA (through Dooars Branch of Indian Tea Association) has completed its 3rd year of implementation. The project area covers 126 member tea gardens of northern West Bengal. So far 88 mothers' clubs have been formed in an equal number of gardens and 1760 members trained on the various aspects of the service delivery. These clubs are playing a vital role in maternity and childcare, couple protection, prevention and management of diarrhoeal diseases, awareness on water supply and sanitation etc. for the overall improvement of the quality of life among the plantation workers. Health check-up among school children to detect worm infestation and provide treatment continued in around 50 tea gardens. This was a motivating factor for the households to have their own sanitary facilities.

UNICEF, in collaboration with UNDP-World Bank Rural Water Supply and Sanitation group, worked out the methodology,

approach and institutional arrangement for undertaking R&D on a) Improvement of design parameters of pour flush latrines, b) Improvements in other sanitation facilities like domestic soakage pit, garbage pit, bathing and washing platform etc and c) Comprehensive study on ground water pollution from pit latrines under different geo-hydrological conditions.

Close rapport with the WHO is maintained as a follow up to the points raised in the last informal regional consultation on hygiene and sanitation promotion and also on waste recycling for agricultural use.

Future Direction :

The Eighth Five Year Plan (1992-97) and the CRSP guidelines (1993) together with the Plan of Operations (1991-95) agreed to between Govt. of India and UNICEF will form the broad framework for future interventions. This will not only include replicating the successful strategies on a wider scale to meet the mid-decade summit goals and set the tone for the end decade goal but also getting into new areas hitherto remaining uncovered. These include promoting sanitation in peri-urban areas and looking at sanitation in the overall context of Primary Environmental Care (PEC). The strategy envisaged in this regard are placed below :

1. Develop social marketing strategies and promote alternate delivery system to accelerate sanitation coverage.

2. Involve schools and Anganwadis as a channel to expand the outreach of the programme.

3. Empower women with knowledge on the improved sanitary practices and also the skill to construct low-cost sanitary facilities.

4. Extend the CDD-WATSAN strategy to more number of districts.

5. Expand the scope of the programme to include both rural and urban (with emphasis on peri-urban).

6. Develop area-specific projects to promote sanitation in the context of PEC.

7. Undertake research and development on technology, design and construction materials to bring down the unit cost of sanitary facilities further.

8. Institutionalize Human Resource Development and IEC to facilitate sustainable development.

9. Develop state-specific projects on linking the Panchayati Raj system with the promotion of sanitation, on a pilot basis.

10. Undertake area-specific projects on parasite control (worm infestation).

11. Link up sanitation with vector control projects (malaria and filaria control).

BBS/ts/cbd
sandon94 (9/8)

SOCIAL MARKETING: A KEY TO SUCCESSFUL PUBLIC HEALTH PROGRAMS*

Marcia Griffiths**

- A husband in Bangladesh explains that his wife cannot use contraceptives because it is her duty to bear children. No, he has never talked to her about this.

  A year later, his wife, with his permission, has sought help in spacing her next pregnancy. In fact, following a multimedia effort to encourage husbands to be wise and talk to their wives about family planning, 44 percent of men in Bangladesh reported doing so and within 12 months of the campaign launch, contraceptive prevalence increased by ten percent.

- A mother in Indonesia explains that the reason she does not add green leafy vegetables to her child's rice is because the green leaves are difficult for a baby to digest; she knows because when she tried, they made her baby's stool green.

  However, later, after being counselled by a doctor on the radio and her local community health worker she feeds her child a mixed food with green leaves. So do 85 percent of the women in this province. By following this and other advice related to improved child feeding, 40 percent of the children under two have significantly improved nutritional status.

- A young woman in Sao Paulo in Brazil states that she could not possibly breastfeed her baby--she did not have milk that was good or abundant enough to satisfy her child. She says she knew this without even trying to breast feed. All her friends feed their babies with a bottle as they see rich ladies doing. In fact, the doctor had even given her some free milk to take home.

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But, eighteen months after policy makers were convinced that breastfeeding could help stop the tremendous drain of their foreign exchange, and a year after a popular mass media program was launched and hospitals were mandated to promote breastfeeding, the situation began to reverse. Women began breastfeeding, and breastfeeding longer. There were hospital reports that child abandonment was dramatically reduced in Recife. And, in Sao Paulo, after five years of the breastfeeding promotion, researchers attributed 12 percent of the reduction in infant mortality that had occurred in that city to the improvement in breastfeeding practices.

- A clinic nurse in Ecuador reports that she doesn't immunize a child unless there are at least four other children in the waiting room who need the vaccine. She can't afford to open a new vial for every child who has missed the mass campaign.

  Nine months later supplies are better, the guidelines have been changed, and the nurse retrained so she never misses a vaccination opportunity. Every month, mothers are reminded to bring their children to the nearest health post if they have not been vaccinated. Vaccination rates more than tripled for the children who were most in need of attention: those from the middle and lower socio-economic groups.

These are just a few examples of the dramatic improvements in health outcomes when social marketing is used to address consumer needs. There are more examples:

- a 30 percent decline in infant mortality from promotion and marketing of ORS in Egypt;
- a decrease of almost 50 percent in deaths due to diarrhea in Honduras following a program to educate mothers about the use of oral rehydration salts.

- And, several examples from developed countries: The Stanford Heart Disease Prevention Program, the North Karelia Project in Finland, and the more recent Project LEAN,

America Responds to AIDS and Project Best Start that will be discussed in detail during these three days.

Since its introduction two decades ago, social marketing programs have continued to show results. Over the 20 years, methods have been refined, programs made more cost effective and sustainable. However, in spite of social marketing's successes, it is not well understood, is not practiced in its entirety in many situations, and has not been used much in domestic programs.

To initiate discussion and provide a context for the presentations that follow, I will:

a) define social marketing, distinguishing it from traditional health and nutrition education and from its commercial counterpart;

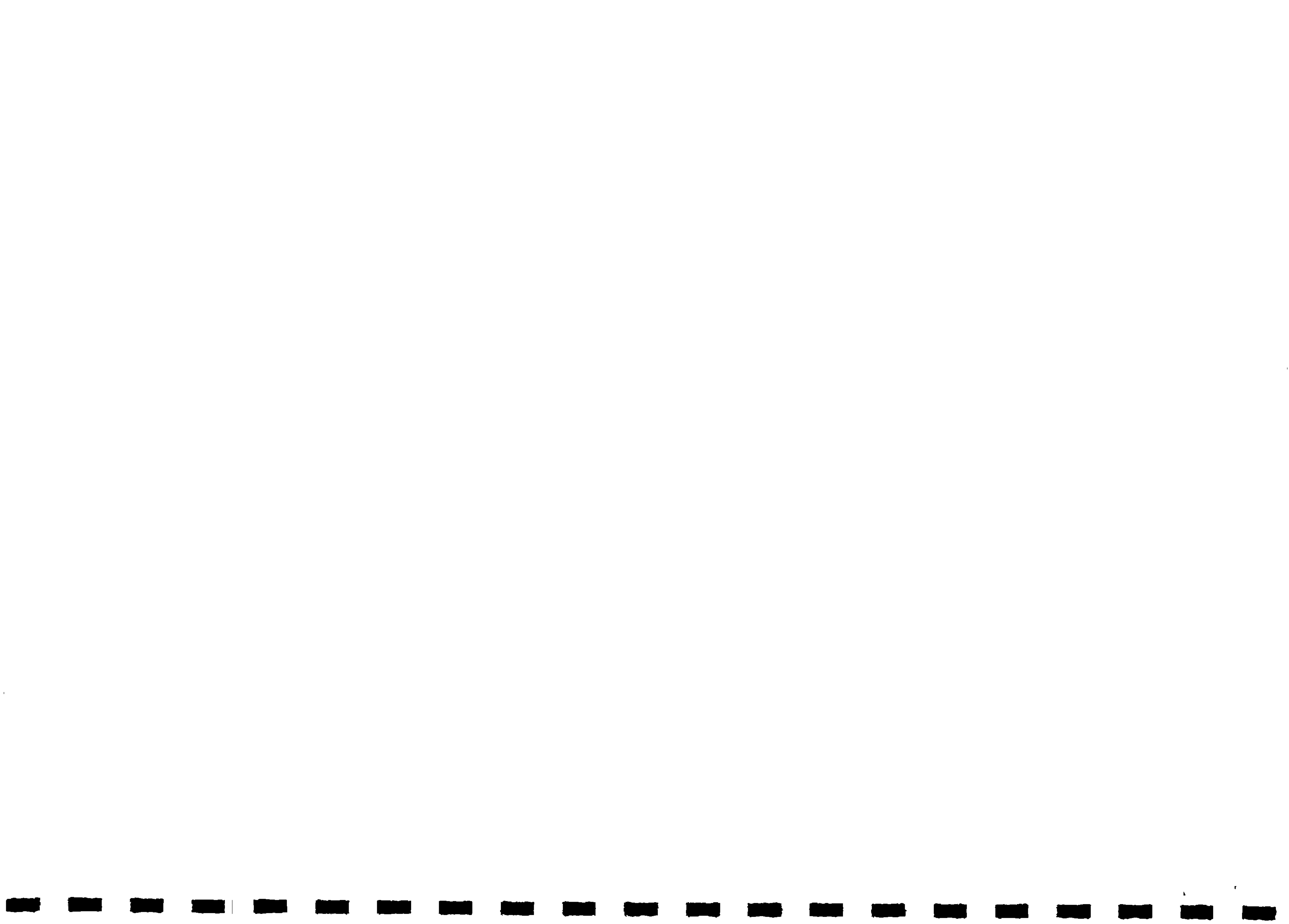
b) give an overview of the social marketing process that will serve as a point of reference for subsequent presentations that will provide more detail on each phase;

