

DRAFT CASE STUDY

SCALING UP SANITATION AND HYGIENE PROMOTION: THE CASE OF KADADABA

INTRODUCTION

The Millenium Development Goal (MDG) sanitation target for Nigeria is 70% coverage by 2015. But over the last decade progress has been poor, and Nigeria is not on track to meet this target. In rural areas sanitation coverage rates have risen just 3%, from 33% in 1990 to 36% in 2004.¹ This target must be met to reduce the toll taken by poor sanitation on Nigerians, and on children in particular. Poor sanitation causes diarrhoea, the second largest killer of children in the country (behind malaria). Diarrhoea not only kills children, frequent bouts of diarrhoea weakens children making them more susceptible to ARI (acute respiratory infection) and to physical and mental stunting. Poor sanitation is also a major contributing factor to low education enrolment and achievement rates, to malnutrition and to poverty as a whole.

Tackling poor sanitation and meeting MDG targets must start with communities. Local solutions, taken to scale, are the only way to ensure a rapid but sustainable rise in rural sanitation coverage rates to improve the lives of Nigerian children and their families. In the northern Nigeria state of Zamfara, the UNICEF and DFID-supported Federal Government of Nigeria (FGN) water, sanitation and hygiene programme is providing the tools to facilitate local action, with encouraging results.

BACKGROUND

Zamfara is one of the Nigeria's poorest states, with a range of socio-economic challenges including sub-standard infrastructure and a lack of basic services. It is in the North West Region, which has the lowest hand-washing rates², the second highest diarrhoea rates and the highest under-five mortality rates in the country. In rural areas the main occupation is subsistence farming and cattle rearing (the presence of a large number of cows in households and communities adds to the sanitation problem). People are predominantly Muslim and the *purdah* system of gender segregation is widely practiced.

The FGN/UNICEF/DFID support to Zamfara state began in 2004 with a range of water- and sanitation-related objectives including water point construction, the promotion of household latrines, and community mobilisation for hygiene

Figure 1: Full sanitation coverage in Kadadaba



promotion. The project also included a WASH in schools component and an extensive capacity-building component for community, local government and state government partners. The main implementing partners were the Zamfara State Rural Water Supply and Sanitation Agency (RUWASSA) and the WASH units of three Local Government Authorities (LGAs): Maru, Tsafe and Bakura.

Two rural communities were selected in each of the three LGAs for community-level intervention, and by 2005 baseline surveys were completed. Specific interventions related to hygiene and sanitation in target communities included:

1. The establishment of WASHCOMs (Community Water, Sanitation and Hygiene Committees)
2. Community action planning
3. Sanitation artisan training
4. Hygiene and sanitation promotion
5. Latrine slab promotion
6. Establishment of school environmental health clubs
7. Provision of IEC materials to state, LGA, communities and schools

One of the six communities, Kadadaba in Maru LGA, is discussed in detail below.

THE KADADABA EXAMPLE

INITIAL PROGRESS

Kadadaba is a predominantly rural community in the Maru LGA of Zamfara state, with a population of 1,300 people in 2006. By July of that year, much had been accomplished in Kadadaba in the area of sanitation through the FGN/UNICEF/DFID project. Most notably, the community embraced the idea promoted through the project of upgrading existing traditional household latrines, making the latrines safer, more child-friendly and easier to maintain.

Slabs were offered to the community initially free of cost during a “promo period” designed to kick start the process. Households who took advantage of this offer were responsible for all other costs, including pit-digging and super-structure construction. Over 90% of the community’s 112 households took advantage of the project’s subsidy scheme to purchase and install the slabs (Figure 3).

Figure 2: Installed latrine slab



However, despite this progress, project appraisals showed that hygiene – specifically hand-washing – had not increased at a similar rate. And while the slabs were popular, there was less enthusiasm in Kadadaba and other communities for purchasing them when the promo period was phased out.

Finally, it was shown that the participation of women in the WASHCOMs and planning discussions was very limited (WASHCOM membership was 100% male).

A MODIFIED APPROACH

In response to these appraisals, a modified approach was developed by the project team. The new approach stressed enhanced community-led planning, the coordination of planning at all levels – community, LGA and state – and improved integration of sanitation and hygiene interventions. Other key changes included the re-design of the WASHCOMs to facilitate the participation of women in *purdah*, better timing of interventions, and the involvement of school children as agents of change for hygiene promotion. Table 1 details the steps taken to re-design the approach.³

