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The Role of Health Education and Communication in Sanitation Programmes

by

John Hubley, Barry Jackson
and Thabo Khaketla



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The Role of Health Education and Communication in the Sanitation Programmes

*A case study of the urban sanitation
improvement programme in Lesotho*

by

John Hubley, Barry Jackson
and Thabo Khaketla

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CENTRE FOR COMMUNITY WATER SUPPLY
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P.O. Box 93190, 2509 AD The Hague
Tel. (070) 814911 ext. 141/142
RN: *W 3818*
LO: *304 88RO*

Dr. John Hubley is Senior Lecturer in Health Education at Leeds Polytechnic,
Calverley Street, Leeds LS1 3HE;

Thabo Khaketla is Urban Sanitation Coordinator and Barry M. Jackson
is Urban Sanitation Advisor at the Urban Sanitation Improvement Team
of the Ministry of Interior, Private Bag A41, Maseru, Lesotho

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CONTENTS

Introduction	1
Urban Sanitation in Lesotho	2
Getting the technology right	3
International experiences	5
Communication needs identified for urban Lesotho	8
Developing the health education strategy	9
Involving the health workers	10
Promoting sanitation in schools	10
Development of communication support activities	13

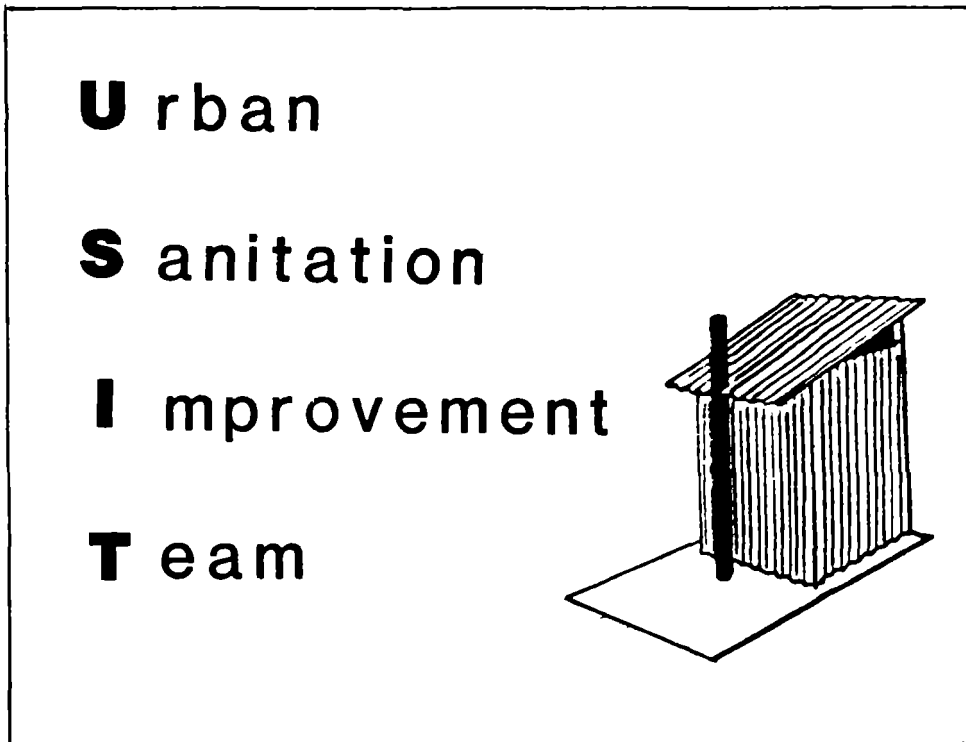
Appendices

1. Problems identified by USIT staff
2. Useful books and information sources
3. Low cost leaflet produced for latrine owners
4. Guidelines on the use of tape-slide programmes

INTRODUCTION

The Urban Sanitation Improvement Team (U.S.I.T.) of the Ministry of Interior in Lesotho is a small group of engineers and field workers working to introduce improved sanitation and health among the fast-growing urban population in Lesotho. In order to generate maximum impact for our small team and achieve health benefits from improved sanitation a sound communication and health education strategy has been essential.

In this paper we will describe the process by which we came to recognize the importance of health education for our work and develop our health education and communication support strategy. We will then describe the different communication methods that we are using and the various learning aids that we have developed. Some examples of our work as well as background reading material and addresses of useful organisations are also provided.



The USIT campaign symbol

URBAN SANITATION IN LESOTHO

Lesotho is a small land-locked mountainous country in Southern Africa with a population of 1.6m. The health profile of the population is dominated by gastro-intestinal and parasitic infections including endemic diarrhoea and typhoid. Tuberculosis, influenza, measles, malnutrition are all common. Life expectancy at birth is estimated at 52 years and infant mortality at 115 infant deaths per 1000 live births.

Globally the WHO have claimed that 80% of the sickness of the world is related to water and sanitation and this global picture also applies to Lesotho. There has been an active water supply programme in Lesotho dating from the early 1970s. Evaluations of health impact on communities showed that improved water supplies was not enough and emphasised the importance of linking water supply programmes with the introduction of sanitation and basic hygiene education.

There is an urban population of 168,000 distributed between the capital Maseru and thirteen smaller towns. Like many developing countries Lesotho has experienced a growth in the urban population. With families forced to live in confined spaces sanitation has become even more important. Many families did not have adequate sanitation. The quality of sanitation in schools was poor and crowded public places such as bus stops and markets had rudimentary facilities. Our surveys showed that only 22% of the urban population had adequate sanitation. Of the 78% with inadequate sanitation 34% have the bucket collection system and 33% have pit latrines which both suffer from problems of flies, smells and greater likelihood of contact with pathogens in faeces. 16% have no sanitation at all and use increasingly contaminated spaces around their homes.