c) highlight some lessons or features of successful social marketing programs.

What is social marketing?

Some people think it is a dating service; others, a mass media campaign of public service announcements; others, any program that establishes a product distribution network. But it is more. Social marketing defies easy stereotyping.

Social marketing is a systematic approach to solving problems, in this case public health problems, related to service utilization, product development and acceptance, and behavior adoption. It is the application of marketing principles to social program design and management. Because it is an approach and not a solution, there is no program template for others to copy. The program examples I highlighted in the beginning were selected because they illustrate a range of social marketing activities from the Bangladesh example where social marketing was used to attract new family planning acceptors by promoting the concept of family planning (not a particular product); to Indonesia, where mass media and individual counselling



were combined to promote and educate about a product (a homemade infant food) for daily use that was developed by a subset of program clients; to Ecuador, where modifications in the health system were foremost, including policy changes about the supply and use of vaccines and health worker retraining; to Brazil, where a social marketing perspective was employed from the beginning to identify and address all the resistances mothers face in breastfeeding: there was a coordinated motivational effort with policy makers, retraining and training of medical personnel, the establishment of women's support groups, creches in the work place and a mass promotion effort to let women know that they can breastfeed. To repeat, there is no social marketing quick fix. Because social marketing is the window on the consumer, applying its techniques can lead to modifications and innovations in the design of all program components.

The fundamentals of the social marketing approach come from marketing principles. This point of departure distinquished social marketing from other health education approaches.

- The focus is on consumer needs.

- Program organization and management may be structured to reflect a marketing operation. For example, health workers' job descriptions and their training are restructured so they become better sales agents for the program, not just deliverers of services.

- Commercial avenues are sought for products traditionally kept in the health sector.

- Alliances are forged with private sector agencies to bring consumer research, advertising and marketing skills into program design and monitoring.

- The results orientation of marketing is brought to bear--progress toward achieving goals is constantly measured.

However, social is an important descriptor of marketing and distinguishes us from our commercial collegues. Commercial marketing techniques require slight modification because:

- the clientele we address are segments of the population usually not targetted by commercial marketers;

- the programs are often public sector programs that promote products, services or behaviors that carry a benefit to society and promise little in the way of profit;

- the budget for the program is usually very low and does not fluctuate depending on "sales" of the product;

- there is a need for good "scientific" information to frame the problem and assist in crafting solutions. Because social marketing products or concepts are not "sold" by image alone, the technical side of the health issue is crucial.

To better describe social marketing, I want to focus on four aspects: two purposes and two techniques that distinguish social marketing from other health education efforts.

1. Social marketing has as its objective <u>changes in behavior</u>, not just imparting information. As we know, people can know their behavior is harmful to their health, for example smoking, but they do not act on that knowledge for a variety of reasons. Social marketers have their eye on what it will take to get people to try something new, whether it is going to the health center, cooking green leafy vegetables everyday for their children or to quit smoking. If peer pressure, legislation, or a new product will lower the resistance to adopting a new behavior, social marketers work to implement these activities. When it comes to promotion and education, unless the information is relevant to changing the behavior, it is not included. Thus, in nutrition efforts, the food groups are not mentioned. In promoting the cessation of smoking, what smokers know is not repeated: that smoking is bad. Instead, the smoking environment might be restricted or workshops set up for smokers on techniques to quit, or on ways to not gain weight while quitting (a major resistance smokers have to quitting).

2. Social marketing concentrates on the half of the marketing equation that is often ignored--creation of demand. Far too often, we think only of supply: building health clinics, producing nutritious infant foods, supplying contraceptives, etc. But often the health clinics are empty, the infant foods not bought, and the contraceptives not picked up or used. Demand has not been realized because we have not understood consumer needs and desires and catered to them. This is something our commercial counterparts have done very well, while we have assumed that everyone will use the health center, or seek the advice of a WIC or EFNEP counsellor, and that everyone will buy an infant food as long as it is nutritious. We are only beginning to recognize and learn how to find out what consumers look for in health services or seek in an infant food, and how to adapt our services and products for them. When we do this, we make programs more cost effective. The biggest waste in health programs may be the cost expended for infrastructures without providing for effective promotion and education. Immunization or prenatal care infrastructures, for example, are not cost effective if only 25 percent of the target audience attends. As that percentage rises, cost effectiveness improves.

3. In promoting behavior changes and in creating demand, social marketing uses, as Dick Manoff has called it, a feed-forward approach that minimizes "feedback shock," or as others would call it, formative research. That is, we go to the community, to consumers, to find out what they want. This helps us shape our product and fine tune the promotional angle. For example, breast milk: It can be promoted as the best food for young babies and as protective since it is full of antigens. However, our most motivating appeal to mothers may be that it is a convenience food, if convenience is what mothers want.

4. Finally, social marketing requires creativity, not just in message design where persuasive, captivating and memorable messages are the goal, but also in implementing qualitative research free of researcher bias, and in developing program strategies through creative interpretation of research findings. It is

particularly the latter that should distinguish social marketing: creative program strategies. Too often we find that good research has been done but has been poorly implemented for program needs. The bridge from research to program is missing: either programs have returned to standard solutions or messages believing that they must convey the textbook information or they literally write the messages from the research losing the creative interpretation, that element that makes it special and memorable.

Although there are other distinctions between traditional health education and social marketing, these four embody much of the difference.

- adopting a consumer's perspective from the beginning, using a feed-forward approach;
- focusing on changing behavior;
- remembering the demand side of the marketing equation;
- and, employing creativity.

What do social marketers do?

Social marketers conceptualize their task in four main phases, not too differently from most project planners. Key, for the social marketer, is strategy. The four steps are: strategy development, strategy formulation, strategy implementation, and strategy assessment/evaluation.

In the first phase, strategy development, consumer research is undertaken with the following in mind: project objectives, target audiences, resistance resolution opportunities, important change agents and media patterns of the target audiences. Much more will be said about this aspect in the next presentation. But I cannot emphasize enough how critical this step is as it sets the content and tone for the strategy.

Although the research may need to have a quantitative component or quantitative elements to document frequency or prevalence of a practice, emphasis is placed on qualitative research to understand the "why" of what people do. We find, usually, that the general health problem or practice

has already been quantified by a national health survey. But, this statistic does not provide the richness of explanation about the problem or practice that would allow for the design of a meaningful intervention to change the fundamental causes of the behavior.

For example, because questions in quantitative surveys, about women's low utilization rate of health services, usually ask about cost and access these are often cited as the reasons more women do not use services. Although these barriers may be real, even if resolved, we find that women are still reluctant to go because of the way they are reprimanded by clinic workers and because they do not like exposing their bodies to those they do not know. In fact, if these latter barriers are removed or addressed, in some cases, women will pay the fee for the services and go out of their way to reach the clinic.

The goal of the research is to uncover these less discussed, less obvious perceptions and reasons. In each new study, we strive to perfect our techniques, be they focussed group discussions, in-depth interviews, or structured observations so that we can better understand how our clients' decisions are made and incorporate more of their perspective in program planning.

This research need not be expensive and, depending on the variety of topics, the methods used, and the geographic area to be covered, can be done as quickly as two months. What is important, again, is that the consumer is consulted and that there is creativity in the research design.