Table 1: Intervention Design Modifications

Component	Modification
The establishment of WASHCOMs	Women became WASHCOM members through a mechanism in which women and men hold separate meetings but integrate their reports and actions through the committee Secretary.
Community action planning	State, LGA and community plans were integrated. Each level was made aware of the linkages between all plans and targets. The roles and responsibilities of each level in the partnership were clearly defined and agreed on.
Sanitation artisan training	The number of trained artisans in the community was increased by RUWASSA to ensure that there was local capacity to meet community demand for slab fabrication and construction.
Hygiene and sanitation promotion in the communities	Women representation in the WASHCOM resulted in more women being involved in hygiene promotion as village hygiene promoters. Their brief included encouraging households to build toilets with hand-washing facilities and the proper disposal of animal dung. Village health workers were also trained as hygiene and sanitation promoters, and environmental sanitation events were held every two weeks.
Slab promotion	The slab promotion was timed to ensure that demand was created by the various sanitation promotion efforts, that the financial contribution mechanisms was clearly explained, and that enough slabs were constructed.
Establishment of school environmental health clubs	Linking the school and community components of the larger FGN/UNICEF/DFID project, school environmental health club members were encouraged to carry out community outreach on the importance of hand-washing facilities.
Provision of IEC materials	IEC materials were specifically designed to accommodate the low literacy rates in the region, especially amongst women.

RESULTS

The re-designed project interventions have helped the community of Kadadaba achieve several important results:

Full sanitation coverage: A coverage level of 100% for improved household latrines and hand-washing facilities (Figure 1). The community has achieved open defecation-free status.

Hygiene improvements: As shown in Figure 1, all household latrines now also have basic hand-washing facilities, a significant improvement over the previous period. Hygiene promotion continues to be carried out on a regular basis through hygiene promoters, health promoters and school environmental health clubs both in Kadadaba and more recently in neighbouring communities (see below).

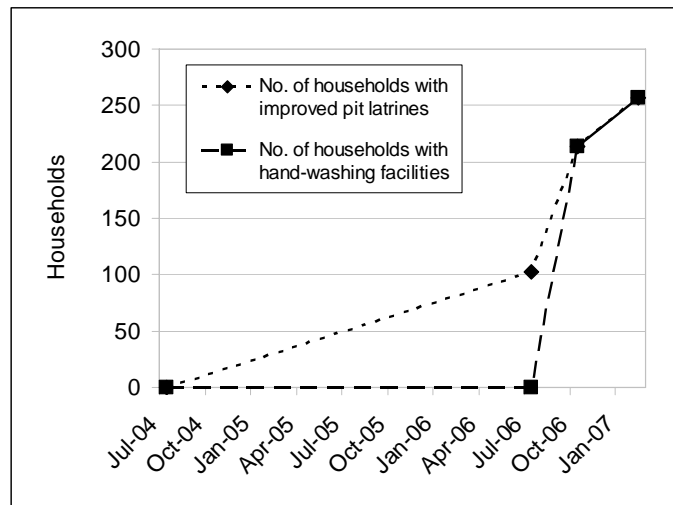
Elimination of subsidies: After the initial promo period (for 40 slabs), households covered – and continue to cover - the full cost of their latrines, including the purchase latrine slabs.

Sustainability: Since October 2006, 43 new households have moved into the community, and all have constructed latrines, conforming to a new Kadadaba bylaw stipulating that all community households must have safe sanitation facilities. The WASHCOM provides support to new householders, while monitoring and enforcing compliance with this rule.

Replication and expansion : The success of Kadadaba has influenced neighbouring communities. With the support of the Kadadaba WASHCOM for training and the latrine artisans (who fabricate and install slabs at a fee of N300 - \$2.4) coverage is now increasing in these communities: Ungwar Tofa (103 households) and Kura Mota (138 households) have achieved 100% sanitation coverage while Jabaka has achieved 88% sanitation coverage. In each case, hygiene promotion is also ongoing.

Community infrastructure: The successful effort has empowered the WASHCOM and community leaders to move beyond household sanitation and hygiene promotion. Kadadaba has now built a three-compartment communal latrine (for visitors) and a community health centre solely with community contributions and labour.

Figure 3: Improved Latrines and Hand-washing Facilities⁴



NEXT STEPS

The Kadadaba experience is serving as the basis for the design of new models for promoting sanitation and hygiene in Nigeria. The Zamfara State Ministry of Planning has identified the Kadadaba model as a viable approach, and has now selected ten communities for replication in the state. The UNICEF-supported programme in Zamfara and beyond will apply and adapt the lessons learned from Kadababa for the benefit of the programme as a whole.

NOTES AND REFERENCES

¹ WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation (JMP). 2006. *Meeting the MDG drinking water and sanitation target : the urban and rural challenge of the decade.* (2004 data set).

² National Planning Commission and ORC Macro. 2003. *Nigeria Demographic and Health Survey (DHS).* (Hand-washing prevalence is indicated by the proxy indicator of availability of water, soap or ash, and a basin in households).

³ The new model is based in part on the “Community Based Health and Hygiene Model”, as described in: Onabolu, B and Ndlovu M. (on behalf of The Mvula Trust). 2006. *A Methodical Approach to Health and Sanitation Integration.* South Africa Water Research Commission Report No: 1380/1/06.

⁴ Data from FGN/UNICEF/DFID baseline figures and assessment reports.