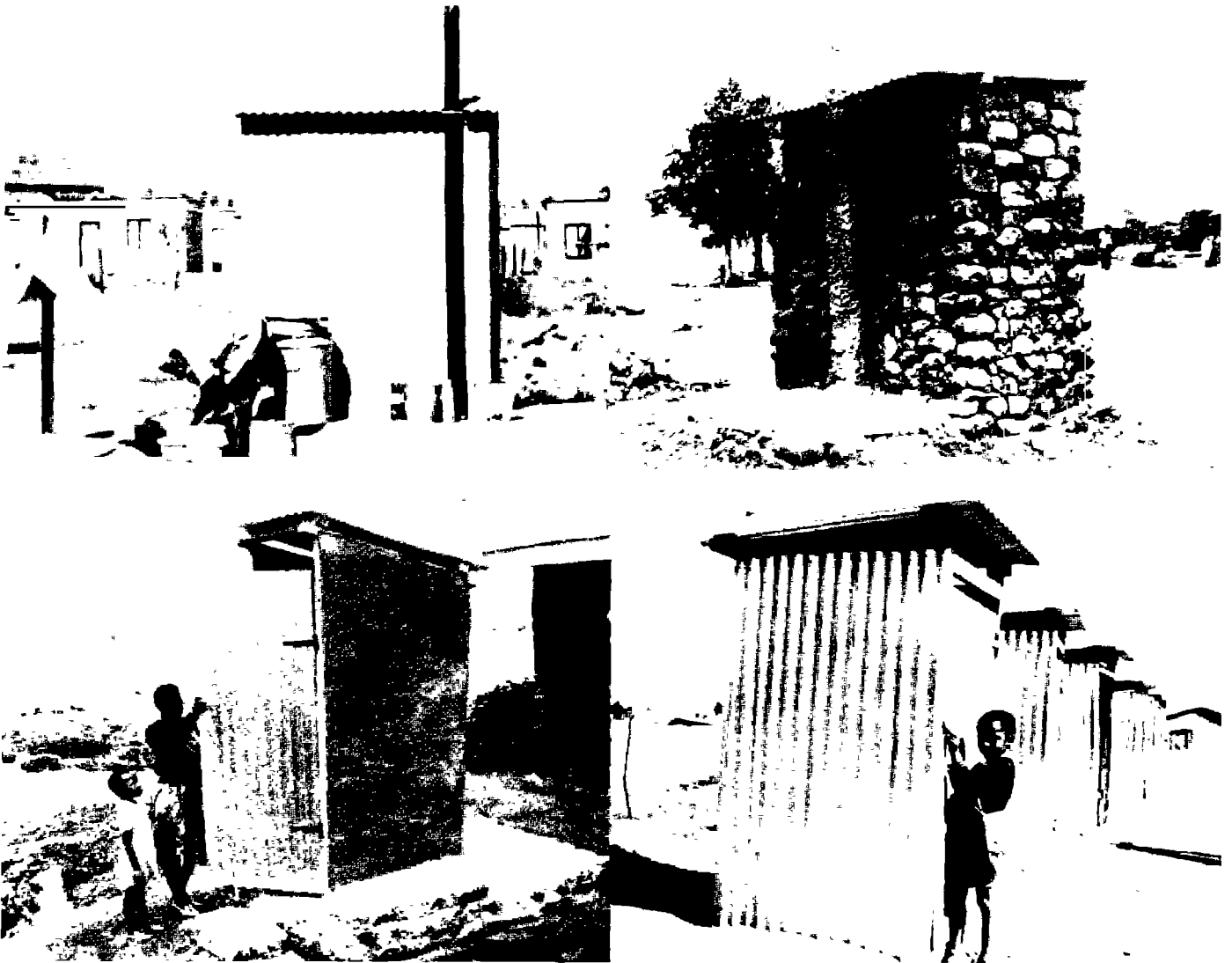
* It was to meet this important need for sanitation that the *
* Urban Sanitation Improvement Team (USIT) was set up in the *
* Ministry of Interior. To tackle this massive problem USIT *
* only had a small team of engineers and community staff *
* based at Maseru. A way had to be found to create maximum *
* impact using a small group of people. *

GETTING THE TECHNOLOGY RIGHT

One of the first priorities was to develop appropriate latrine designs that were effective, affordable and culturally acceptable. Neither the bucket latrines nor ordinary pit latrines are effective in safe disposal of pathogens. There was high status attached to the water flush latrines but the high cost, the heavy water use and the high level of maintenance made these inappropriate. The solution chosen was to adapt the Ventilated Improved Pit Latrine (V.I.P.) which had originally been developed as the Blair Toilet in Zimbabwe and is being extensively promoted by the Technology Advisory Group of the World Bank.

The Zimbabwe latrines were modified to make them culturally acceptable in Lesotho. These modifications included providing seats rather than a squat hole and introducing a door. Local carpenters were already making simple pit latrines out of zinc sheet and wood to be bought at markets and placed over a pit. This existing latrine design was adapted to make a zinc sheet VIP latrine that became widely available at a modest price.

Another type of latrine developed was the twin pit VIP latrine which is more suitable for rocky ground or when a permanent structure is needed. Each latrine has two pits, only one of which is in use at one time and the contents of the other could be emptied by hand after a safe period of time or using special tankers. This principle has been used to design rows of VIP latrines for institutions such as schools and public latrines.



The VIP latrine is the most appropriate form of sanitation for countries such as Lesotho where water is scarce. Both USIT and the Rural Sanitation Project have developed VIP latrines using a wide range of locally-available materials.

COMMUNICATION AND SANITATION - INTERNATIONAL EXPERIENCES (**)

In our monitoring and evaluations it became clear that the programme would have to extend well beyond merely promoting construction of latrines. At the outset it was necessary to carefully analyse the different health education and communication components of our programme to plan our communication strategy. A broad review of experiences in Lesotho and many other developing countries suggested the following components:

Motivation to install sanitation.

When the normal practices has been to defaecate in the open one of the most important tasks will be to motivate the community to use latrines. Considerable sensitivity is needed to uncover what the community feel about using latrines. Common objections to latrines may be unwillingness to share them with other persons, fear of contact with faeces, smells and flies. Other reasons may be the cost either in materials or time of building a latrine. Within this category it is important to separate out the various sub-groups which will require quite different treatment in a communication programme. One subgroup are persons living in their own home, another are persons living in rented accommodation. Another are landlords in urban areas who may see rented property as an investment.

Motivation to up-grade to improved sanitation

Part of the community in Lesotho are already using some form of latrine such as an ordinary pit latrine or bucket latrine. We do not have to convince this group of the benefits of using latrines. Instead the emphasis is put on the advantages of the improved latrines e.g. Ventilated Improved Pit Latrines

General procedures on construction

Once people are motivated to build or improve their sanitation they will want to find out general procedures for constructing the latrines. They must be explained the advantages and disadvantages of various latrine types and helped to make decisions on the design and materials most suited to their needs. They are given plans and lists of builders that we have trained to make the latrines. This communication is directed at householders, community leaders and local officials and persons responsible for institutions where latrine provision is desirable e.g. schools, health centres, markets and other public places.

** The section on international experiences is derived from:

Hubley JH (1987) Communication and health education planning for sanitation programmes. Waterlines vol. 5(3), 2-5.