With the research results, the social marketer engages in the second task: strategy formulation. First, concentration is put on better defining the target audiences (mothers, fathers, teenagers, etc.). A key question concerns the homogeneity of the audience in relation to the concept or practice. Are there segments, or parts of these audiences that are different? For example, within the audience of mothers, are all to be treated the same with respect to recommendations on child feeding? Or, do mothers of babies under a year need to be segmented from those with children between one and two because of their different concerns about child development and the foods those infants can eat? Do all teens share the same views on safe sex or do boys need different motivation from girls? Second, the "products" or

concepts that are to be promoted are specified in detail, e.g. the product, a condom; the concept, safe sex. Third, the message tone and elements are established, e.g. the tone will be straight forward testimonials: "I did it, you can do it.", and the messages will always counter a common misconception and will always refer people to more information. Fourth, the media plan is specified: here we have learned that multiple media produce more impact. Clinic nurses, counsellors, extension agents, and school teachers--all are media and need to be in the plan, if appropriate.

The third stage is strategy implementation. It begins with the developing and testing of prototype "products". These can include recipes for low fat cooking, a bowl to help mothers measure quantities of food for their children, and of course, the messages--radio spots, counselling materials, etc. After materials are tested, the media plan is set, the promotion or publicity for the program begins (often a forgotten aspect). Other needed activities, such as a change in clinic hours, or new legislation are put in place and the "sales agents", such as clinic staff, are trained.

Following the launch of the social marketing program, the fourth phase begins: strategy assessment or evaluation. Strategy assessment is undertaken to: determine program strengths and weaknesses, introduce improvements in the process, uncover new resistance points and to measure progress towards the objectives. This activity usually involves qualitative and quantitative measures of progress and impact. There are several common errors made in this stage: 1) resources are underestimated; 2) the program itself is not well documented so that impact results stand alone, unrelated to program implementation; and 3) baseline surveys are conducted too early in a program's evolution. Often they are done during or combined with the formative research. This is before the subtleties of the project are known. When done at this stage they do not measure these aspects which make attribution of the results much clearer.

After almost two decades of work in social marketing, what have we learned, what do we see as common features in successful programs and what are the challenges ahead?

The lessons and challenges are many. I have tried to keep the list short and will use this opportunity to

summarize much of what I said earlier. Features of successful programs include :

1. *A focus on behavior,* not just on information. The resistances to changing behavior must be viewed broadly. System/infrastructure changes and the perception/attitude changes must go hand-in-hand. The challenge is to use social marketing even more in the area of strategic program planning to make the pursuit of health-promoting behaviors easier for individuals.

2. *A program plan based on what the consumer requires to change practices.* Although great strides have been made in new research methodologies that combine techniques from anthropology, psychology and market research, the challenge is still before us to better understand our client; to penetrate the lifestyle context in which decisions are being made.

3. *Creatively designed solutions.* Creativity is elusive. But it is clear that to really make a difference, we must break away from old mind-sets and pat solutions. Fresh perspectives, new combinations of activities, partnerships with private sector talent and creative concepts are required.

4. *Media selection based on maximizing the reach (or coverage) of the message and the frequency with which it is delivered plus ensuring that the message is received when it is most relevant.* The challenge is making our media plan cost effective by means of precise targetting through better audience segmentation.

5. *Message design principles are rigorously enforced.* The message is designed to: call for action, resolve resistances convincingly, offer meaningful benefit and be memorable. The challenge again is creativity.

6. *Program personnel receive special attention:* their morale, improving their perceptions and behaviors and training them to be good sales agents means they need to know technical content and how to educate. The challenge is to work this into the competing demands for their time. The program often needs its own internal promotion campaign with staff.

7. *Implementation pays attention to:*

a) *The mix between centrally-run activities and locally developed and managed activities* involving communities or neighborhoods as much as possible in reducing the barriers to health-promoting behaviors. This often means taking precious resources from one's own budget and transferring them to someone else's.

b) *Coordination and integration* are central in a well run social marketing program. The social marketing component of a program often functions as coordinator. This is the perfect role since all messages must be harmonized.

c) *Communications inside (for project staff) and outside the program* (with other social sector programs) can be the difference between a good or bad program image.

The challenge in implementation is good management.

8. After program launch, there is *regular program monitoring and the chance to refine program strategies*. Too often what is produced and aired is thought to be forever. But consumers change and may act unpredictably. The challenge is to preserve this flexibility when there are competing demands for shrinking resources.

9. *All program decisions consider sustainability*. Over the years, social marketing has been criticized for putting in place expensive, unsustainable programs. While this has happened, it is in part because there has been little opportunity to refine initial activities and the opportunity was not always available to involve the private sector in doing the work and in sponsoring a program. The challenge is before us for cost effective progrmas that continue, albeit modified, year after year since the practices we strive to improve, such as healthful diets, are not achieved overnight.

Social marketing is an accepted discipline with the advantages of: making a program more cost effective by improving demand; building public-private sector alliances and good program relations; and, producing positive impacts on health outcomes because consumer needs have been met. Enough is known now to make social marketing indispensable in reaching our public health goals. Social marketing is, as Dick Manoff's 1985 book is subtitled, the new imperative for public health.

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PROMOTION OF LATRINES (SANITATION) AS A PRESTIGIOUS PRODUCT

This input paper was presented at the second meeting of the collaborative council working group on promotion of sanitation, Hilterfingen, October 1994.

D. O. IKIN

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PROMOTION OF LATRINES AS A PRESTIGIOUS PRODUCT

October 1994 Derrick Owen Ikin SKAT

1. Before and after promotion

A. BEFORE PROMOTION

A brown liquid, with about 4 teaspoons of sugar per cup, and known to eat holes into a cotton cloth that is soaked in it overnight.

AFTER PROMOTION

? (Coke)

B. BEFORE PROMOTION

Kills you slowly, often not directly, but through blood circulation diseases and heart attacks.

AFTER PROMOTION

? (cigarettes)

C. REALITY ?

A rather heavy, expensive, not very fuel-efficient means of transporting two people often using 300 bhp to run an airconditioner while the occupants wait impatiently.

FACT ??

A sleek Mercedes sports car driven by those who know what they want and get it.

(waiting in a traffic jam with the AC running!)

2. Analysis of how prestige products are promoted

Mercedes has a reputation as a prestige car. It is a good, reliable product as are Toyotas, even the new Lexus. The Mercedes advertising campaign focuses on:

* status
* association with status people
* association with doing the right thing
* associated with looking after your family, i.e. traditional values
* protecting your loved ones with safety
* the car is good - so are the drivers of this car
* quality

These associations are made through the links in the image promoted through advertising. Pictures of children in the car are used as well as pictures of obviously well-off status people driving the car. The language used is also aimed at the more discerning reader. The magazines in which the promotion takes place are ones read by "better" readers. The advertising register, i.e. the language and style, uses facts that are said to appeal to a certain buyer. The background in the pictures are often luxury settings, i.e. villas, 5-star hotels, or country scenes.

The adverts are targeted and the content carefully selected to suit the potential buyer (e.g. successful young executive) and the price is even mentioned! A Mercedes is the "in thing" for rising executives! Although BMW may indirectly claim that Mercedes are for staid, old rich people and to be really "in" one should buy a BMW! The BMW image is far sportier, younger and apparently more dynamic. This image cost millions of dollars to build up and it is said that BMW spends over 30% of its income on promotion. Promotion is not free!

3. What factors influence creating a prestigious image and thus willingness to pay or to take action?

(Proposed theoretical model)

The input for willingness to pay included the basic needs of Maslow; the factors relating to basic needs are very evident in the advertising that Mercedes uses.

The hierarchy of needs put forward by Maslow perhaps adds some clarity to the factors that are involved in promoting a prestigious product as well as willingness to pay at various levels. Maslow suggested that people have priority of needs; once those are met, the next level becomes a priority (Koontz & Weihrich, Management, 1985, McGraw-Hill). As one need is met, so the next becomes more pressing. This is an oversimplification of reality. For example, a religious or status need can overrule all the others.

The basic needs are seen as follows:

1. Protection/survival needs that include food, water, shelter and sleep.
2. Security/safety needs where one is free of danger and has work, property or shelter.

Once these basic needs are met then other needs emerge:

3. The affiliation and acceptance need can be seen as a need to belong and be accepted.
4. Esteem needs manifest in the need to be respected, have power and self-confidence.
5. The need for self actualization, i.e. to become a complete, successful and coping human being.

