



Information, Education and Communication  
in Water Supply and Sanitation

# Communication Case Studies for the Water Supply and Sanitation Sector

Revised August 1993

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**Sources from which this material was prepared:**

**A Proposal to Eradicate Guinea Worm Disease in Nigeria by 1095** - Global 2000 and UNICEF. March 1989.

**Review of Ghanaian and Nigerian Guinea Worm Eradication Programs** - Carter Center. July 1991.

**Social Mobilization for Sanitation** by Philip Wan - Watsan, newsletter of NGO Forum for Drinking Water Supply and Sanitation. Sixteenth Issue. Jan - March 1993.

**Successful Promotion Accelerates Sanitation Coverage in Bangladesh** - IRC Newsletter 211, October 1992.

**People, Water & Sanitation. What they Know, Believe and Do in Rural India** - The National Drinking Water Mission. 1990.

**A Pilot Project for an Integrated Drinking Water and Sanitation Programme with People's Participation** - by Bharat Gyan Vigyan Samithi. 1993.

**Communication** - A Guide for Managers of National Diarrhoeal Disease Control Programmes - WHO. 1987.

**The Water Utilization Project** - A Case Study on a Water and Health Education Project in Northern Ghana - CIDA. 1990.

**Facts for Life** - A Communications Challenge - UNICEF, WHO, UNESCO. 1989

**All for Health** Resource Book - UNICEF. 1989.

**The Philippine Experience** - Facts for Life (Video) - UNICEF (Richard Stanley Productions). 1990.

**Rural Sanitation in Lesotho** - From Riot Project to National Program - UNDP-World Bank Water and Sanitation Program and PROWWESS. 1990.

**Building on What is There** - Human Resources Development.- Speech of Siri Melchior-Tellier to Collaborative Council Global Forum, Oslo. September 1991.

**Towards Putting Farmers In Control-** Case Study of Rural Communication System for Development in Mexico's tropical wetlands -- FAO. 1990.

**Sharing Knowledge** video film on communication amongst Mexican farmers - FAO. 1991.

**Hie New Delhi Statement.** Global Consultation on Safe Water and Sanitation for the 1990s - UNDP. 1990

**Resource Booklet for Communication in Water Supply and Sanitation** - Information, Education and Communication in Water Supply and Sanitation - Eirah Gorre-Dale, Dick de Jong, Jack Ling. (Draft) 1991.

The advice and support of Dick de Jong (IRC) is acknowledged.

## Introduction

**T**hese case studies in the water supply and sanitation and related fields have been written at the request of the Core Group on IEC. This group is working with a mandate from the Water Supply and Sanitation Collaborative Council, a global forum composed of sector professionals for developing countries, external support agencies and others instigating action in the water supply and sanitation sector. The material forms part of the effort which aims to accelerate water supply and sanitation provision, building on the changing sector approaches which came out of the 1980s. Intensified communication and promotion in and beyond the sector is a key component in this changing process at a local, national and global level.

We can learn from these studies that effective action depends on changes in people; those who make and influence decisions about development priorities and at village level those who change their everyday lives. The cases show that these changes depend on effective communication efforts. They are presented in the following order:

### **1. Campaign to eradicate guinea worm disease in Nigeria and Ghana**

Both Nigeria and Ghana are on course for eradication of guinea worm disease, after a successful campaign characterised by nationwide searches for cases, and by highlighting the socio-economic impact. Internationally, the campaign was boosted by former President Jimmy Carter, who was able to open doors at top level. Nationally, it was characterised by personal communication by national leaders. Communication impact at local, national and global level came together for maximum effect.

### **2. Rural sanitation in India**

In India, millions spent on safe water and sanitation were not having sufficient impact on disease and child deaths. The Government invited UNICEF to find out what people really thought and did about water, revealing a huge gap between sector and people. In some areas the Department of Rural Development now allocates 10% of the sanitation programme to IEC. Although modest in scale, pilot projects are giving people a real voice in planning.

### **3. Promoting safe latrines in Bangladesh**

In Bangladesh efforts to persuade people to build and use safe latrines showed little success. Research showed that campaigns based on health risks were misplaced. Now, the Integrated Approach links the provision of wells to progress on latrines. A national social mobilisation effort has stressed the convenience and privacy of latrines. Families are encouraged to build 'do-it-yourself' latrines if they cannot afford water-seal models. Now at last there is a rapid rise in the provision and use of latrines.

### **4. Diarrhoea! disease control**

The means exist to prevent dehydration and malnutrition in the wake of diarrhoeal disease, which is responsible for up to a quarter of child deaths in the developing world. The challenge is to communicate this to mothers, doctors, nurses and health workers. In many countries the challenge has been met. In Egypt, after a two year communication campaign, 90% of doctors prescribe ORS, and 70% of mothers can correctly mix it. In Swaziland the number of mothers who know how to feed their children after diarrhoea.