Detailed procedures on construction

Only a basic level of advice and support is necessary to enable the householder to construct the simple latrine types made out of local mud or thatch using. However detailed advice and technical support is required for more solid and permanent latrines such as the alternating twin pit V.I.P. latrines with stone or cement block superstructure and reinforced concrete slabs. Nothing will bring your sanitation programme to a halt faster than a pit latrine collapsing with someone important inside! The communication approach here is in the form of a latrine construction workshop where all the necessary practical information and skills are provided for constructing latrines. This would include detailed information on materials, construction techniques, following blueprints, choosing sites.

Correct use of latrines

Once the latrines are built they must be used by everyone! Our communication programmes stress the importance of everyone using the latrines. The need for using latrines is explained to older persons and a special effort is made to ensure that children use the latrines. The faeces of very young infants should also be disposed in the latrine. Parents may regard children's faeces as harmless. Children may be afraid of falling into the pit or may have difficulty climbing onto the seat. Parents may lock the latrine for security and children cannot get in.

There may be special requirements according to the latrine type. People in Lesotho prefer latrines with doors and advice has then to be given to close it to keep the interior shaded. Advice is also given on to clean the latrine, seat door handles etc. If disinfectant is used it is explained that it should not be poured into the pit and prevent bacteriological action. It is also emphasised that refuse should not be thrown in the pit or it will fill up too quickly.

Maintenance

A latrine that is not working properly is more of a danger to health than not using one at all! It can undo all your efforts to convince the community of the value of latrines and provide substance for beliefs that latrines are smelly, dirty and full of flies. With V.I.P. latrines, maintenance requirements to communicate include checking of the flyscreen for tears, ensuring that the pit is completely sealed at the base, checking for broken slabs, doors falling off. At the time of first contact with the community it is necessary to carefully explain the need for regular inspection and maintenance.

It is particularly important to explain the need for setting aside funds for maintenance of latrines to schools, health centres, public places and other institutions where the latrines will be subject to heavy pressure of use. Lack of maintenance and repairs is one of the most serious problems in institutional and public provision of sanitation.

Good hygiene practices

Provision of protected water supplies and use of latrines will not on their own lead to improvements in health. It is dangerous to promise the community that all their health problems will disappear once they have started to use latrines. One of the main route for infection lies through direct contact with faecal matter on hands and the general surroundings. Improved sanitation will only lead to health benefits if accompanied by the package of hygiene measures shown below.

```
*****
*
*                               *
*          THE HYGIENE PACKAGE *
*                               *
* washing of hands after using latrine, handling infants *
* nappies, faeces and before preparing food, eating food *
*                               *
* covering of food (especially if there is a time *
* interval between preparation and eating); clean storage *
* of cooking utensils *
*                               *
* clean storage of drinking water and using clean cups to *
* remove water for drinking, avoidance of contamination of *
* drinking water by dirty hands *
*                               *
* cleaning of surroundings, disposal of children's faeces, *
* putting of rubbish into pits, disposal of waste water *
* (sullage) into soakaways *
*                               *
* personal hygiene especially washing of infants, soiled *
* nappies (and disposal of water used to wash them) *
*                               *
*                               *
*          LATRINES WITHOUT HYGIENE WILL NOT IMPROVE HEALTH *
*                               *
*****
```

General health measures

There are a range of general health measures to be carried out by mothers, grandmothers and others looking after the young children. These have not traditionally been considered part of a sanitation programme but are essential if sanitation improvement are to lead to health benefits. These child health measures are mostly concerned with the prevention and control of diarrhoea and include promotion of breastfeeding, discouragement of bottle-feeding, early recognition of signs of diarrhoea and giving oral rehydration solution. But other child health measures are also important such as immunization against childhood diseases especially measles which interact with diarrhoea to make it more serious.

COMMUNICATION NEEDS IDENTIFIED FOR URBAN LESOTHO

The arrival of a health education consultant from Britain provided the impetus for a review of communication needs in urban Lesotho. Two days were set aside for a workshop where all levels of technical and field staff participated in a review of problems and needs. The problems identified by USIT field staff and the solutions that they proposed are listed in Appendix 1 .

Children were not always using the latrines - either because they were afraid to, or the latrines were kept locked. Our latrine programme would have little impact on diarrhoea if it did not ensure that the faeces of children aged under two were safely disposed. A latrine that is not used properly is a danger to health. A particular problem was the maintenance of latrines in public and institutional settings such as schools.

Preliminary data on housing schemes showed that even in situations when all homes had VIP latrines there was still diarrhoea and the clean water supply was often contaminated by the time it was drawn from the water storage containers in the home. The importance of a range of hygiene measures including hand washing, food preparation and water storage became clear. General health measures such as breast feeding, oral rehydration therapy and measles immunisation were needed to obtain the full health benefits from improved sanitation even though these were considered to be the responsibility of other government ministries.

The health education aims identified for the urban sanitation programme in Lesotho are listed below.

- ```

*
* HEALTH EDUCATION AIMS OF URBAN SANITATION PROGRAMME *
*
* motivation of groups with no sanitation to build VIP *
* latrines especially householders, landlords of rented *
* properties, school governing bodies, local authorities *
* responsible for public places, hospital administrators *
*
* motivation of groups with existing sanitation such as *
* bucket and pit latrines to up-grade them to VIP latrines *
*
* encouraging full use of latrines by all members of the *
* household especially children *
*
* ensuring that latrines are cleaned and maintained, *
* flyscreens checked for damage and refuse or toxic *
* materials and disinfectants are not poured down the pit *
*
* encouraging hygiene practices such as hand-washing with *
* soap, disposal of infant faeces, cleanliness of food *
* preparation and clean storage of drinking water *
*
* promotion of child health practices such as oral *
* rehydration therapy for children with diarrhoea and *
* breast-feeding in preference to bottle feeding. *
*

```

**DEVELOPING THE HEALTH EDUCATION STRATEGY**

An extensive health education and communication component was thus needed to complement the technical inputs. On our own, the small size of our team meant that we did not have the infrastructure of field-workers to work closely with community groups in a community participation approach. We had to find ways of maximising the impact of our small team by mobilising agencies and field workers who were already working with communities and could help us promote sanitation and hygiene. The strategy adopted consisted of the following:

- ```

*****
*
*          COMMUNICATION STRATEGY
*
* continual technical development of latrine design, building
* materials, emptying technology etc. to produce designs that
* were as affordable and acceptable as possible
*
* involvement of as many different groups as possible in
* supporting our work and carrying out health education with
* communities e.g. health workers, local urban council
* officials, latrine builders, teachers etc. in promoting
* sanitation
*
* use of our small team of fieldworkers for surveying
* communities, the promotion of a network of demonstration
* latrines and liaison with local fieldworkers in other
* sectors e.g. teachers, health workers
*
* use of radio to spread awareness of the VIP latrines and
* availability of builders who had been trained by USIT in
* construction of VIP latrines
*
* involvement of specialist agencies within Lesotho and
* overseas in the production of a range of educational
* materials e.g. leaflets, posters, tape-slide programmes and
* video to support the different activities described above.
*
*****