4. Linking Mercedes with Maslow, then later Mercedes to latrines.

* The safety element of Mercedes is strongly linked to needs number 1 and 2, i.e. the protection and survival need as well as to the security and safety need.

* The status that a buyer acquires with a Mercedes satisfies needs number 3 and 4, i.e. the affiliation and acceptance, and the prestige needs. With a Mercedes one has arrived, is accepted and belongs to a certain level of society.

* Obviously the needs to be respected, have power (300BHP!) are also met by owning a Mercedes (need 4).

The need for self-actualization is more complex because an individual who is really "there", i.e. is confident, successful and assured may not need a product that brings all this as she/he may not need this type of affirmation!!

5. Mercedes and latrines

The lesson from the Mercedes example could be that the basic user preferences in sanitation should be promoted in such as way that they are linked/associated with Maslow's basic needs to create a new and acceptable image for sanitation. This linking is what Mercedes has done to create their image. **Sanitation is not a smelly hole, but a way of looking after your family, gaining privacy and convenience for your loved ones and achieving the status of a person who has a latrine.**

This sort of promotion has been done indirectly in Bangladesh by the initial promoting of status water seal latrines. People looked up to them and their owners. However, they were too expensive for over 80% of the population. In Africa the promotion of the VIP latrines has a similar role. This is seen as a seeding role, but is not applicable on a large scale because of the mismatch between price and the ability and willingness to pay.

The real challenge is to promote sanitation and its products for all people. This start has been made in Bangladesh by the promotion of home-made latrines (sanitary latrines) in a prestigious way. The simple latrines have been given status in numerous ways, for example, through their association with status people and modern media such as radio and TV. The promotion aim was not to give this status, but probably inadvertently this has happened.

The link of social mobilization to a prestigious product:

* involves community leaders

* involves national leaders

* involves media such as film, radio and TV

* involves local elites such as school teachers and children take part

Peer pressure related to a need to be affiliated and belong was also a factor in that nearly all in a village took part in building a latrine: one took part to belong.

6. The link to sanitation as a prestigious product.

LATRINE/SANITATION BEFORE PROMOTION

* no privacy
* smelly hole
* women go when it is dark
* low priority
* only poor people have that sort
* we can't afford one
* the basic one is no good
* because we make it, it is not good enough
* only low caste people clean it
* the bush is more convenient and pleasant

LATRINES AFTER PROMOTION

* we look after our family and children by having a latrine
* we now have privacy
* a community or village with 100% latrine coverage is a better village
* our basic latrine is good enough
* our prime minister supports basic latrines
* we can't live without one
* we can build one ourselves that is good enough
* we follow the law
* our religious leader supports sanitation
* our school teachers support this simple type of toilet
* our children now demand a latrine
* our village head supports latrines
* tv and radio support latrines
* there are pictures of our latrines in books
* we are better people because we have a latrine

7. General

Promotion is often thought of as being something that is only done commercially and for profit. Yet campaigns are run in many countries for numerous reasons. Examples in more recent times are vaccination campaigns for polio, eye-testing campaigns, family planning campaigns and now campaigns to prevent AIDS. For promotion to be long lasting, i.e. from generation to generation, has to be done at many levels.

Promotion gives you a choice, telling the truth and presenting facts in a way that is pleasant and easy to digest.

Promotion occurs at different levels such as

* internally in a family that is passed on from generation to generation;
* in schools;
* through religion;
* via peer pressure;
* through media;
* through NGOs;
* within projects.

All these routes are said to eventually result in internalised information that leads to changed beliefs and behaviour. At all these levels the idea of sanitation carrying prestige should be considered.

Basic principles (also applied by the Mercedes promoters)

* know your audience
* know their needs and priorities
* not only factual information (does not sell or convince)
* focused message
* repetitive

8. Common problems of sanitation promotion

* the prestige factor is mostly not considered
* limited budgets in programmes for promotion
* in many projects done by technical staff
* no focused goals
* professionalism lacks
* no material testing
* the available material does not reach user
* the material is not field-tested
* the message is not clear or relevant
* limited to printed matter
* lecture type of information and mostly boring
* children not focused on

9. Suggestions for promotion

* use professionals in the communications field

* a significant %age of the project budget should be for promotion

* a significant %age of staffing should be promotion professionals

* targets should be set, i.e. upgrade the status of low cost, but sound technologies

* use promotion techniques that engender status such as quality and appropriate media, e.g. famous film stars, leading community figures

* link the product and its use to accepted family values such as protecting the family, looking after the family, especially children

* downgrade other options as health hazards, danger to community and family

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Willingness to Pay

This input paper was presented at the second meeting of the collaborative council working group on promotion of sanitation, Hilterfingen, October 1994.

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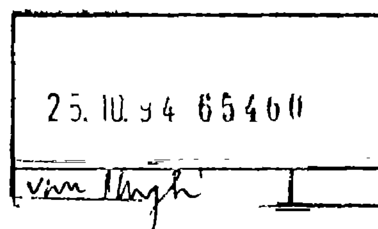

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1. Introduction

The aim of this paper is to provide input for discussions on willingness to pay. This input is not an exhaustive study or complete but rather an attempt to put willingness to pay in perspective in relation to sanitation and sanitation promotion.

Willingness to pay is examined in a societal and sanitation programme context and is then linked to practical examples. The uses and limitations of the willingness to pay studies are also examined. Parallels to the commercial world are made and some rough guidelines are suggested in conducting studies relating to sanitation.

A review of current literature and an assessment of published willingness to pay studies is at present being undertaken by Corinne Wacker for SKAT and some of these finding are used in this paper. In addition feedback was given by the team leader, Mr Jakob Straessle, from a willingness to pay study that is currently being carried out in Benin. This brought into focus some of the successes and difficulties at the operational level.

The basic question of the necessity of willingness to pay studies or which tool to use is covered very briefly and it should be kept in mind that there is scepticism concerning the use of WTP studies. Alternatives range from simple interviews, numerous appraisal methods to the more traditional studies.

World perspective

The world perspective[1] is that for example urbanization in 1950 in developing countries was 300 million and today it is 1.3 billion. By the year 2000 there will be over 400 cities with populations of more than 1 million. These increases put the problem of meeting the demands for infrastructure services such as water and sanitation into perspective. It seems that there is simply no choice other than to seek payment for services from the users. In most cases the model where the government alone finances and provides capital for the needed services is no longer applicable. Most developing countries (governments and municipalities) do not have the money for the traditional model of water and sanitation services.

2. Overall context

Willingness to pay is often taken for granted to mean the people who are said to benefit from a service or facility. However the users are one of many players in the payment game that also includes governments, donors, a municipality, political leaders and the community itself. Willingness to pay is thus applicable to many different people and organisations. This is further complicated by different individual conscious and unconscious perceptions and motives at each level.

The sought after result of willingness to pay, is the actual making of a payment immediately

[1] Summarised from the Introduction "A Case Study of Kumasi, Ghana" UNDP-World Bank Water and Sanitation Program, No 3, 1992

and/or in the future for goods and services received. This decision to pay is at each level linked through complex mechanisms to ability to pay. Both willingness to pay and ability to pay are affected by external and internal factors that are susceptible to change.

3. Commercial viewpoint

Willingness to pay can be also seen as one of the points assessed in examining a market for particular products and services. Commercially, ideas/products/services have to be sold. To sell or market a product, knowledge of the market (users/customers) is needed in designing a marketing strategy. This means matching the product to the market segment and that segment's willingness and ability to pay. This market knowledge or user knowledge puts the willingness to pay into the context of the individual and community that is being asked to pay.

Thus to minimise the investment risk, companies do market studies that traditionally link key indicators such as education, income, sex, status, common cultural / local practices to the product sold (and to the asking price) and subsequently use these factors to sell the product.

To minimise the risk of an unsuccessful project/programme, community surveys and willingness to pay information is gathered. Through these willingness to pay and community surveys, the same logic is followed as in the commercial sector, i.e. know what your customers' needs are and meet these needs by providing affordable solutions. Commercially what is promoted, and then sold should be affordable to bring profit. What is promoted/disseminated by a project should be affordable to allow sustainability. Both the service only and commercial only approaches have severe limitations. In its extreme, a service orientation is not sustainable and a commercial orientation in its extreme, neglects the poor and underprivileged.

4. Definitions in the Sanitation context:

What is willingness to pay?

It is a an indicator of the extent that a person (govt, community or family) is prepared to use their income (money and resources) for facilities, services and products that provide or improve sanitation for the individual and community.

