



# Depend or survive — sanitation and hygiene promotion in the Aral Sea disaster zone

Frank Haupt

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**Even communities with little tradition of taking responsibility for their own hygiene and health are willing to take part in projects if they feel they are being taken seriously, and see the possibility of addressing real needs.**

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**B**etween 1996 and 97, as part of a larger water supply investment project, a group known as the Swiss NGO Consortium implemented a pilot programme in the poverty-stricken and environmentally degraded area south of the Aral Sea in Uzbekistan. This project, backed with funds from a World Bank PHRD (Programme and Human Resources Development) grant, was designed to test and develop innovative methodologies for health and hygiene promotion; formulate operational strategies for maximizing community participation in rural areas; and define investment needs for the project overall.

After the end of the one-year pilot period, a project impact assessment found that the number of intestinal diseases in the pilot communities had fallen

significantly, and now the villagers were keen to improve their sanitation practices.

## Knowledge, attitudes and practices

A study into the knowledge, attitudes and practices of the local people found that although the lack of *food* is perceived as the biggest day-to-day problem, they are also keen to improve their health through a safer water supply and more convenient sanitation facilities. Health and hygiene education is typically carried out by hospital workers, at midwife stations, through home visits, and at schools. Although knowledge of health issues is fairly limited, men, women and children are generally familiar with safe hygienic practices and understand that improved sanitation facilities would have a positive effect.

In 1996, most families were found to be using unlined and unventilated pit latrines — poorly constructed and maintained, and often reaching down to the same sub-surface groundwater used for drinking. Handwashing facilities are rare, and pit-emptying facilities are usually out of order and too expensive to restore.

Although the cost of addressing these problems is prohibitively expensive, there are other basic steps (such as more regular toilet cleaning and maintenance) which would have a significant impact. Taking the initiative is unusual, however, as Uzbeks still expect government authorities and health workers to sort out health problems. One of the major challenges for the pilot project is to reverse this dependency and motivate people to assume responsibility for their own health and hygiene.

## Background

In 1991, Uzbekistan became an independent state and began the difficult transition to a market economy. Uzbekistan's economy has suffered greatly from the disruption of traditional trade ties that followed the breakup of the Soviet Union. Economic restructuring has also led to a significant decline in health and nutritional standards, hitting the rural poor (and women, in particular) especially hard.

Conditions are even worse in the mostly agrarian-based region south of the Aral Sea. Most households depend on the rapidly shrinking pensions of the elderly and the disabled. The harsh climate means people rely heavily on irrigation for crop production, a problem exacerbated by the shrinking of the Aral Sea by more than half as a result of its diversion during Soviet times. The effects of this have been devastating — water shortages and sharp declines in soil fertility continue to undermine crop production, the salinization of soils and agro-chemical pollution are widespread, and many families now drink highly saline water from irrigation channels or shallow wells. Poor sanitation practices make the health situation even worse.

Acute respiratory infections (ARI), diarrhoeal and parasitic diseases, tuberculosis, hepatitis A, typhoid and paratyphoid are common. Malnutrition and cholera are also rampant, but their statistical levels are difficult to assess — the accompanying stigma means many cases go unreported. The high infant mortality rate (officially about 30 per 1000 live births) is mostly due to ARI, and diarrhoeal and perinatal diseases.

## A three-tiered approach

Project workers focused on the need to bridge this gap between knowledge and practice through 'social marketing' (see box, below), efforts to increase community participation, and improved training and education. Activities were designed to complement the messages from the marketing campaign, and demonstration pilot latrines, equipped with soap and handwashing basins, were set up. Messages and activities were rotated seasonally to address the more prevalent health concerns at various times of the year. Diarrhoea, skin and eye diseases, for example, were the main themes in the summer months, while autumn and winter campaigns focused on respiratory problems.

Promotional media included newspapers, a bi-weekly project newsletter, radio and television, popular theatre and pop concerts. Project activities were planned in conjunction with popular events such as soccer games and lotteries, and schoolchildren were introduced to hygiene and sanitation issues in games and other fun activities. At the same time, regular meetings were held with various government officials to prepare the ground for changes in health policies.

More direct dissemination strategies were based on the premise that people can best be reached and motivated by addressing the things that matter most in their daily lives, so healthy children, cleanliness, and easing the workload of women became the focus of the project's messages. For example, the slogan 'the cleaner, the easier' was used successfully to target mothers, communicating the idea that cleaner children are healthier children.

## Person to person

Another key strategy was to encourage person-to-person information dissemination, as experienced fellow neighbours can explain the details, implications and possible adaptations of a new product or behaviour more convincingly than project workers. On a similar level, child-to-child learning was employed, taking advantage of the fact that children are effective and enthusiastic communicators, and that they copy and learn from each other more easily than from adults. Child-to-child learning encourages children to participate, and



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Korasub — three generations of Uzbek women. Health and hygiene education must address the things that matter most in their daily lives.

makes a strong link between theory and practice so that things learned at school are immediately put into practice, and the application of new knowledge and skills becomes part of their daily lives. In a group exercise, for example, children can find out and then share with the group how many children in their families have been sick recently, how they have been treated, etc. Then they can discuss these findings, plan subsequent actions and carry them out together, and then evaluate their impact.