```

PROMOTING SANITATION IN THE COMMUNITY

A priority was to build up an infrastructure of local builders trained in the construction of VIP latrines and to publicise their existence using radio and posters. They were also briefed to give simple health education on use and maintenance of the finished latrines. Our field staff worked directly with individual families to develop a network of highly visible demonstration latrines. A simple diffusion process was set up by which interested families would hear of VIP latrines through the radio or from neighbours and either contact our office for information or directly contact a local builder.

INVOLVING THE HEALTH WORKERS

Lesotho is developing an infrastructure of primary health care based on clinics, nurses, health inspectors and health assistants and village health workers. Emphasis has been on primary health care in rural areas although the concept is beginning to be applied in the urban areas. A priority for our small team has been to try and incorporate the promotion of sanitation and hygiene into this emerging urban primary health care structure.

A great deal of our learning materials for the general public are appropriate for health workers but we have also produced a special training programme. This consists of three tape-slide programmes which cover the links between faeces and disease, the different modes of transmission through water, fingers, flies and food, the functioning of the VIP latrine, use and maintenance and the various child care and hygiene measures involved in the prevention of childhood diarrhoea. These are intended to be used over three sessions and a series of starter questions and activities are used to promote active discussion and dialogue.

PROMOTING SANITATION IN SCHOOLS

Many of our schools do not have adequate sanitation. Not only does this have a direct influence on the health of the school child but it severely undermines the credibility of the health education taught at schools and our sanitation work in the community. Earlier attempts to build school latrines ran into problems of inadequate maintenance, poor general cleanliness and a lack of hygiene practices such as hand-washing..

A range of designs for single- and double-pit VIP latrines for schools were developed drawing on World Bank Experiences. Our health education guidelines on use, maintenance and hygiene practices are summarised in the 'Ten Point Programme'. (see Figure 1).

When a school decides to up-grade its sanitation and takes the initiative to consult us, a member of our team pays a visit to the teachers and school managing body and shows a tape-slide programme. This explains fully the decision-making process that they must go through in deciding how many latrines, what designs and how much the materials will cost and what maintenance should be costed in. The importance of hygiene practices and maintenance are emphasised and the Ten point Programme explained. The role of USIT in assisting with plans, inspecting building work and follow-up is described.

Once the building work is completed our staff visit the school and conduct health education sessions with each class explaining the new VIP latrines, the links between sanitation and hygiene and the Ten Point Programme. This is done through songs, a wall chart (Figure 1) and a tape-slide programme 'New Start for Health'.

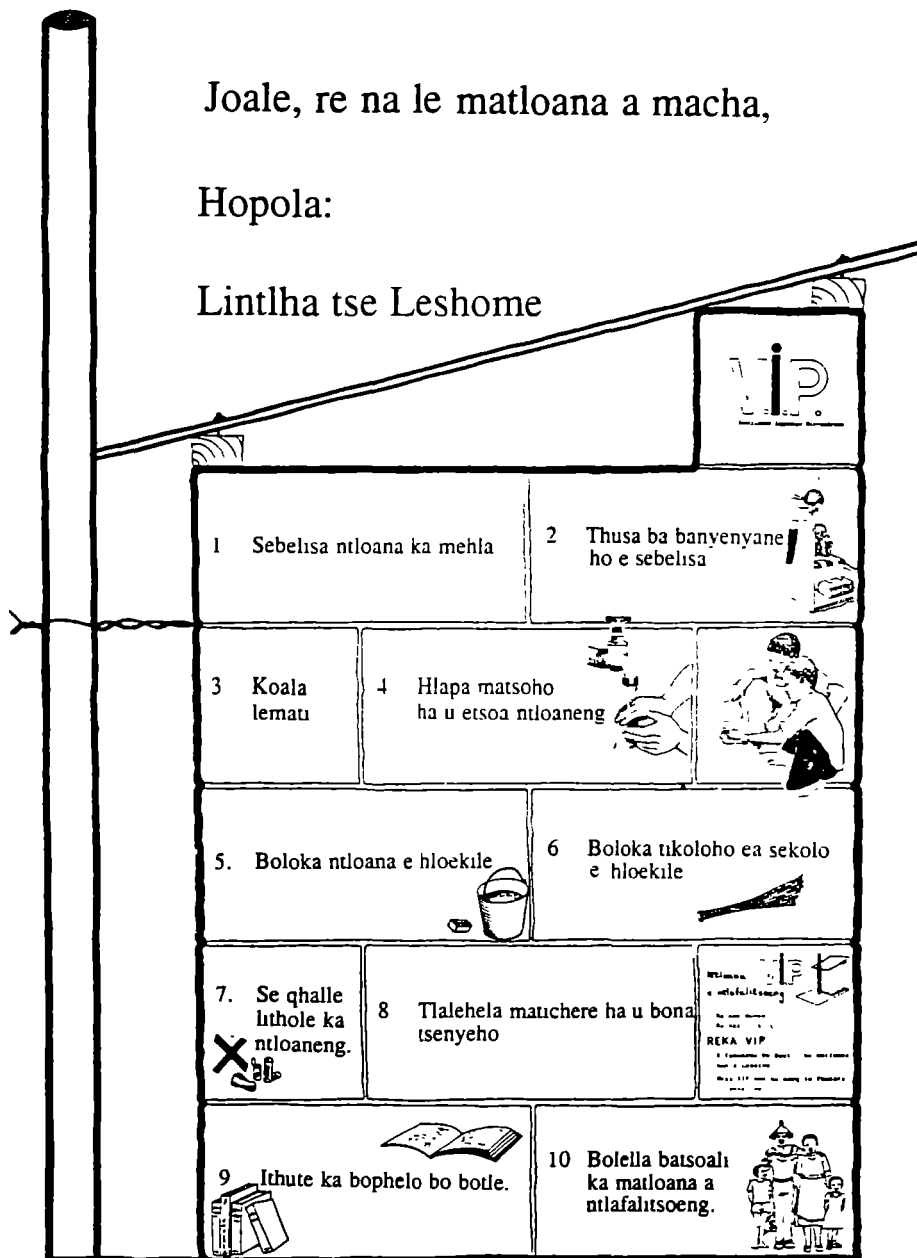
This direct involvement of project staff in schools is necessary at present but our long-term aim is to ensure that health education on sanitation and hygiene is carried out by the teachers themselves. Sanitation and hygiene should not be seen in isolation from other health issues and our staff are now working with curriculum development advisers and teacher trainers to improve the school health education syllabus and the training of teachers.