What is its link to reality?

The results are linked to reality by the actual use of the resources/money to take action to improve sanitation ie buy and maintain a toilet or pay for the services provided.

5. Usefulness and goals

usefulness?

* assessing existing projects / countrywide schemes
* linking technology to reality
* sustainable solutions
* input for new projects / programmes

* linking willingness to pay to the community (market) segments can indicate if the systems promoted reach enough people
* limiting risk of failure
* lets people be involved in choices of services and technologies
* establishes real needs linked to payment
* policy input
* developing financial models for O&M and capital amortization

currently sought after goals?

a) demand led projects
a) community involvement and choice
b) sustainabilty through participation
c) match the project to the people

6. What factors influence willingness to pay?

(Proposed theoretical model)

The hierarchy of needs put forward by Maslow perhaps add some clarity to the factors that are involved in willingness to pay at various levels. Maslow suggested that people have priority of needs that once met, the next level become a priority: (Koontz, H and Weihrich H, Management. 1985 Mc Grau - Hill). As one need is met so the next becomes more pressing. This is an oversimplification of reality and for example a religious or status need can overrule all the others.

The basic needs are seen as follows:

1. Protection survival needs that include food, water shelter and sleep.
2. Security /safety needs where one is free of danger and has work, property or shelter

Once these basic needs are met then other needs emerge:

3. The affiliation and acceptance need can be seen as a need to belong and be accepted
4. Esteem needs manifest in the need to be respected, have power and self confidence
5. The need for self actualization, i.e. to be a complete successful and coping human being

Sanitation is a basic need:

Sanitation is a basic need and influences the quality of existence achieved by the individual. It ranks with food, shelter and water needs. It is also linked to the danger, a need to be respected and accepted. This is illustrated by the status that some sanitation facilities have or the lack of status people have when no facilities are available. In overcrowded living conditions sanitation is a threat to the survival (health) of the community. Sanitation in all societies carries certain taboos that range from not talking about it to strong dictates as to sanitation practices.

It is suggested all players in the sanitation game have an internalized list of needs that relate to their conscious and unconscious perception of sanitation. These perceptions directly affect the willingness to pay and can be used in promotion to increase the willingness to pay.

It is suggested that when confronted with the question of how much he/she/ or a government is willing to pay, these need factors are used internally as a sort of cost benefit assessment. The result of the assessment is the willingness to pay.

The following table loosely translates the above basic needs in terms of sanitation. These are generalisations and would be different from society to society or even from community to community.

A: basic need

An area or place to defecate.

B: Factors linked to this basic need[2] C: Factors that influence B

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Privacy	age
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perception of existing facilities	geographical situation
perception of cost of existing facilities	climate
	type and range of alternatives
	cost of alternatives

2 Factors B and C are not prioritized or complete

7. Characteristics of the players

The characteristics of the players that are related to willingness to pay and to ability to pay can be described as follows:

Governments (both recipient and donor)	Donor agencies/ NGOs
genuine commitment and concern political will general awareness of problem awareness of possible solutions preconceived ideas cultural background political capital (votes) both hidden and open motives degree of support and acceptability fixation on a particular technology lack of knowledge of target community prefer expensive options	genuine commitment and concern push through some policy or other limit funding push funding political will preconceived ideas cultural background general awareness of problem degree of support from govt and acceptability

Community/ individual
genuine need raised hopes to get expensive options funded by govt different priorities to programme satisfied with existing options existing options have no status politically and socially acceptable internalised priorities different to decision makers do not know alternatives limited ability / willingness to pay

How these players can influence willingness to pay studies will be seen by looking at the tools used and who uses them.

8. Existing tools to determine willingness to pay

The community and individual:

There are a number of tools used to assess willingness to pay:

a) An assumption on the part of the programme designers that people will and can pay. This is based on an often false confidence of "knowing the people". This is probably the most

often used tool and currently is being overtaken by more logical methods. It is not user based.

b) Using broad generalisation based on, for example, that a family with a specific income should spend "X" percent of its income on sanitation. This is not really an indicator for willingness to pay and the danger is that people are not told the real costs but only what is demanded as participation. This can result in choices that are not sustainable.

c) Questionnaires only, disadvantage of limiting choice to pre-selected choices that may or may not be realistic. This can be improved by using open questions and not relying only on closed and pre-choice type questions.

d) A sample of questionnaires and interviews with communities. These follow conventional survey techniques and have all their advantages and limitations.

e) Community participatory approaches that are a mix of community involvement, promotion and information gathering. These can give indicators as to whether the community wants to participate and contribute in both cash and kind.

9. Some open questions and limitations concerning willingness to pay:

* What if there is no willingness to pay? This affects the donor/project philosophy of making a project demand oriented or demand led programme.

* What if the ability to pay is too low for any of the existing options?

Limitations

* is only an indicator
* is open to methodological errors
* bidding is complex and should be cross checked
* is exposed to manipulation by govt, communities researchers. donors etc
* study can be skewered by inappropriate product or service choice given to communities or individuals.
* fixation of a Government, donor or NGO on a status expensive solution. Generally if a cheaper solution is available it has to be sold and people convinced. Usually the local solution (home made, mix or simple) has no status and may even be unacceptable to officials ie decision makers.
*Hidden agendas and motivations can influence the study
* The danger that unsuitable or too expensive WTP assessment methods will be used

Influence of Governments / Donors on WTP studies

How much and under what conditions are government and donors willing to pay (finance) a project?

a) genuine need by all parties to provide sustainable services!

b) willingness to pay may be linked to a policy that may be based on supporting non

sustainable solutions ie an expensive national sanitation plan that would perhaps cover a small number of people. If the proposal fits these conditions a willingness to pay exists.

c) An often misguided belief that poor people can't or will not pay therefore services should be provided. If a service project is thus proposed it will be accepted. (Common with NGOs)

d) Both sides have a sanitation policy and seek common grounds that lead to a willingness to pay (finance) on the part of the govt /donor.

c) Recently pre-conditions to financing are made that include revenue collection, social/community participation, technology selection and willingness to pay.

e) Vested interests in promoting a particular technology, product or service. If the proposal meets these "hidden" criteria then it will be financed.

10. Comments on practical experiences

10.1 Benin :

Brief description:

A pre-appraisal of a water supply and sanitation project is in the process of being carried out and the data is presently being analyzed. A proposal for a 3 year, US$ 15 million project is being made to DANDA and IDA. The planned phases are as follows:

Phase 1

A) One year for preparatory work including demand assessment, conceptualization, training, institution capacity building and decentralization. Also included in this phase is social promotion that includes WTP surveys as a tool for assessing the demand for water and sanitation services. Relevant socio-economic, environmental and technology data will be gathered.

B) 2 to 3 years of physical implementation: 2 out of 6 regions before a nation wide replication.

Phase 2

Assessment of phase one and based on demand an expansion to whole country.

World Bank pre-financing conditions:

a) Water/sanitation should be sold not free. The WTP study should establish how much could be paid and this would be linked to financial models for O&M.

a) Participation of the Benin government in form of human resources, infrastructure, land for buildings, and Govt salaries (roughly estimated to be 10% of total project costs).

How will WTP and related socio-economic data be used?

The results will be used to taylor the project to the needs and WTP of the users. It will also no doubt influence Government and donor decisions relating to technology choices and services. It will also influence the financial models chosen for O&M costs and the types of systems chosen. However the impression was gained that the government had probably already set its objectives regarding technology choice and purchase.

Some initial finding and comments on survey:

The usual survey aspects were taken into account such as random sample, pretesting of questionnaire, training of interviewers and group interview etc.

* What technology to put on the questionnaires was a point of much discussion. The government had the main say but eventually the Mozambique dome (MD) was put on at a price ie F 30.000 instead of the estimated F 10.000. A VIP latrine for F75.000 was also one of the choices given to the users. The high price of the MD was a commercial price that in reality would not apply as it does not take user participation in building and installation into account. It was felt that the cheaper version was less acceptable to the planners because it would mean less money for the project.

* The Mozambique dome was not generally known and it was explained by the interviewer using drawings. A photo of the VIP latrine was shown and this type is generally known. More interest was shown in the VIP than in MD.

This is a problem faced when introducing new choices to users. In this case it is complicated by the high illiteracy rate of the users (80%) and the use of a drawing that generally requires literate skill or training to understand. A picture of the VIP showed a good solid super structure but not the interior. Using pictures of a technology with a verbal description to an illiterate audience could cause problems as generally illiterate people may interpret pictures differently. A Picture test is essential. (No testing with villages was done due to the time constraint of only 1 week for preparation)

* At present only 10% of respondents use a latrine. Traditionally 4 areas were used:

a) bush 90%
b)field 10%
c) rubbish heap was also used.