### **5. Water and health in Northern Ghana**

An 18-year programme to bring safe drinking water to rural areas was revolutionised by understanding the need for communication. At first boreholes were provided on geological criteria. Then education was attempted, without involving the main users and fetchers of water, the women. Finally a proper assessment was made of the communication challenge and clear messages were prepared and targeted. The outcome is an increase in knowledge, improved village pump maintenance, 5,000 trained community water organisers and safe water for 75% of the rural population.

### **6. Facts for Life in the Philippines**

UNICEF, WHO and UNESCO prepared Facts for Life<sup>1</sup> messages to help parents prevent child deaths and disease. The challenge in the Philippines was to adapt the material to their culture, and to use it effectively. Communication was focused on key people at national, regional and provincial level leading to a mass campaign, using every conceivable method. The result was an effective mass distribution of material, adapted for local circumstances and built into the training of key workers in urban and rural areas. In one of the poorest provinces immunisation rates rose from 12% to 85%.

### **7. Rural sanitation in Lesotho**

A pilot scheme to build 400 VIP latrines in southern Lesotho became a mass national campaign after people in rural areas became so convinced of the benefits that they were willing to pay a month's wages to buy one. Studies of local knowledge and beliefs were used to prepare to train 4,000 village health workers to promote latrine construction and use. The programme became more successful after printed messages were supplemented with personal contact. A study showed that children were healthier in the pilot project area. The World Bank technical adviser was able to withdraw early because the project was secure.

### **8. Improving agriculture in Mexico**

A Rural Communication System in Mexico succeeded where earlier projects had failed, working with local people to improve drainage and production in tropical wetlands. The project used video and other methods to explore what peasant farmers and families wanted and how problems could be tackled. The World Bank calculated that the development project spent 1.18% of its budget on communication, but improved output by 7% more than expected. The World Bank assessed the project as one of the most successful it had supported and said it owed much of that success to the Rural Communication System. Child deaths in some villages were reduced to zero.

Interpreting real life is never easy. The link between cause and effect has to be weighed and estimated. When we see one good result in a programme we may question whether it was due to communication, luck or some other factor. Taking all these cases together however leaves little room for doubt. Whenever communication was neglected the programme went awry; whenever communication was tackled it was put back on course. These cases show that communication is more than just information or education. It is a two way process.

The Voluntary Health Association of India, says: "Ask people about their problems. Elicit their opinions and views. Listen carefully to the answers. These answers are most important for helping you to decide what you want to communicate. Listening helps build trust. Listening helps you identify priorities." •

## 1.1 Campaign to eradicate guinea worm disease in Nigeria and Ghana

**ABOUT 10m people across the world are affected by guinea worm \* a parasite which infects drinking water and can leave its hosts in pain, unable to work and open to infection.**

**Now the fight against guinea worm disease is at a critical point. The 44th World Health Assembly in 1991 unanimously agreed a resolution to eradicate the disease by the end of 1995.**

**Ghana is on target for eradication by the end of 1993, while Nigeria expects to eradicate the disease by 1996.**

**Nigeria and Ghana, had the highest incidence of guinea worm disease in the world, but a campaign to eradicate it is having spectacular successes.**

**Both countries instituted a case by case search and high profile social mobilisation campaigns.**

**In Nigeria the number of cases has fallen buy 76% in four years. In Ghana they fell by 81 % in three years.**

**The results are testimony to a high profile global approach, political commitment at the highest level, and a broad approach to prevention and cure. At every level a communication challenge has been met.**

Guinea worm, disease was for many years under-reported and neglected. Before the international campaign to eradicate it gained momentum barely one case in 20 was known, although guinea worm disease is a major cause of disability and the third biggest cause of tetanus.

The effect on the economy is also devastating. In Nigeria it was estimated that 50 million working days, in the cultivation of rice, cassava and yams, were lost each year, and that children were missing 40 million days a year because of the disease.

The key messages which people need to know and act on if guinea worm is to be eradicated are:

- guinea worm comes from contaminated drinking water;
- infected individuals should not be allowed to bathe in or contaminate water sources used for drinking.
- guinea worm wounds should be cleaned and bandaged.
- drinking water should be filtered or boiled.

Messages have to be acted on at village level, but they need action at national and global level. The campaign needs money to repair wells and pumps, nylon to make filters, training for village health workers, and vehicles and equipment to spread the message. This requires cooperation between donors and government departments.

The major national efforts in Nigeria and Ghana which helped to lay the groundwork for a successful campaign were the village by village search for cases, to build up national pictures. In 1989 village drives identified more than 800,000 cases in the two countries, and showed where they were concentrated. Now village health workers make monthly reports on the number of cases, so that the campaign can be monitored nationally and internationally.

## Campaign to eradicate guinea worm disease in Nigeria and Ghana - 2

Both Nigeria and Ghana reported spectacular results. In Nigeria the number of cases fell by 76% in four years and in Ghana there was an even steeper decline - 81% in three years. In Nanumba District in the Northern Region of Ghana there was a 77% reduction in guinea worm disease in a single year.