A nurse explaining the workings of a demonstration VIP latrine to mothers coming to her clinic. The 'Working for Health' tape-slide series was developed as a resource to train health workers in the promotion of sanitation and hygiene in their communities.

Figure 1. THE TEN POINT PROGRAMME

1. Always use the latrine
2. Help others to use the latrine
3. Close the door after use
4. Wash hands after using the latrine
5. Keep the latrines clean
6. Keep the school clean
7. Do not put rubbish into the latrine
8. Report any damage to teacher
9. Learn about health in class
10. Tell your parents about V.I.P. Latrines



DEVELOPMENT OF COMMUNICATION SUPPORT ACTIVITIES

An examination of health education experiences in Lesotho and other parts of Africa suggested the guidelines for effective health education summarised below.

```
*****
*
*          CHARACTERISTICS OF EFFECTIVE HEALTH EDUCATION (1)
*
*
* promotes actions which are realistic and feasible within
* the constraints faced by the community
*
*
* builds on ideas, concepts and practices that people
* already have
*
*
* repeated and reinforced over time using different methods
*
* adaptable, and uses existing channels of communication
* - for example songs, drama and story telling
*
*
* entertaining and attracts community's attention
*
*
* uses clear simple language with local expressions and
* emphasises short-term benefits of action
*
*
* provides opportunities for dialogue and discussion
* to allow learner participation and feedback on
* understanding and implementation
*
*
* uses demonstrations to show the benefits of adopting
* practices
*
*****
```

(1) derived from: Hubley, J.H. (1984) Principles of Health education British Medical Journal 289, 1054-1056.

The development of an extensive range of learning resources was an essential part of the health education strategy. Our field workers were spending a great deal of time meeting local officials, teachers and health workers and community groups. A need was identified for a range of audio-visual materials to help explain the links between water, sanitation and disease, outline different kinds of sanitation and the ways in which our team could work with them.

Some of the communication support activities and media that were produced are listed in Table 1. In selecting learning resources we chose those that were affordable, simple, flexible, capable of arousing interest and generating discussion. All materials were produced in the national language Sesotho as well as English. Radio was a useful way of spreading a simple information to the general public and our staff produced a range of spot announcements and drama programmes. Media such as video and tape-slide programmes require specialised production and viewing equipment but the expense has been justified by making full use of the end products.

The tape-slide programme is a useful medium which can be easily up-dated and modified to suit local audiences by substituting relevant slides. A tape-slide programme preserves the integrity of the message - it does not get distorted or changed when a field worker repeats a teaching session several times in a day. It presents the facts and conserves the field-workers energy for stimulating follow-up discussion. "Caramate" portable tape-slide units and generators were locally available which could be used either for day-light viewing with a small screen or projected on a screen or wall. These have been used for teaching sessions as well as drawing crowds at exhibitions and shows. A copy of the background notes that we have prepared for our field staff on using tape-slide programmes is given in Appendix 4.

Video is a much cheaper medium than film and is particularly valuable for producing locally-relevant programmes. The medium is ideally suited for showing the different stages of construction of a latrine. We were lucky to have access to professional grade video production and editing facilities within the Ministry of Education. We used these to produce an introductory 20 minute programme "Mathabo Builds A Latrine" in which our staff acted out the process of counselling a client ("Mathabo") on the best way of building a latrine and the different production stages were then shown. We have started using a simple domestic video camera ourselves and even these unsophisticated programmes can attract a good deal of attention and form the starting point for a lively discussion.

The print media that have been developed so far have consisted of information leaflets to reinforce the one-to-one advice sessions and various posters and wall charts. Now that health workers and teachers have begun to take an interest in sanitation and hygiene we are starting to develop a wider range of print materials such as flip-charts that they can use in their health education activities within the community. An example of a simple low-cost leaflet produced for householders is given in Appendix 3.

Table 1 **Communication support media for sanitation and hygiene**

poster	to put outside latrine maker's shop to publicise availability of VIP latrines
leaflets	for householders describing VIP and VIDP latrines
video	20 minute programme introducing the VIP and VIDP latrine and how USIT can advise on construction
tape-slide programmes	to: introduce the VIP latrine to the general public introduce the sanitation programme to the officials in each of the towns train health workers in water, sanitation and hygiene brief school health officials on the decisions required to up-grade the sanitation in their school introduce sanitation and hygiene to school children
Wall chart	for use in school classrooms to summarise key points in use of latrines and hygiene
radio	radio spot announcements and short dramas
newspapers	articles and advertisements

Poster placed on door of latrine as reminder

Manamisa kahare lemateng la ntloana ho bala lehlakore lena

**koala
sekoahelo
sa
setuloana**



(close the seat cover)



**hlatsoa
matsoho**



(Wash your hands)



**ruta bana
ho sebelisa
ntloana**

(encourage children to use the latrine)

hopola:

**boloka
ntloana e
hloekile**



(keep the latrine clean)

CONCLUSION

In developing learning resources our aim has been to try and use as many local resources as possible. Assistance was provided by the United Kingdom government who provided a health education consultant at an early stage but our own staff were fully involved in the planning, script-writing and acting. Two of our staff received specialist health education training in Britain and are now fully involved in the production of radio programmes, developing school curricula and learning materials.

In this report we have provided a brief description of only one aspect of a programme involving both technical and communication inputs which are still continuing. The urban sanitation programme in Lesotho is still in its early stages but the V.I.P. Latrine is well established in Lesotho with over two thousand already in use. Much of the success of our work has been due to the emphasis we place on health education and communication support which has enabled a small team to make a significant impact. The lessons learned in the early work have now been put into practice in a recently-established Rural Sanitation Project. An integrated national programme for sanitation improvements is now being developed with health education and communication support an essential component.

ACKNOWLEDGEMENTS

We would like to acknowledge the work put in by all of the technical and field staff of the Urban Sanitation Improvement Team in the Ministry of Interior especially Seetella Makhetha, Mamonaheng Ramonaheng, Mpho Mathebulla, Nomsa Dlangamandla and Manuna Klein. We also thank the Overseas Development Administration of the British Government for technical assistance and WHO for providing a training scholarship in health education.