* The Mozambique dome was chosen by 33% the VIP 52%

The initial results however could reflect a bias towards a cheaper solution rather than a technology. 55% were willing to pay more than F5000 for the Mozambique dome and 46% would pay more than F10.000 for the MD. The average willingness to pay was F18500.

*** About 55% want a latrine and would want to buy one from a private entrepreneur. Only 15% want Government help.** This is seen as an opportunity to involve private latrine producers right from the start of the project.

In real terms the really basic low price may be the only alternative to achieve high sanitation coverage but these products carry a low status. This high coverage probably could also not be achieved through a WB/government project alone. The private sector should be included in the planning at all stages.

General

* The checking of the interviewers was limited to:
a) supervisor and interviewer check (paper check review)
b) group discussions that included the people interviewed (real check)

No double check was carried out as is customary in many similar studies.

* The interviewers were carefully selected, tested and trained. The questionnaires were translated into the local language. A gender balance was a main focus point.

Government participation

* The government already had a policy that listed technologies foreseen to be included in the project. For example the Department of Finance also gave figures of how much people are expected to pay for water i.e. pumps 10% and solar energy 35% . These figures are not related to actual costs of the systems under discussion. This is seen as a serious problem. The government also influenced the selection alternatives to be put to the users. Technical feasibility studies assisted in clarifying the situation.

* Government officials requested that their candidates be used for the job of interviewers but all candidates had to pass the strict selection procedures.

* Government officials participated to a limited extent in training and assisted in defining key terms.

* Government officials were occasionally present as observers during the field work (4 to 5 group discussion out of 54).

(Handout: Information on the Benin Project, World Bank/ DANIDA / IDA)

10.2 Bangladesh:

Brief description

The Government of Bangladesh/UNICEF Rural Water and Sanitation Programme has been running for over 18 year with a total investment of about 300 million US$. It is a countrywide programme and the successes are:

a) Over 85 million people now have access to safe drinking water.
b) A WHO survey showed that 90% of all pumps installed are still functioning.
c) Latrine coverage has gone up from below about 3% to over 20% .

Willingness to pay

Some pioneering work was done in Bangladesh in the field of willingness to pay by Martin Strauss (IRCWD) and Skylark Chadha. The survey interviewed 400 families who already had a latrine and 2400 families who did not have a sanitary latrine.

Results: (page 6 Chadha & Strauss, Handout)

4% can/want to pay Tk 450 or more
27% can /want to pay up range of Tk 250 to 450
69% can pay more than Tk 250
19% cannot pay more than Tk 100
7% cannot pay more than Tk70

Roughly translated in terms of rural water and sanitation programme it meant that over 80% of the population could not afford the subsidised latrines then promoted in the UNICEF and government of Bangladesh programme. The same could be said for most latrines promoted by NGOs. However the 1000 government run latrine production centres and their products played a major seeding role in popularising the idea of sanitation. Private latrine producers set up business and competed with the subsidised government products!

These facts together with numerous other influences slowly led to a change in focus of the rural water and sanitation programme in Bangladesh.

a) The simple and affordable home made pit latrine was professionally promoted and this resulted in massive building of home made latrines (about 40.000 in the Barisal area alone).
b) Sanitation options were now offered.
c) Promotion became a key factor in the sanitation programme linked to affordable products.
d) The private sector was now seen as a potential ally in achieving country wide sanitation coverage.

10.3 Ghana: Kumasi

A well formulated study that took great care to cross check questioning methods, choices and linked results to other socio-economic factors. It provided much knowledge on what type of latrines and how much people were willing to pay. It showed that convenience was more important than community health dangers related to methods of waste disposal.

A colleague recently visited Kumasi and told that he had seen the cleanest public toilets he had ever seen. Public toilets are privately managed and paid for by the users.

(Hand out of selected chapters from " Household Demand for Improved sanitation Services: A case Study of Kumasi", Ghana 1992 no 3 UNDP-World Bank Water and Sanitation Program.)

11. Survey recommendation based on Benin experiences: Corinne Wacker (hand out)

* Gender balance
* include bidding on existing options
* include low cost options
* include option to repair current system

12. Conclusions

* WTP should not be used in isolation. It should be seen in the context ranging from the government to the user.

* WTP should be linked to other basic information and examined in relation to the market.

* WTP should strongly influence the technology/system promoted and linked to financial models for O&M and capital costs.

* The private sector should not be excluded from the conceptual thinking in using willingness to pay information.

* A full "conventional" WTP study is not always appropriate for all situations and the method chosen should be matched to the community and project concerned.

* As more experience is gained in sanitation and as sanitation becomes a major priority for communities other more usual indicators could be used such as income, education etc to indicate willingness to pay.

* Sanitation promotion and demand creation (as in the commercial advertising sector) directly play a major role in influencing WTP and information and experience concerning this link are only just starting to become available in the sanitation sector.

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SECOND MEETING OF THE COLLABORATIVE COUNCIL WORKING GROUP ON PROMOTION OF SANITATION, HILTERFINGEN, OCTOBER 1994

WILLINGNESS TO PAY October 1994 Derrick Owen Ikin, SKAT

1. Introduction

The aim of this paper is to provide input for discussions on willingness to pay. This input is not an exhaustive study or complete but rather an attempt to put willingness to pay in perspective in relation to sanitation.

Willingness to pay is examined in a societal and sanitation programme context and is then linked to practical examples. The uses and limitations of the willingness to pay studies are also examined. Parallels to the commercial world are made and some rough guidelines are suggested in conducting studies relating to sanitation.

A review of current literature and an assessment of published willingness to pay studies is at present being undertaken by Corinne Wacker for SKAT and some of these finding are used in this paper. In addition feedback was given by the team leader, Mr Jakob Straessle, from a willingness to pay study that is currently being carried out in Benin. This brought into focus some of the successes and difficulties at the operational level.

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Willingness to pay is often taken for granted to mean the people who are said to benefit from a service or facility. However the users are one of many players in the payment game that also includes governments, donors, a municipality, political leaders and the community itself. Willingness to pay is thus applicable to many different people and organisations. This is further complicated by different individual conscious and unconscious perceptions and motives at each level.

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The results are linked to reality by the actual use of the resources/money to take action to improve sanitation ie buy and maintain a toilet or pay for the services provided.

4. Usefulness and aims

usefulness?

* assessing existing projects / countrywide schemes

* linking technology to reality
* sustainable solutions
* input for new projects / programmes
* Funding by the communities at present is the only real solution
* Linking willingness to pay to the community (market) segments can indicate if the systems promoted reach enough people
* limiting risk of failure
* lets people be involved in choices of services and technologies
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* policy input
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currently sought after goals

a) demand led projects
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c) An often misguided belief that poor people can't or will not pay therefore services should be provided. If a service project is thus proposed it will be accepted. (Common with NGOs)

d) Both sides have a sanitation policy and seek common grounds that lead to a willingness to pay (finance) on the part of the govt /donor.

c) Recently pre-conditions to financing are made i.e. revenue collection, social, technology and willingness to pay on the part of the community.

e) Vested interests in promoting a particular technology, product or service. If the proposal meets these "hidden" criteria then it will be financed.

9. Comments on practical experiences

9.1 Benin :

Brief description:

A pre-appraisal of a water supply and sanitation project is in the process of being carried out and the data is presently being analysed. A proposal for a 3 year, US$ 15 million project is being made to DANDA and IDA. The planned phases are as follows:

Phase 1

A) One year for preparatory work including demand assessment, conceptualization, training, institution capacity building and decentralization. Also included in this phase is social promotion that includes WTP surveys as a tool for assessing the demand for water and sanitation services. Relevant socio-economic, environmental and technology data will be gathered.

B) 2 to 3 years of physical implementation: 2 out of 6 regions before a nation wide replication.

Phase 2

Assessment of phase one and based on demand an expansion to whole country.

World Bank pre-financing conditions:

a) Water/sanitation should be sold not free. The WTP study should establish how much could be paid and this would be linked to financial models for O&M.

a) Participation of the Benin government in form of human resources, infrastructure, land for buildings, and Govt salaries (roughly estimated to be 10% of total project costs).

How will WTP and related socio-economic data be used?