For the water industry this has been a challenge on several fronts. Water pumps and wells which had been broken or neglected needed to be repaired, and ways found of ensuring that they were maintained. Whole programmes had to be re-orientated so that villages with a high incidence of guinea worm disease became priority areas for the provision of wells and pumps.

Health education is being tackled on a wide front, through radio jingles, in schools and through village level meetings. In Ghana 10,000 T-shirts with guinea worm messages have been distributed and a survey has been launched to discover exactly what people understand about the disease.

In parts of Nigeria traditional leaders have toured infected villages and UNICEF is supporting workshops for religious leaders to enlist their support.

At national level the role of heads of State and Government ministers has been crucial in focusing attention. In Ghana the Head of State visited 21 endemic villages in the Northern Region soon after the national programme began. In Nigeria the Vice President unveiled commemorative stamps and ordered that local government areas allocate 10% of their health budgets to the campaign.

Sometimes the public gesture was even more direct. The State Commissioner of Health in Kwara in Nigeria watched a guinea worm being extracted and then took the worm with him to show to the military governor of the state. The Governor immediately approved the money for a well.

President Jimmy Carter has been a leading figure internationally in helping to mobilise resources, sometimes able to open doors and gain a hearing when a lower profile approach would have failed. He has been able to act as an ambassador for the campaign, inviting heads of state and government ministers to view a video film outlining the problem and potential for eradication, before discussing what can be done.

The first formal review of the collaborative projects were held at the Carter Centre in Atlanta USA in July 1989. It stressed the need to focus on the endemic areas, and the need to repair wells and to encourage villagers to protect their water supplies from contamination.

Mobilising the community at village level, mobilising Government and local government departments at national level, and mobilising agencies and Governments at international level has set a unique communications challenge. From the figures now being reported, it seems that this challenge is being met. *m*

## 2,1 Rural sanitation programme in India

**IN 1991, India's Department of Rural Development allocated 10% of its rural sanitation programme to IECX**

The decision to give a high profile to communication was reached after the Government of India invited UNICEF to help bring about changes in attitude and behaviour amongst the people; water engineers and planners.

The sheer size of India makes it unlikely that there will be one national solution. Pilot schemes are being launched which involve local people in planning of water and sanitation.

of the Rural Sanitation Programme in India is now being spent on IEC projects.

- This puts \$US 1.9m each year into increasing awareness and understanding of water and sanitation issues at every level from state decision makers to rural villagers.
- The action was taken after a survey showed huge gaps in what the sector thought and ordinary people did.
- Fundamental changes in the practice by water engineers and planners are being brought about by this communication exercise.
- Villagers are ready to take on responsibility for maintaining their clean water supply.

To bring about changes in attitude and behaviour UNICEF needed to know which target group they were trying to reach, what behaviour patterns needed changing and what messages would best bring about those changes.

These questions raised more fundamental ones. What do people already know, believe and do in terms of water use and hygiene?

At the Government's request UNICEF commissioned the Indian Market Research Bureau to carry out a survey of 7,900 people in eight states to find out the answers, using face to face interviews and direct observation. The market research company also talked to those who were implementing the water supply and sanitation programme.

Results were dramatic. On crucial issues there were huge gaps between what those implementing the programme believed, and what those using the water actually did. The survey also showed alarming gaps in people's knowledge about the link between polluted water and disease.

Four out of five people had access to a handpump in their villages. Those implementing the water programme believed that this would be the main source of drinking water for more than half the population. In fact, only a third of those surveyed used it as such. The survey showed a variety of reasons. Some said that the pumps were too far from their homes, compared to dug wells. In a country where family water collectors - usually women - spend two hours a day fetching water this is a powerful disincentive. Others said that it tasted salty, mineralised or medicinal, or that it looked rusty. They judged purity by how the water looked, smelled and tasted. In some cases this led them to choose polluted water from a dug well in preference to safe water from a handpump.

## Rural sanitation programme in India - 2

A quarter believed that you could see 'germs' in impure water, and more than two thirds of women judged the water by whether they thought it 'cooked well'. Implementors had never heard of this concept.

A link between bad water and health problems was recognised, but most people thought that they were at risk of fever, colds, coughs and bad throats. Fewer than one in five understood the risk of diarrhoea and cholera, and 13 per cent believed that bad water could cause malaria.

The survey had identified two important gaps in knowledge.

- \* Those implementing the programme had inaccurate information about how people used the water and what they thought about it.
- \* Most people were seriously misinformed about the real risks of polluted water.

There was a third gap. Implementors believed that people would not pay for the maintenance of handpumps, or contribute towards installation. In fact two-thirds of people said they would be prepared to pay towards maintenance. The survey showed that there was a possibility of the community becoming 'owners' of their water supply.

The survey was completed in 1989, when the Rural Water Supply and Sanitation Programme was already under way. Later an action programme was drawn up by the Indian Government. However, the tradition of state autonomy in India has limited the areas in which a National Drinking Water Mission communication package is being tested. An integrated drinking water and sanitation programme with people's participation is being piloted in eight areas selected from eight districts nationwide. The pilot schemes will cover land and water management, drinking water and sanitation, agriculture and waste land development, the first time that all these elements have been tackled in one project. It involves the formation of participatory groups which allow local people and outside experts to take part in planning.