A P P E N D I C E S

Appendix 1

**STRATEGIES PROPOSED BY USIT STAFF WORKSHOP
FOR OVERCOMING SELECTED PROBLEMS**

	PROBLEM	PROPOSED STRATEGY
A Willingness to Upgrade.	Low priority of sanitation for community compared with other possible expenditure.	Raise priority/status of improved sanitation by action at a national level using respected leaders/mass media etc.
	Low income.	Lower unit cost of sanitation: consider possible subsidies and community action programmes.
	Unwillingness of landlords to upgrade sanitation.	Prepare a promotional package to show actual cost of improved sanitation and possible income. Consider legal measures.
B Use and Maintenance.	Neglect of cleaning.	Emphasise dangers from not cleaning. Increase frequency of message eg at health clinics, other groups. Competitions.
	Seat covers not closed.	Prepare alternative designs without lids.
	Children not allowed to use latrine.	Stress danger of children's faeces. Encourage parents to teach children to use latrine. Explore alternative design eg with second smaller hole. Provide a step.
C Hygiene Practices.	Not washing hands after defaecation.	Continually repeat basic message. Suggest provision of special bucket with soap and disinfectant.
	Poor water handling/storage.	Work through women's organisations, clinics and churches.
	Sullage (waste water) disposal.	Build sullage disposal unit. Educational programme. Continue search for cheaper soakaways.

PROBLEMS IDENTIFIED BY FIELD STAFF/continued

c) **HYGIENE PRACTICES**

lack of convenient water
poor water handling/storage
washing hands - after defecation
 - after handling food
sullage disposal
poor disposal of nappy wash water
indiscriminate defecation by children
indiscriminate urination by children
problems of bottle feeding
covering food (flies)
contamination of weaning foods

d) **DELIVERY PROBLEMS**

builders fail to read drawings
modifications made out of ignorance
lack of building skills
lack of availability of materials
lack of replacement flyscreens
need for better doors/painting/fitting
need for vandal-resistant designs
emptying services.

Appendix 2

USEFUL BOOKS AND INFORMATION SOURCES

Sanitation and hygiene

- Boot, T.M. (1984) 'Making the Links' Guidelines for Hygiene Education in Community Water Supply and Sanitation. International Reference Centre for Community Water Supply and Sanitation. (I.R.C.) P.O. Box 5500 RIJSWIJK (The Hague) The Netherlands
- Feachem, R.G. (1984) Interventions for the control of diarrhoeal diseases among young children: promotion of personal and domestic hygiene. Bulletin of the World Health Organisation. 62(3):467-476(1984)
- Hebert-Simpson, M. (1983) Methods for Gathering Socio-Cultural Data for Water Supply and Sanitation Projects. TAG tech. note No.1, (World Bank)
- Karlin B, Isely RB (1974) Developing and using audio-visual materials in water supply and sanitation programs. Wash Technical Report No. 30, Water and Sanitation Health Project (WASH)/USAID, Washington.
- Perret, H (1983) Planning of Communication Support (Information, Motivation and Education) in Sanitation Projects and Programmes. TAG technical Note No. 2, World Bank
- Perret, H (1983) Monitoring and Evaluation of Communication Support Activities in Low-Cost Sanitation Projects. TAG tech.note No.11 (World Bank)
- Perret, H (1983) Social Feasibility Analysis in Low-Cost Sanitation Projects. TAG tech.note No.5 (World Bank)
- White, A. (1981) Community Participation in Water and Sanitation. Concepts, Strategies and Methods. Tech. Paper Series No.17 (I.R.C.)
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- World Health Organisation (1982) Diarrhoeal disease control - Examples of health education materials. WHO Diarrhoeal Diseases Control Programme, WHO Geneva

General Books on Communication

- Bertrand, J T (1978) Communications Pretesting. Media Monograph No. 6. Communication and Family Study Centre, Chicago
- Hilton D (1980) Health teaching for West Africa - stories, drama and song. MAP International, Illinois.
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- Rogers EM, Shoemaker (1971) Communications of innovations - a cross-cultural approach. Free Press, NY.
- Saunders, D J (1979) Visual Communication Handbook. Teaching and Learning Using Simple Visual Materials. U.S.P.G., Lutterworths, Guildford.
- Treweek C & Zeitlyn J (1983) The Alternative Printing Handbook. Penguin Books.
- Werner D & Bower, B (1982) Helping Health Workers Learn. Hesperion Foundation, Palo Alto, California.

SOME USEFUL NEWSLETTERS/PUBLICATION SOURCES

WATER AND SANITATION SERIES (*)

WASH
1611 N Kent Street (room 1002)
Arlington, Virginia 22209
USA

LOW COST SANITATION SERIES (*)

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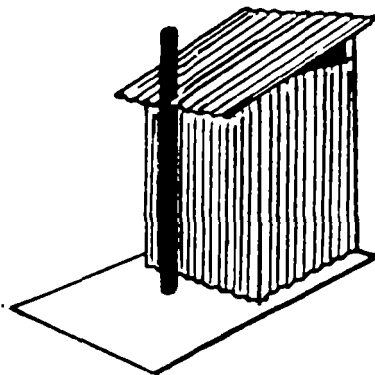
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VIP

Ventilated Improved Pit-latrine



Improved pit latrine

Congratulations! You have shown good judgement in buying a Ventilation Improved Pit latrine (a VIP). This latrine has been improved to reduce the problem of flies and smells. The main improvements are these:

- a cover for the seat
- all the gaps around the seat closed
- all the gaps over the pit are closed
- a ventilation pipe with a flyscreen on top

How does this latrine work?