The results will be used to taylor the project to the needs and WTP of the users. It will also no doubt influence Government and donor decisions relating to technology choices and services. It will also influence the financial models chosen for O&M costs and the types of systems chosen.

Some initial finding and comments on survey:

The usual survey aspects were taken into account such as random sample, pretesting of questionnaire, training of interviewers and group interview etc.

* What technology to put on the questionnaires was a point of much discussion. The government had the main say but eventually the Mozambique dome (MD) was put on at a price ie F 30.000 instead of the estimated F 10.000. A VIP latrine for F75.000 was also one of the choices given to the users. The high price of the MD was a commercial price that in reality would not apply as it does not take user participation in building and installation into account. It was felt that the cheaper version was less acceptable to the planners because it would mean less money for the project.

* The Mozambique dome was not generally known and it was explained by the interviewer using drawings. A photo of the VIP latrine was shown and this type is generally known. More interest was shown in the VIP than in MD.

This is a problem faced when introducing new choices to users. In this case it is complicated by the high illiteracy rate of the users (80%) and the use of a drawing that generally requires literate skill or training to understand. A picture of the VIP showed a good solid super structure but not the interior. Using pictures of a technology with a verbal description to an illiterate audience could cause problems as generally illiterate people may interprete pictures differently. A Picture test is essential. (No testing with villages was done due to the time constraint of only 1 week for preparation)

* At present only 10% of respondents use a latrine. Traditionally 4 areas were used:

a) bush 90%
b)field 10%
c) rubbish heap was also used.

* The Mozambique dome was chosen by 33% the VIP 52%

The initial results however could reflect a bias towards a cheaper solution rather than a technology. 55% were willing to pay more than F5000 for the Mozambique dome and 46% would pay more than F10.000 for the MD. The average willingness to pay was F18500.

* **About 55% want a latrine and would want to buy one from a private entrepreneur. Only 15% want Government help.** This is seen as an opportunity to involve private latrine producers right from the start of the project.

In real terms the really basic low price may be the only alternative to achieve high sanitation coverage but these products carry a low status: This high coverage probably could also not be achieved through a WB/government project alone. The private sector should be included in the planning at all stages.

General

* The checking of the interviewers was limited to:

a) supervisor and interviewer check (paper check review)
b) group discussions that included the people interviewed (real check)

No double check was carried out as is customary in many similar studies.

* The interviewers were carefully selected, tested and trained. The questionnaires were translated into the local language. A gender balance was a main focus point.

Government participation

* The government already had a policy that listed technologies foreseen to be included in the project. For example the Department of Finance also gave figures of how much people are expected to pay for water i.e. pumps 10% and solar energy 35% . These figures are not related to actual costs of the systems under discussion. This is seen as a serious problem. The government also influenced the selection alternatives to be put to the users. Technical feasibility studies assisted in clarifying the situation.

* Government officials requested that their candidates be used for the job of interviewers but all candidates had to pass the strict selection procedures.

* Government officials participated to a limited extent in training and assisted in defining key terms.

* Government officials were occasionally present as observers during the field work (4 to 5 group discussion out of 54).

Handout:

Information on the Benin Project (World Bank/ DANIDA / IDA)

Bangladesh:

Brief description

The Government of Bangladesh/UNICEF Rural Water and Sanitation Programme has been running for over 18 year with a total investment of about 300 million US$. It is a countrywide programme and the successes are:

a) Over 85 million people now have access to safe drinking water.
b) A WHO survey showed that 90% of all pumps installed are still functioning.
c) Latrine coverage has gone up from below about 3% to over 20% .

Willingness to pay

Some pioneering work was done in Bangladesh in the field of willingness to pay by Martin Strauss (IRCWD) and Skylark Chadha. The survey interviewed 400 families who already had a latrine and 2400 families who did not have a sanitary latrine.

Results

4% can/want to pay Tk 450 or more
27% can /want to pay up range of Tk 250 to 450
69% can pay more than Tk 250
19% cannot pay more than Tk 100
7% cannot pay more than Tk70

Roughly translated in terms of rural water and sanitation programme it meant that over 80% of the population could not afford the subsidised latrines then promoted in the UNICEF and government of Bangladesh programme. The same could be said for most latrines promoted by NGOs. However the 1000 government run latrine production centres and their products played a major seeding role in popularising the idea of sanitation. Private latrine producers set up business and competed with the subsidised government products!

These facts together with numerous other influences slowly led to a change in focus of the rural water and sanitation programme in Bangladesh.

a) The simple and affordable home made pit latrine was professionally promoted and this resulted in massive building of home made latrines (about 40.000 in the Barisal area alone).
b) Sanitation options were now offered.
c) Promotion became a key factor in the sanitation programme linked to affordable products.
d) The private sector was now seen as a potential ally in achieving country wide sanitation coverage.

Ghana: Kumasi

A well formulated study that took great care to cross check questioning methods, choices and linked results to other socio-economic factors. It provided much knowledge on what type of latrines and how much people were willing to pay. It showed that convenience was more

important than community health dangers related to methods of waste disposal.

A colleague recently visited Kumasi and told that he had seen the cleanest public toilets he had ever seen. Public toilets are privately managed and paid for by the users.

Hand out: chapters from " Household Demand for Improved sanitation Services: A case Study of Kumasi", Ghana 1992 no 3 UNDP-World Bank Water and Sanitation Program.

10. Recommendation based on the survey run in Benin: Corinne Wacker (hand out)

* Gender balance
* include bidding on existing options
* include low cost options
* include option to repair current system

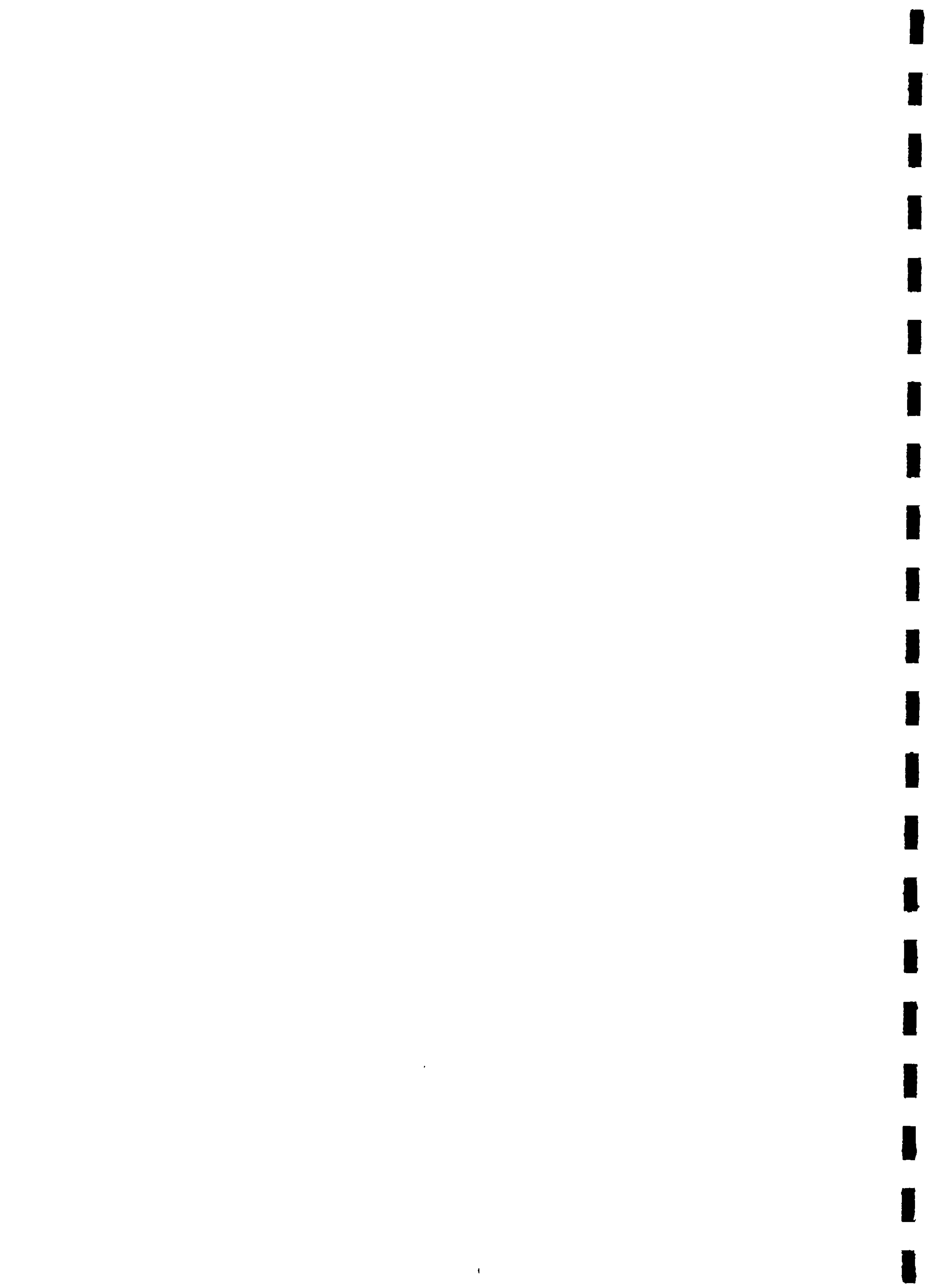
11. Suggestions

* WTP should not be used in isolation. It should be seen in the context ranging from the government to the user.