The India experience underlines the difficulty in making changes on an adequate scale in a country of great size, population and complexity. But it also shows that the problems of change can only be understood when the beliefs, knowledge and attitude of the people are addressed.

Ashoke Chatterjee, coordinator of a series of workshops organised by the National Drinking Water Mission in the Himalayas, to promote communication for community participation and management, wrote afterwards: "The experience as a whole has demonstrated the validity of... emphasis on community participation and management as prime concerns, and the harnessing of NGO initiative to act as catalyst for this process. The Mission's IEC strategy - of communication as a process of self-reliance, and not merely as the production of media materials - has been vindicated. This cooperation has already moved well ahead of water and sanitation IEC into other areas of health, education, adult literacy and wasteland development."



## 3,1 Promoting safe latrines in Bangladesh

**SAFE latrines in Bangladesh have been promoted since the 1960s, were still given tow priority by most people.**

**An integrated approach was introduced, linking latrine construction to the provision of tubewells. Latrines were promoted on the basis of privacy, convenience and benefits for women. These factors, rather than often repeated health messages, were found to attract the majority of the population, With effective advocacy, and the use of powerful allies, the situation has been radically improved.**

### **In Bangladesh**

- + The percentage of rural families with a sanitary latrine rose from 10 - 25% in two years.**
- Use of sanitary latrines rose from 4% to 24%.**
- + Handwashing after defecating rose from 5% to 27%.**

**The Integrated Approach, adopted in target areas, is now being expanded to cover the whole country by 1995.**

**S**afe latrines have been promoted in Bangladesh for nearly 30 years - but until the end of the 1980s they won little acceptance amongst the majority of the population. This was in marked contrast to the success in bringing safe water supplies to villages. Safe water covered 80% of the population while sanitation coverage was only 8%.

Cole Dodge, UNICEF representative in Dhaka, set out to find out why the UNICEF and Government sector programme for the previous ten years had used all its available funds, yet failed to meet a single annual target for sanitation.

Between 1964 and 1978 all of Bangladesh was included in a water-sealed latrine programme, with promotion based on the health and germ theory. However, research showed that, for the 75% of the population who were illiterate, the main attractions of latrines were privacy, convenience, comfort of women and prestige.

To change this mismatch between the sector and the community, a process of social mobilisation was launched.

- Advocacy was used to mobilise senior Government staff, MPs, the media, NGOs and the community.
- The phrase 'pathogen overload' was used to described a situation where every sector of society was prone to water borne disease.
- Politicians and senior government decision makers were told that sanitation was a top priority in the drive against diarrhoea, which accounts for 300,000 child deaths each year.

This advocacy was successful. There was a report that a cabinet minister had appropriated a whole district's production of latrine materials for his own village. While this report showed that action needed to be taken to promote equity of provision, it demonstrated that the ability to construct latrines had become a prized asset amongst those who sought to build political influence.

UNICEF found allies to help promote sanitation.

- The leadership of a village based organisation, Ansars, with four million members, trained its officers in sanitation.
- Islamic clergy allowed a UNICEF communications officer to address 1.5 million people at a religious gathering and to distribute half a millions leaflets on sanitation.
- By 1992 the Prime Minister agreed to launch a logo for the new communication drive at a national rally.

Sanitation promotional material now highlighted women's preferences and cultural values, rather than simply repeating health messages. A strategy for participatory planning was agreed, and courtyard meetings were used to explain the benefits to 25 or 30 families at a time. The popularity of the tubewells programme was exploited. Groups often families had to show that they had installed latrines, before a tubewell would be provided.

At the same time the sector and UNICEF agreed that they would stop promoting one single form of the waterseal latrine as the only hygienic option. Although sold at a subsidised price, this version was still out of reach of many families. A more modest version was designed, less than half the price of the original. A do-it-yourself latrine was also approved. Although not sealed, this was regarded as acceptable option where families would not be likely to install a waterseal latrine. The do-it-yourself pit latrine has a life about five years and can be produced at little or no cost to the family.

This new Integrated Approach adopted in Bangladesh will cover the whole country by 1995. Even before national coverage, the percentage of rural families with a sanitary latrine rose from 10% in 1989 to 26% in 1991.

A recent survey of 10,000 randomly selected families showed good results, compared to 1985. Use of sanitary latrines was up from 4% to 25%.

- Use of tubewell water for drinking reached 92% (up from 80%).
- Handwashing with soap or ash after defecating was up from 5% to 27%.

The survey also showed that there are still challenges to be met in the dialogue between sector people and the community, before communities are convinced about the value of some of the behaviour changes being sought.

- Handwashing before handling food had remained unchanged at 3%.

However in the parts of the programme where coverage had been high, where more than 70% of families had latrines, use of the latrines was reported at over 90%.