## The subsidy scheme

Initially, a voucher system of finance was selected, to confer a sense of participation and ownership by allowing users to select the type of toilet they wanted as well as the most suitable cost-sharing arrangement. The designers hoped that the system would provide more incentives than classic supply-driven schemes and would ensure quality construction of facilities.

However, the plan proved to be too complicated — not only for users but for the fieldworkers and accountants as well. Subsequently, simpler forms of monitoring and subsidies were introduced (see box on page 32).

## Impact

Twelve months after initiation of the project, an assessment carried out by an independent sociologist found that the

### Social marketing

Social marketing in the Uzbekistan pilot programme area was based on sociological surveys designed to answer the following questions:

- What **common ethical values** do community members hold and what is the relative importance of these values?
- What **social, professional, political and other types of group** can be seen in the community and what is the role of each?
- What are the best **channels** (articles, television, posters, traditional healers, etc.) for disseminating the project's message?
- Which **communicative style** (authoritarian, conducive, educative, etc.) will ensure the greatest possible attention to the message and how should its contents be presented?

**Subsidy options**

**Voucher system**

Ninety per cent of the substructure and 50 per cent of the superstructure are subsidized by the project (project cost — approximately US\$100 (around £64) per household). This option proved unpopular because it was too complicated.

**Free slab-plus**

The concrete slab and technical assistance are provided free of charge. US\$40 is given to each household for materials once the toilet has been finished. Administrative costs are relatively low (project cost — approximately US\$50 per household + technical assistance). This option is popular because it provides cash income to households.

**Substructure only**

The substructure is subsidized by 100 per cent, but no subsidy is provided for the superstructure. This option could work best for mobile teams (project cost — approximately US\$70 per household).

**Shared subsidy**

This is a voucher system for very poor areas whereby the government contributes a substantial share in kind (according to its ability), which can be in the form of labour, transport, or materials such as bricks, sand, gravel, and cement. The project contributes basins for handwashing and technical assistance, as well as other items that the government cannot make available. The household provides roofing, labour, and the door.

*References*

Ayşe Kudat et al, 'Needs assessment for the proposed Uzbekistan water supply, sanitation and health project', World Bank, Washington, 1995.

Bailey, Donna et al, *Child-to-Child: A resource book*, The Child-to-Child Trust, London, 1994.

Esrey, Steven A., 'Multi-country study to examine relationships between the health of children and the level of water and sanitation service, distance to water and type of water used', McGill University, Quebec, 1994.

Ewles, L. and I. Simnett, *Promotion Health: A practical guide*, second edition, Scutari Press, Harrow, 1992.

WHO, *New Directions for Hygiene and Sanitation Promotion*, Regional Office South-east Asia, September 1993.

**about the author**

Frank Haupt is a Senior Water and Sanitation Specialist. The project was implemented by a consortium of three Swiss NGOs: Helvetas, the Swiss Red Cross and SKAT.  
Frank Haupt, IC Infraconsult AG, Bitziusstrasse 40, CH-3006 Bern, Switzerland. Fax + 41 31 351 2587. E-mail: <frank.haupt@infraconsult.ch>

number of cases of acute intestinal diseases and diarrhoea had decreased by half. Project planners conclude that the success of the pilot project was due in part to the application of the following lessons:

- Effective intercultural communication involves more than merely translating one language into another. It requires continuous exchange and learning, and sensitivity to the local culture.
- Project organization must be decentralized, and as integrated into community life as possible.
- Household participation must be voluntary; self-motivated/sustained action requires that everyone understands their duties, rights and options. There is no participatory tradition in the project region — so, for example, whilst there are four types of toilet, people tend to choose the same one to conform. Participation must be introduced carefully; this takes time — rigid target numbers, deadlines and fund allocation are inappropriate. This also implies that *people have the right to decide not to invest or participate*.
- Success depends on a change in attitude, not only within the communities but among the fieldworkers. As both groups are accustomed to one-way, top-down communication, the fieldworkers must lead the way.

- Planners must insist on and ensure that quality standards are agreed. These are crucial to the creation of demand.
- Subsidizing schemes must be simple and transparent.
- Health education will be more effective if it is presented in a creative and enjoyable way.

A final lesson from Uzbekistan — before planners implement a pilot project, they must ensure that it can be 'bridged' to the subsequent full-scale programme. In this case, despite the success of the pilot project described here, the failure to establish continuity with the follow-on programme led many of the processes initiated during the pilot to collapse. In cases where there is such a profound gap between knowledge and practice, long-term sustainability can be achieved only if fieldworkers maintain the same level of effort long after the pilot has given way to the regular programme.

Note: For a detailed explanation of child-to-child learning, see *Waterlines*, Vol. 17, No. 1, IT Publications, London, April 1998.