It takes the smell away:

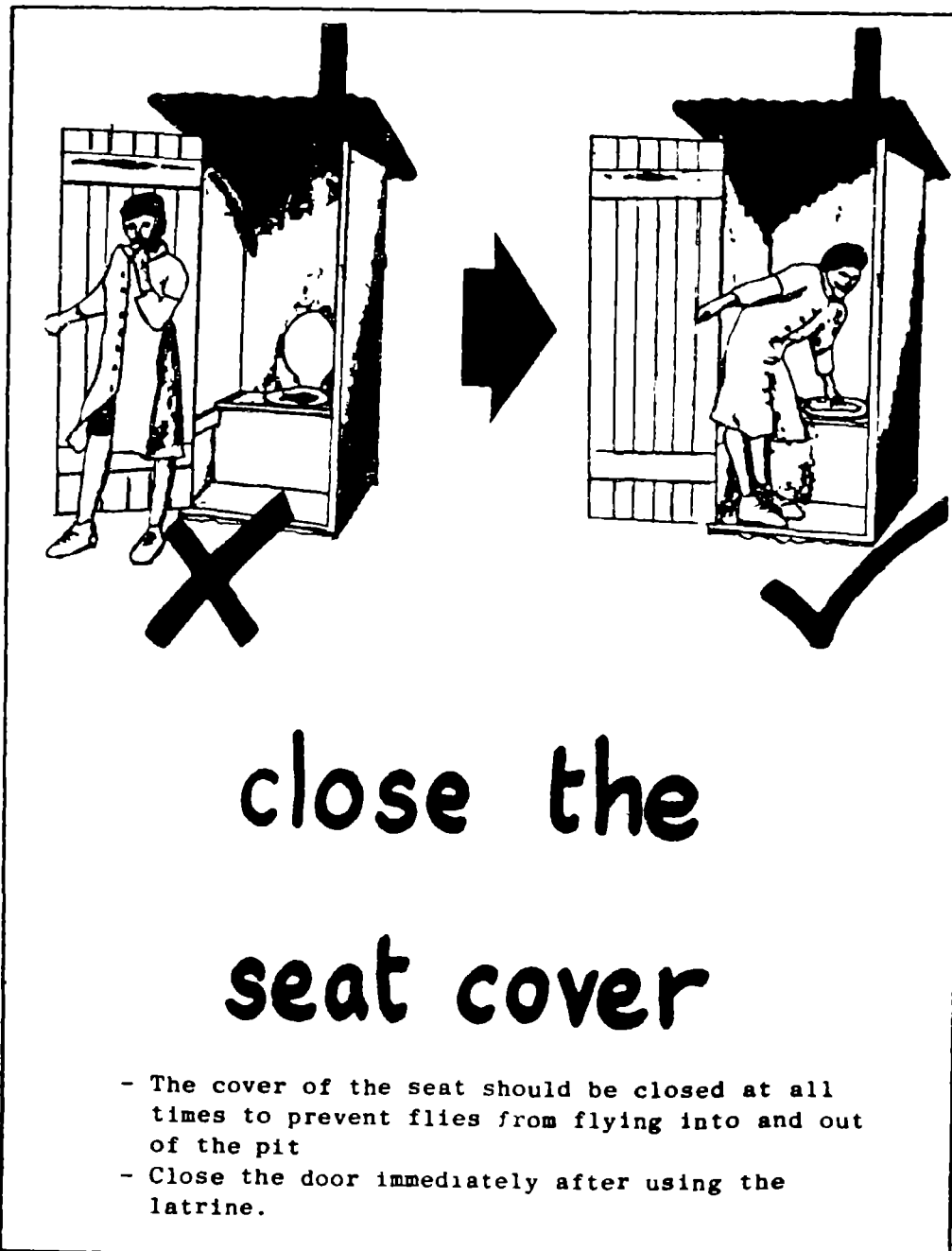
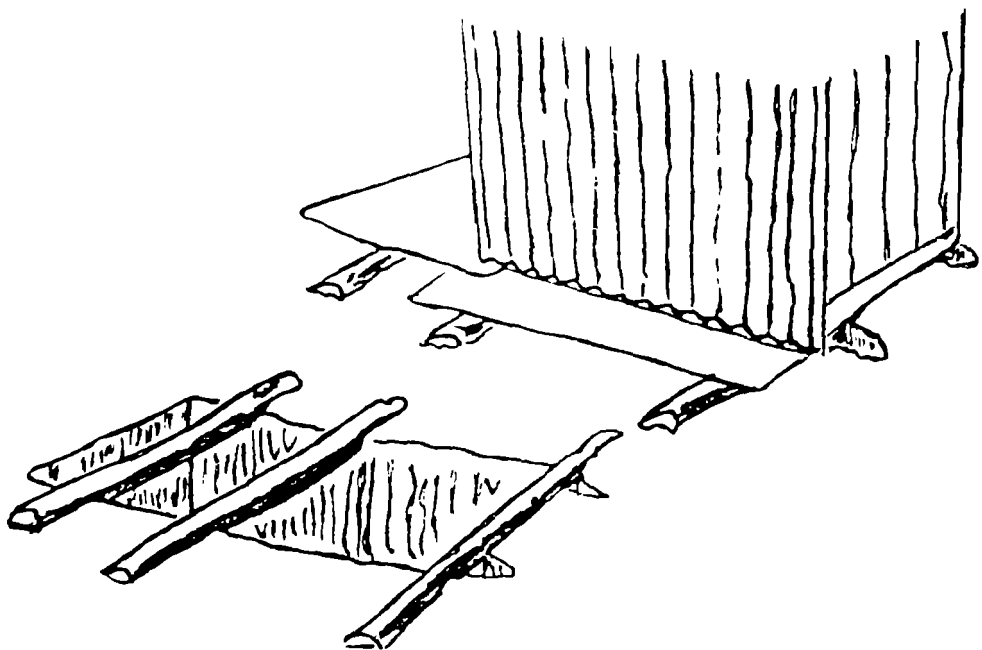
The wind blows across the top of the pipe and sucks the smells out of the pit. Fresh air enters the pit under the seat cover.

It reduces flies:

Flies are kept out by the seat cover and the flyscreen on top of the pipe. If flies get in they will fly up the pipe towards the light (if the seat is kept closed) but they will be prevented from leaving by the flyscreen. They will not fly down again and will die at the top of the pipe.

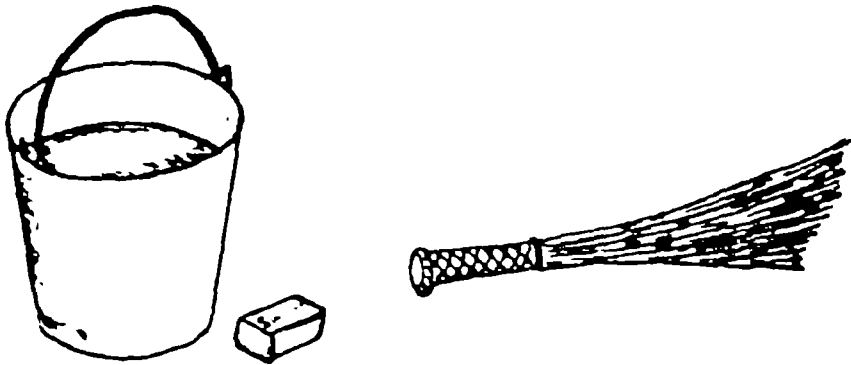
How to build a VIP

- Choose a place in the yard where the soil is deep, away from any spring, borehole or water tap and a place which does not flood.
- Dig a hole about 0.8 metres wide, 1.5 metres long and at least 2 metres deep (even deeper if possible)
- Place the soil from the pit around the pit so that it prevents rainwater from entering the pit.
- Use three strong gum-poles and place them across the pit. Two under the structure above the ground and one under the cover sheet (flat iron) at the back.
- Fit the ventilation pipe in position and make sure that there are no gaps between the pipe and the cover sheet. Close all holes into the pit