The Bangladesh example shows that resources can be used more effectively where the efforts of the sector are closely tuned to the knowledge and beliefs of the community, and where use is made of advocacy, and appropriate and effective allies. The combination of these factors is shown to have brought a real change in people's thinking and behaviour.

## 4.1 Diarrhoea! disease control programmes

**CHILDREN in poor areas of developing countries can expect between six and 16 bouts of diarrhoea in a single year - and millions of children across the world do not survive.**

**According to UNICEF figures diarrhoea) diseases are responsible for over 25% of all child deaths.**

**Most of these deaths can be prevented by good practice in the home and by parents understanding when to seek expert treatment.**

**In Egypt** After 2-year campaign

- **90% of doctors prescribe ORS.**
- + **Mothers' knowledge of signs of dehydration rose from 32% to 90%.**
- **Seven in ten mothers could mix ORS packets correctly.**

**In Swaziland** After 8-month campaign

- **The number of mothers who knew that children needed more special food after diarrhoea, virtually trebled to 44%.**

**in Honduras** After year's campaign

**4 Use of ORS had been unused one year earlier. It rose to 48%.**

**In Nicaragua** After 2- year campaign

- **Use of ORS during diarrhoea episodes in children under six rose from 24% to 43%.**

**T**he key information for parents to act on if their baby develops diarrhoea is to continue to feed the child. For young babies breastfeeding is the best protection against the malnutrition and dehydration associated with diarrhoea. Parents need to know when and how to apply oral rehydration therapy - including how to mix salts and sugars, or to prepare pre-mixed packs of Oral Rehydration Salts (ORS). Parents must also learn to recognise when the life of a child is at risk and when help needs to be sought

Improving the communication skills of those who provide services - doctors, nurses, village health workers, midwives or traditional healers - is an essential part of improving case management at health centres and in the home. Communication efforts aimed at increasing the knowledge, skills and motivation of mothers can be achieved only when people at every stage of the programme are motivated and have the skills to pass on their knowledge.

Communication has a critical impact on the achievement of targets by:

motivating health staff to practice effective case management  
improving the skills of health staff in educating mothers  
improving the prestige of health services motivating  
providers to distribute Oral Rehydration Salts motivating and  
educating mothers.

As our panel shows, the worldwide campaigns to control diarrhoeal disease have achieved notable successes where communication techniques have been introduced.

## 5,1 Water and health in Northern Ghana

**ALMOST 20 years ago the water supply programme in Ghana backed by the Canadian International Development Agency (CIDA) launched the first concerted campaign to bring safe drinking water to rural areas, in eight years it sank 2,700 boreholes and installed handpumps in 1,000 communities.** "

**At first it seemed this was a technical question of getting engineers to drill wells. It soon became clear that communication was as important as technology if changes were to last.**

- Those who attended village education sessions had a 28% increase in knowledge.
- A survey showed evidence that health had improved where communication had taken place.
- Maintenance of pump sites improved by 50%.
- 100,000 people attended water education sessions in 2,000 communities.
- The project now has 5,000 Community Water Organisers, and 2,500 pump sites producing safe water.
- Changes for the better came about when communication targets were clarified and key messages identified.

**T**he Water Utilization Project was launched in 1973 in the two Upper Regions of Ghana, bordering on Burkina Faso, where 1.2 million people live in scattered villages and water and sanitation related diseases are responsible for most illness and death in young children.

The first borehole sites were chosen from census figures based on geological criteria, with little consideration of social factors. It soon became apparent that although pumps were well used in the dry season, many women chose to use unprotected water closer to home in the rainy season.

Over the next 18 years, the programme went through a process of evolution and change. The importance of the role of women in making and sustaining change was only slowly understood. Gradually programme organisers realised that the way that knowledge was brought to a rural village; the way messages were devised and delivered; were crucial to the success of the programme, which has now brought safe water to an estimated 75% of the rural population.

As early as 1976 it was decided to add an educational component to the programme, training village education workers to increase understanding of health and water usage. By 1982 a community education programme had been launched in five districts. This campaign made some gains but there was doubt over how effectively messages were being given, and a recognition that too few women were involved.

In 1983 a comprehensive evaluation concluded that the programme was a qualified success. Each pump was used by 400 rural people, and health had improved, with a reduction in guinea worm and diarrhoea. However it also found that too little attention had been paid to selecting messages, developing effective material and building communication links with other rural programmes.

In 1985 Phase II of Project was launched, with priority given to water and health education and to training community based workers and pump caretakers.

## Water and health in Northern Ghana - 2

Caretakers had been appointed because they had some technical skill. However the most successful pumps did not lend themselves to local maintenance. There were other roles for the caretakers, including collecting a pump tariff from users to cover maintenance costs. Many villagers felt that pumps should be free of charge, but project organizers believed that if people understood the link between clean water and good health, they would pay a levy.

In 1987, the caretaker post was combined with a newly created Community-based Worker to create a single focus for communication at village level. Water Education for Health (WEFH) trained the Community-based Workers to back up Government field-workers at district and sub-district level, and built close links with other agencies. A rapid increase in training was achieved covering 5,300 Community Water Organizers by 1990.