* WTP should be linked to other basic information and examined in relation to the market.

* WTP should strongly influence the technology/system promoted and linked to financial models for O&M and capital costs.

* The private sector should not be excluded from the conceptual thinking in using willingness to pay information.



SECOND MEETING OF THE COLLABORATIVE COUNCIL WORKING GROUP ON PROMOTION OF SANITATION

HILTERFINGEN, SWITZERLAND

OCTOBER 3-5, 1994

WHAT DO WE KNOW ABOUT THE

POTENTIALS AND LIMITATIONS OF ~~EXTERNAL SUPPORT AGENCIES~~, GOVERNMENTS, AND NON-GOVERNMENT SECTORS

IN SANITATION PROMOTION AND DELIVERY OF SANITATION SERVICES ?

PRESENTED BY: EDUARDO A. PEREZ
USAID / ENVIRONMENTAL HEALTH PROJECT
(formerly the WASH Project)

THE FOLLOWING IS BASED ON LESSONS LEARNED FROM:

* 14 YEARS OF THE WASH PROJECT SUPPORTING USAID PROJECTS WORLDWIDE
* COLLABORATION WITH MANY ESAs AND NGOs
* LEARNINGS OF THE WASSANCO PERI-URBAN WORKING GROUP

SPECIFIC RECENT ACTIVITIES INCLUDE:

* A REVIEW OF WORLDWIDE EXPERIENCES WITH CREDIT FOR URBAN AND PERI-URBAN HOUSEHOLD WS&S

* A JOINT PAHO, WORLDBANK, IDB, USAID/WASH WS&S SECTOR ASSESSMENTS AND SUBSEQUENT POLICY DIALOGUE IN EL SALVADOR AND ECUADOR.

* A REVIEW OF LESSONS LEARNED BY ESAs, NGOs AND THE GOVERNMENT IN BOLIVIA IN PROGRAMMING, DESIGNING AND IMPLEMENTING SANITATION PROGRAMS.

* DEVELOPMENT OF A METHODOLOGY TO MEASURE SUSTAINABILTY OF RURAL WS&S PROJECTS INCLUDING TWO FIELD CASE STUDIES IN BOTSWANA AND INDONESIA

* ONGOING R&D ON THE CHALLENGES OF IMPROVING PERI-URBAN SANITATION.

* COLLABORATION WITH UNICEF / N.Y. ON THE REVIEW OF SANITATION PROGRAMS FROM APPROXIMATELY 40 EXISTING EVALUATION REPORTS.

FUNDAMENTAL ISSUES:

1. LACK OF COMMON DEFINITION OR CRITERIA FOR SUCCESS.

   WASH/EHP DEFINES A SUCCESSFUL SANITATION PROGRAM AS ONE THAT :
   IMPROVES HEALTH, IS SUSTAINABLE AT THE COMMUNITY AND INSTITUTIONAL LEVELS, IS COST-EFFECTIVE, AND INCREASES EFFECTIVE COVERAGE LEVELS

2. A NATIONAL SANITATION SECTOR PER SE IS NON EXISTENT IN MOST COUNTRIES AND IS USUALLY SUBSUMED IN A TYPICALLY WEAK WS&S SECTOR

3. IS THE PARADIGM CONSUMER / DEMAND ORIENTED OR SUPPLY ORIENTED ?

4. CONSUMER PREFERENCE AND WILLINGNESS TO PAY CONCEPTS ARE FUNCTIONALLY INCONGRUENT WITH A SUBSIDIZED APPROACH.

5. THE ROLES AND RESPONSIBILITIES OF NATIONAL WS& S SECTORS IN DEVELOPING COUNTRIES ARE CHANGING FROM SERVICE PROVIDER TO FACILITATOR AND REGULATOR DUE TO TRENDS TOWARD DECENTRALIZATION AND DEMOCRATIZATION

DEFINING THE SANITATION SECTOR ?

	ROLES? : POTENTIALS AND LIMITATIONS		
PLAYERS	Promoting Sanitation (creating demand)	Building & Financing Sanitation Facilities	Changing Health Behaviors
	Urban / Peri-Urban / Rural	Urban / Peri-Urban / Rural	Urban /Peri-Urban /Rural
International Finance Institutions			
Multi-lateral External Support Agencies			
Bi-Lateral External Support Agencies			
International Implementation NGOs			
International R&D/T.A. NGOs & Universities			
Government National Ministry of Health			
Government National Ministry of Public Works			
Government National WS&S Utility			
Regional Authorities			
Municipal Authorities			
National NGOs			
Formal Private Sector			
Informal Private Sector			
Communities			
Households			

WHAT DO WE THINK WE KNOW

* At least in the peri-urban areas, far and above the major player in providing sanitation facilities is the informal private sector financed directly by the households.

* The IFIs, ESAs, and to a lesser degree the International NGOs, significantly determine and even dictate the roles that Governmental and Non-governmental institutions play in both the promotion of sanitation and the provision of services. The roles are therefore largely determined by the coverage target goals of the ESAs and IFIs. The goals of improving health, sustainability and cost-effectiveness are given lip service by the ESAs and IFIs for the most part. The IFI and ESA paradigm is, with a few exceptions, largely supply driven including the imposition of the type of sanitation technology.

* Ministries of Health are run by Medical Doctors whose success paradigm is defined by reducing mortality and not reducing morbidity. Priority is therefore given to curative services such as ORS, building health clinics, etc. Preventive health activities such as sanitation promotion are given very little attention.

* WS&S Utilities are run by Engineers whose primary paradigm is to supply the appropriate technology that meets health and environmental standards. Engineers are uncomfortable "soft technologies" that seek to change people's behaviors and are hostile to a consumer approaches in which households are asked about their current practices, their preferences and what they are willing to pay for.

* "Successful NGO projects often have a narrow definition of success. The majority of "successful" NGO projects are often not replicable, are not sustainable without continued external financial support, reach a relatively small number of families, and have little institutional capacity to scale up.

* A major institutional constraint to effective provision of sanitation services is the conviction that sanitation programs must be largely subsidized to reach the poor. This is crippling to Government agencies and, to a lesser degree, NGOs.

* A worldwide review of sanitation programs with a credit component revealed that government agencies fared dismally in recovering the costs. Some NGO programs have been extremely successful in recovering the funds and in reaching the poor.

* There is an unnatural fit between sanitation projects and government institutions. Responsibility for sanitation falls between a number of government institutions: health, public works, rural/urban development, education, finance, social service. No single institution is equipped to deal with all the requirements of sanitation programs. But reality is that government institutions are notoriously weak at coordinating among themselves.

* Government is not often suited to the marketing approach required for promoting local participation in decision making and in construction and maintenance of the facilities. Many government systems are centralized and local government structures are weak. The continuous link with communities required for sanitation programming does not come easily to traditional government institutions.

* Frustrated by the above realities, donor agencies have increasingly chosen to set up a separate implementing arm for the project (either donor or locally run) or avoid public sector altogether and work directly with non-governmental groups and the private sector. Both approaches facilitate project implementation. However, the projects are almost never sustained after donor funding dries up and their impact on national level capacities building is often limited or even counter productive.

* Existing human resources are a constraint on institutional capacity. Most staff currently engaged in sanitation programs are technically oriented. Expertise is lacking in health, communication and education and institution building. This is true even when the implementing agency is a Ministry of Health. This is also largely true among all of the IFIs, ESAs, International NGOs, local NGOs, research institutions, etc.

* Direct government - donor style projects are often less likely to meet project objectives than projects organized as collaborative efforts between donors, government, local NGO, and the private sector.