- The cover of the seat should be closed at all times to prevent flies from flying into and out of the pit
- Close the door immediately after using the latrine.

keep it clean

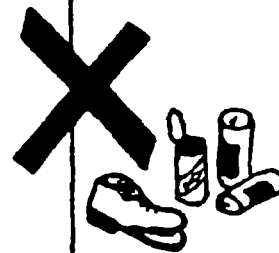


- Keep the inside of the latrine and the seat clean using water and soap. You can throw the water into the pit but not too much.
- Do not sprinkle Jeyes Fluid, Sanpic or anything which is used to kill the smell because this will prevent what is in the pit from decaying (and this will make the pit fill up much quicker)
- It is also NOT necessary to use things to kill the smell, because the smell from the pit will escape through the ventilation pipe.

wash
your hands



Everybody must wash their hands after using the latrine.



no rubbish

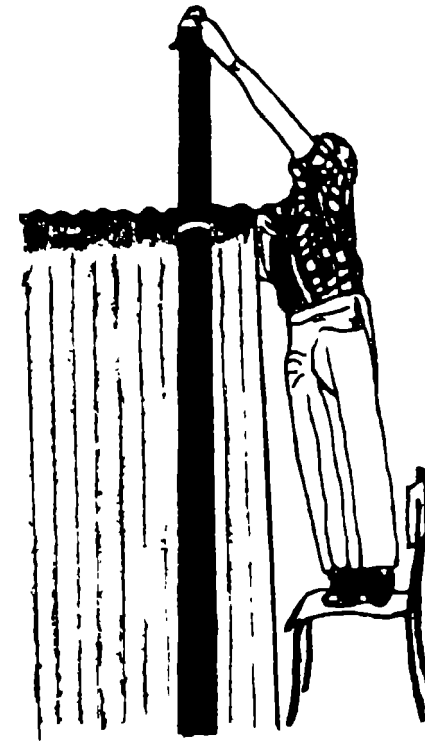
Do not throw stones or rubbish into the pit, these will fill up the pit too quickly.



teach children
to use
the
latrine

Do you know that children's faeces, just like adults' faeces contain the same harmful disease germs?

- Make sure that all members of the family as well as visitors use the latrine.
- If you have children, place a stool or concrete block in the latrine for them to stand on, and fix the door handle low enough for them to reach.
- Empty babies' dirty nappies into the latrine, also the water that is used to wash the nappies should be thrown into the pit.

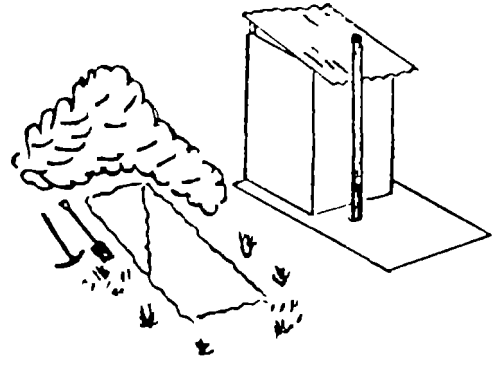


check for holes

- Once every month check for holes inside and outside of the latrine because flies get in and out through such holes.
- Also check to see whether the flyscreen is not broken. This must be done at least twice a year (we recommend that this must be done in Summer as well as in Winter)

structure above the ground in its new position as
and replace them if necessary. Set up the
poles and the wood of the latrine are not rotten
-Cover the full pit with soil, check that the gum-
the previous pits were).
in a line along a fence you will remember where
to it, about 1 metre away (if you make the pits
-When the pit is about 2/3 full dig a new pit near

What Happens When The Pit Is Full?



LESOTHO HEALTH EDUCATION PROJECT

NOTES ON USING TAPE SLIDE PROGRAMME

What is a Tape-Slide Programme?

A tape-slide programme consists of a sequence of slides with a spoken commentary recorded on a cassette. A signal on the tape instructs the tape-slide projector to move to a new slide.

Tape-slide programmes can be played on tape-slide projection units. If these are not available they can still be shown using an ordinary slide projector and cassette recorder. In that case you should have the script in front of you and change slides in the correct place.

One of the advantages of tape-slide programmes is that they are flexible. You can stop them in the middle for discussion or substitute slides for others.

How Tape-Slide Programmes Can Be Used

- 1 Directly as tape-slide programmes with an introduction and follow-up discussion.
- 2 Adapted for the local situation with slides of your own.
- 3 As slides alone with you giving your own commentary. You can include other slides.

Recommended Procedures For Using Sets

- 1 Ask some questions before showing the tape-slide programme to make people think.
- 2 Show the tape-slide programme.
- 3 Ask follow-up questions to check understanding and promote discussion on key points.
- 4 Show key slides again to reinforce points.
- 5 Show the tape-slide programme again to summarise the points.

SOME HINTS ON TEACHING

- Remember - these tape-slide programmes are only learning aids. You are the important person in the teaching process. You can promote effective learning by asking questions, making points and clearing up misunderstandings.
- Read the commentary to the tape-slide programme and carefully look at the slides. If you have locally relevant slides of your own, substitute them for the ones in the set.
- Read the introductory notes and decide how you are going to use the tape slide programme. Choose what questions you are going to ask. Carry out any necessary reading to make sure you can answer them.
- Find out about the participants in the session. Bear in mind their characteristics and special features when you choose your questions and possible answers. Find out how many people will be there.
- Check that you can use the equipment. Make sure that it is working properly and that there is a spare bulb.
- Find out what room you will be using for the session. Even if there is electricity it is best to bring a generator with you. Decide whether you can black-out the room and project the slides on a screen. If there are more than 20 people it is not possible to use the back-projection screen and you must project on a screen and have blackout.
- Use slides to get people to talk about their own experiences.
- Don't tell people what is on the slides. Ask them to comment on what they see.
- Ask open-ended questions that encourage people to discuss issues.
- Let participants discuss points with each other. Encourage different viewpoints. People remember things better if they talk about them.

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