One decision was to narrow the range of the campaign so that the content of each message was clear and gave villagers achievable targets. This lean and clean' approach led Water Education for Health to concentrate on preventing dehydration in children suffering from diarrhoea. This led to a detailed study of the knowledge, attitudes and practices of mothers. Some local remedies such as breast feeding, herbal tea and sugar-salt solutions, were reinforced and oral rehydration salts were promoted, in the hope that effective remedies would naturally drive out ineffective ones (such as mashed cow dung).

Field workers were expected to 'unlearn' technically correct but impractical advice like always boiling water. The aim was "to avoid repeating the same tired messages imploring villagers to be clean and hygienic<sup>5</sup>". Tools included radio, picture books, songs, and dramas. Cassette tapes were prepared by actors improvising dialogue in each of the local languages.

A pilot project in 1986 showed that those who had attended village education sessions had a 28% increase in knowledge. Later evaluation showed that maintenance of pump sites increased by up to 50% after training. During a mass campaign in 1989 approximately 100,000 people attended education sessions in 2,000 pump communities. By June 1990 the project had 5,000 Community Water Organizers at more than 2,500 pump sites. A high proportion of the pumps were delivering safe water. Knowledge of the link between water and disease had increased, and there was evidence that health had improved.

A study prepared for CIDA in 1990 concluded: "Social change does not automatically occur as a result of technical input like the installation of handpumps. Development efforts aimed at improving the quality of life cannot be divorced from appropriate education and a well thought out communications strategy. The experience does serve to emphasize the importance of education and communication in the development of water resources for the urban and rural poor."

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## 6,1 Bringing Facts for Life to the Philippines

**IN 1989 UNICEF, WHO and UNESCO launched Facts for Life -summing up the most important messages for child health, including birth spacing, immunisation, nutrition, sanitation and oral rehydration.**

**Bringing this together in a simple and effective way, was an achievement. The challenge was to communicate it so that the knowledge became part of every family and community.**

**The launch of Facts for Life coincided with a political commitment in the Philippines to put mother and child health issues near the top of the agenda.**

- **A crucial package of Facts for Life was translated into six languages after a personal approach to the President.**
- **Provincial Governors supported the campaign after seeing material with photos of Filipino children, and being told about the child health problems in their own provinces.**
- **Communicators spent days living in rural villages so that they could ensure the drawings and language they used would hit the mark.**
- **In one province immunisation rates rose from 12% - 85% after a massive campaign of information, education and communication.**

**T**he Philippines is a country expressing a wide variety of cultures and languages, and extremes of wealth and poverty. Rowena Guanzon, City Mayor of Cadiz, says that child health problems are the problems of poverty.

"A sense of urgency is what I would really want our people to have, because we seem to be running out of time trying to save children. It is very important that poor people know that they have an alternative. They have an alternative to getting sick, to dying of poverty. They have an alternative to ignorance."

For Dr Pratima Kale, then UNICEF representative in the Philippines, the first task was to convince national leaders that Facts for Life could become their own. She said: "The challenge was not to let the Philippines feel that international agencies had prepared something and that it was their function to accept it. We would have to let them test it, and then accept it if they wanted."

A task force set up to implement mother and child health initiatives invited agencies, including the Departments of Health, Agriculture and Social Welfare and the Education Information Agency, to review Facts for Life. Dr Kale recalls: "The medical profession challenged the technical components; communication experts came in to argue in favour of culture specific material. When we heard that in fact it had been accepted, that was about half the battle won. In each project we go through this process and there comes a time when we have gone over that hump and it becomes theirs, and that's when it becomes very exciting and rewarding."

Winning backing from key agencies was the first communications hurdle. Equally important was political support at the highest level. The task force decided on a direct approach to the President. Dr Kale said: "When President Aquino was there for a ceremony, I presented a set of material that we had prepared, and shared with her a copy of Facts for Life. She seemed very interested and asked us as to how that was to

## Bringing Facts for Life to the Philippines - 2

be brought to every Filipino mother and father, and what about the Tagalog version? The secretary of the Department of Agriculture was with us and then it became really exciting because he agreed to translate Facts for Life into Tagalog and five languages."

The Philippine Information Agency agreed to publish the material jointly with UNICEF. The Department of Health decided to distribute copies to every worker at regional, provincial, municipal and barangay level. The Department of Agriculture asked for 6,000 copies. At national level the programme was going well, but that was no guarantee that the message would reach grass roots. The next step was to enlist the support of regional and provincial representatives.

Dr Kale said: "Like everybody else Filipinos will respond to the information that 40,000 children die every day in the world, but they respond much more dramatically if you relate it to the Filipino situation. If you tell the governor what is happening, or not happening, in his or her province, and the mayor, about how many children are immunised in his or her municipality, that appeals to people."

A communications network was set up to make sure that the messages were properly understood by those who were going to use them. Baniel Lacson, Governor of Negros province, said: "Mayors have to come in and see through the programme. Regular symposiums and workshops have to be established in order that they themselves become the articulator of the programme rather than those asking the questions."

In Negros this approach paid off. Immunisation rates rose from 12 per cent before the joint programme with UNICEF, to 85 per cent today.

Reaching parents effectively means a massive training programme of those who work most closely with mothers; midwives, traditional birth attendants, health volunteers, and teachers. Bituin Gonzales Programme Officer for Ifugao, said: "Very few people really read, even if it is translated into their own dialects. That is where visualising it with a story that brings out the message should come in; or bringing in famous cartoonists or artists. Another way is dramatisation through radio. This has to be done by experts who know local conditions, who have taken the effort to study what would be understandable."

Artists commissioned to produce comic strip stories with Facts for Life messages spent five days in the villages, following midwives on home visits and sitting through classes for mothers, learning to draw peasant women as they were - not in an idealised style. Ely Santiago, one of the artists who went back to the drawing board, said: "We have touched ground. We are communicating directly with rural mothers and families."

The support of political leaders; the training of key implementors; sensitivity to the culture of people who use the material - these are essential steps in the communication chain. Completing this process also takes resources, organisation and commitment. The Philippines experience shows however, that tackling the communication challenge at every level is essential if large scale changes are to be made.

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## 7.1 Rural sanitation in Lesotho

**IN RURAL**, areas of Lesotho only one family in five has a latrine, and children suffer from diseases associated with poor drinking water.

But across the country things are changing, most clearly in villages taking part in the National Rural Sanitation Programme. Here many people have their own ventilated improved pit latrines, most of them well maintained, clean and hygienic.

The latrines were bought and paid for by the families and were built by some of their fellow villagers.

- Poor rural villagers have each invested \$US 75 -150, a month's income, in having their own latrines built.
- People who recently had no latrine now beautify them with pictures, plants and carpets.
- The change came when people understood the role of sanitation in their family's health and welfare.
- A small pilot project was translated into a national programme - through a campaign of education and communication.
- 4,000 rural health workers have become advocates for VIP latrines, built by villagers who earn their living from the project.

In 1975 Lesotho invited donors to collaborate in integrating sanitation into a rural water supply project. The ventilated improved pit (VIP) latrine was arousing interest as an alternative on-site affordable technology. With a mesh filter to prevent flies from getting in, and a vent pipe to take away smells, the VIP latrine works efficiently when properly constructed.

In 1983 a three-year pilot scheme was launched by the Technical Advisory Group (TAG) in the southern district of Maseru's Hoek, funded by UNDP, UNICEF and the Government, to win support amongst rural communities to build 400 VIP latrines.

It would have been possible for experts to build three latrines a week and meet the target. Instead TAG devoted the whole of the first year to building a team, finding the best way to build latrines locally and getting to know local communities. A series of planning workshops allowed local people to review the designs and building methods. Studies were conducted of local knowledge and beliefs and sanitation related messages were integrated into primary health education.

The Government contributed to the cost of organising and training, but not the production of latrines - to be met by families themselves. Local latrine builders (LLBs), would earn their income from making and selling latrines.

The 400 latrine target was easily surpassed - 600 were built in three years, and 90% of these latrines had been fully paid for by householders. Each latrine costs somewhere between US\$75 and \$150, about one month's wages. For families to invest this, they needed to be convinced that they would see significant improvements in their lives.

In 1986 Government decided to expand the project through the National Rural Sanitation Programme, backed by a number of donor organisations and by 1990 all ten



## Rural sanitation in Lesotho - 2

districts had a project - with half the cost met by donors and a quarter each by Government and rural households.

Nationally the programme is handled by a core team supporting district sanitation teams. They win the support of communities through 4,000 village based health workers. District sanitation teams use home visits, community meetings and small group meetings to talk through the issues. Those who have volunteered to become LLBs promote the latrines while the village health workers handle community education and motivation.

The programme goes through five stages, each having key communication issues. They are preparation and education of the team, discussion with village leaders and village meetings, training LLBs and promoting latrines, a period for consolidation during which latrines are built, and a period of monitoring and evaluation.

At first health and hygiene messages were relatively ineffective because they were limited to printed material. As the programme expanded more personal contact was made - particularly with women, emphasising the advantages from making an investment in sanitation and hygiene.

The Theatre for Development acts out realistic stories about the link between sanitation and health. In one village a quarter of households who bought latrines did so after seeing a play.

A study in the first pilot area of Mohale's Hoek in 1988 found that children from families which had latrines suffered far fewer diarrhoeal illnesses than other children, were more healthy overall and were less likely to suffer from malnutrition.

In 1989 the UNDP-World Bank technical adviser was able to pull out ahead of schedule because the programme was so secure.

In many areas the health workers themselves have become latrine builders, seeing strongly the link between sanitation and health.

US AID estimates that 45% of rural households can afford to pay for a VIP latrine, 30% need credit to do so, and 25% cannot afford one without a subsidy. Women's groups are beginning to address this imbalance by exploring ways of organising credit for families.

A Water and Sanitation Discussion Paper published by UNDP- World Bank Water and Sanitation Program and PROWESS, concluded: "Great efforts have been made to increase the awareness of rural residents of the advantages of improved sanitation and to alter hygiene practices to maximise health benefits. The use of participatory education methods has allowed district health assistants and village health workers to reach the people, and changes in attitudes towards sanitation and hygiene behaviour are certainly apparent in those districts with well-established projects."

Communication and training persuaded households to bear the cost of latrine construction, demonstrating the value that rural villagers place on sanitation. H

## 8.1 Rural communication in Mexican agricultural programme

**FARMERS** in the tropical wetlands of Mexico have tried for many years to increase their community income. Agriculture in much of Mexico developed, but they used traditional methods. To succeed land had to be drained and infrastructure improved.

Ambitious plans were launched in the 1960s in Tabasco to drain land, build roads and new villages. These projects concentrated on technology: people were marginalised. The result was resentment, opposition and the comparative failure of the ambitious and expensive Plan La Chontalpa.

- The World Bank estimated that PRODERITH spent less than 1.2% off its budget creating and running the communication system - yet results were 7% higher than expected.
- It named the project as one of the most successful the World Bank had supported.
- The Bank attributed much of this success to the Rural Communication System.
- In one year 6,600 village people watched videos produced by the local communication unit.
- Child deaths, which had been very high in one village, were eliminated after mothers asked for a meeting on water issues.

In the 1970s, when The Secretariat for Agriculture and Water Resources (SARH) looked to the tropical wetlands for an increase in agricultural output, they resolved that this time development would take into account the living and working conditions of rural families, and ensure their participation in planning, conducting and evaluating the results.

Three project areas were established in tropical wetlands, with the aim of increasing production, improving working and living conditions and preserving natural resources. The initial aim was to work with 3,500 farmers, many of them banded together into ejidos - a tenure system which gives individual user rights.

This initiative came to be known as the Programa de Desarrollo Rural Integrado del Tropico Humedo (PRODERITH). It was supported by a World Bank loan and by technical assistance from the Food and Agriculture Organisation (FAO).

The PRODERITH team set up a Rural Communication System to:

- Gain insights into the lives of the farmers, and build up a picture of local communities;
- Support education and training programmes;
- Support the flow of information between agencies connected to the programme.

This was tackled by letting peasant farmers talk on video and on tape, about what they hoped to achieve, and how they thought it could be done. In six years the Rural Communication System produced 452 videos, seen by 117,000 people. The WorldBank calculated that PRODERITH had used only 1.18 per cent of its budget on creating and running the Communication System, but that improvements in production in the target areas were 7% higher than had been planned. It assessed the project as one of the most successful development projects that the Bank had supported. It attributed much of that success to the Rural Communication System.

## Rural communication In Mexican agricultural programme - 2

After 1984 PRODERITH was expanded to nine project areas covering 1.2 million hectares, a period that coincided with a severe economic crisis in Mexico. The reduction in technical support forced changes, to give the community a larger role in communication. The team used communication to:

exchange information between communities; create a consensus over strategy and aims; support training and non-formal education, make the flow of technical information easier, improve the reach and quality of technical messages; foster better coordination between sectors and agencies.

One fundamental aim was to strengthen the capacity for action and management by producer organisations, to ensure that they could secure fair prices for their crops.

In Pujal Coy in the Gulf of Mexico, near the Santa Clara and Tantoan rivers an intensive development zone was created, working with a union of 17 ejidos with a total of just under 1,000 agricultural producers. The area suffered from poverty, and top down development. In the Santa Marta community of 270 families 17 infants died in one summer from contaminated water and poor nutrition. Many drainage ditches were blocked, and the drinking water system did not function properly.

Organisers set up a rural communication unit at the town of Tamuin (RCUT). The aim was to provide training and equipment which would gradually give the communities themselves control of the communication strategy. A video editing unit was installed and playback equipment distributed to local ejidos. Solar powered loudspeaker systems were set up in villages. Training was learning by doing'. Recruits - a balanced number of men and women - made videos about water use, the upkeep of roads and drains as they trained. Courses in graphics, photography and radio production paid attention to the language and expressions of local people.

In one year more than 6,600 people watched videos that the unit had produced, while in Santa Marta child deaths from poor nutrition and polluted water were eliminated, after community meetings were organised. One healthy sign is that local communities are picking and choosing which material they use and when they use it.

Young people coming forward for training need their confidence built up. A report on the project described one nervous young man after training. "Here he was, standing on a platform in a prosperous ejido's meeting room and addressing over 50 much older farmers with all the aplomb and composure of a veteran public speaker."

This new confidence is apparent in the water supply and sanitation sector. Fernando Villareal, director general of the National Water Commission (CNA), said: "We have taken on the responsibility not to begin anything which has not been previously discussed and accepted by the future beneficiaries. This means that we can have more democratic development with increased participation by the rural communities." g