Use Latrine in rural areas, new social norm in response to post emergency and cholera outbreak in Haiti

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1. Sanitation issues and cholera outbreak in Haiti

In both rural and urban areas, access to improved sanitation infrastructure for the management of excreta is extremely low and, over the past decade, has actually been decreasing. Some 24% percent of urban-dwellers and 10% of people living in rural areas have access to a toilet/latrine (JMP 2008) and approximately 30% of the total population in Haiti still practices open defecation (49% of people in rural areas).

To reaching the Millennium Development goal related to sanitation (reducing by half the number of persons without appropriate sanitation) by 2015, Haiti needs to implement sustainable and innovative approaches to reach the 63% targeted rate objective.

Fig 1: Sanitation in Haiti (source MICS and EDH)

This figure reveals the regression of the open defecation with a reduction of 13 points in 18 years: 62% down to 49% in 2008. The January 12 humanitarian disaster has likely worsened this situation with many households with their sanitation facilities destroyed.

Since October, Haiti is experiencing a cholera outbreak for the first time since a century. The figure below shows the cholera outbreak’s evolution since October 2010. The lethal rate is more than 1% (the maximum according World Health Organization -WHO) and reaches some times 5%, that is calamitous.
Rural areas very disadvantaged (insufficiency of safe water access (45% only), very remote areas and far from health centers) are paying the of the cholera outbreak consequences).

2. The behavioral rule: current situation.

Within the cholera outbreak, while carrying out activities of installation of chemical toilets and desludging operations, UNICEF oriented its support towards remote and rural areas to reinforcing the knowledge and the best behavior changes to disadvantaged populations where data reveals that 1 out of 2 people practice OD (open Defecation).

Out of 50 villages identified for a pilot project, Sanitation project has targeted 25 villages in Jacmel area (South Department) to the community response to the cholera outbreak.

With the presence of feces in specified areas, we presume that people do OD as revealed by the UNDP surveys (the same trend that in national level). So, the behavioral rule is people defecate during the night. People are likely very comfortable to do it at this time when they are not seen or identified. These areas are utilized as socialization meetings mainly for women.

Conditional preference (CP): There is no CP.

Empirical expectation: I think that actually others will continue OD.

Normative expectation: No NE. No shame because not everybody is ODF as the large part of population (50%) does. It’s anonymous to OD as it’s done during the night.
Open defecation is not a norm but is an accepted practice. Thus, this harmful behavior is common with the majority of the rural population who defecates in the nature as shown on the above graph.

3. The new social norm: not to open defecation, the ideal situation

The objective (desired outcome) is to have 25 ODF communities in order to contribute to reducing the under 5 mortality and the response to the post emergency and the cholera outbreak response, UNICEF supported pilot project seek to stop open defecation in 25 villages targeted.

For reducing the diarrheal diseases sustainably, it is expected that 100% of all households stop defecating in the nature and utilize appropriate latrines. The threat of diarrheal diseases and cholera outbreaks still exist with the dissemination of vectors transmission through fluids, fields, flies and fingers (F Diagramme after Wagner & Lanoix 1958 in Hunt 2001). Sanitation breaks transmission by preventing the contamination of 'fluids' and 'fields' and via removal of breeding grounds for flies (Wagner, 1958).

3.1 The rule is: Not to open defecation

The rule’s specification is the utilizing of latrine and being aware about the improvement of their immediate sanitation including the safe evacuation of household excreta. The payoffs are the respect, the self-esteem and a safe environment reducing the costs related the diseases contracted by their members of their families. With the project, we plan to support the construction of water point that could be a socialization meeting point in lieu et place of the defecation areas.

OD is an inappropriate behavior with worst results in terms of health and economic issues. To change this inappropriate behavior, we need to shift this to social norms: no open defecation.

The conditional preference: if the group is following the rules of no OD individuals will stop the practice of open defecation.
The empirical expectation: Individuals believe half of people will stop open defecation and everyone will follow the rules.

Normative Expectation: Self think that everyone else thinks self follows the rules to not OD otherwise they may sanction self (shame, self-esteem, stigmatization ….). The benefits of sanitation within communities and household members are disease prevention (less commonly cited), privacy, improved dignity and status, women’s security, children’s safety and comfort. In some rural areas: avoiding the discomforts of the bush; gaining prestige from visitors; and avoiding dangers at night are the main benefits

For ODF through the utilization of appropriate latrine, everybody knows the rules and share the expectation.

So the open defecation free should be a social norm of the whole community. Its interest is to shift from a natural practice (open defecation) to a change behavior. The finality is to eliminate the risk of contamination from pathogenic organisms into fields, foods, fluids, streams, rivers, wells and fingers. This coordinated social change behavior enables a better environment reducing the threat of public health.

With the norm in place, the majority of the population agrees that ODF is the rule. People practicing open defecation are not well perceived and it’s a shame for them. They are not respected and seem to be marginalized persons.

3.2 Theoretic Model (ideal Situation)

With the interdependency of the making decision to practice Open Defecation or to utilize appropriate latrine we have the followings:

Box 2: Current situation with no norms

A: Self Use toilet, Others Use Toilets: 2nd best for as most of population are OD. Their status doesn’t change because few people are using latrines.
B: Self Use toilet and others are OD: the worst situation for Self and the Best for all: no sanction against them.
C: Self OD and others use latrines: The best for self in a better environment where people are OD.
D: Self and others, all OD: The 3rd best solution for all in comparison to the others options.

3.3 The new social Norm: not to Open Defecation

This case occurs likely when the family of self has no interest, no payoffs to ODF. Self has a small advantage by not utilizing latrine while others are ODF.

Box 2: Final situation with new Norm

For the results after introduction of the norms:

**A: All practice the ODF:**
How it is the best result:
All communities utilize latrines. They have a safe environment without feces in the immediate surroundings of households with a substantial gain: reduction of the prevalence of diarrheal diseases at community level. All populations have interest to live in such environment where the well-being is widely shared.

This is the stable Nash equilibrium.

**B: Self ODF, other OD**

The worst for Self who depends on the practice OD of others (the Third best for others). In this case; the result is that the prevalence of diarrheal diseases remains and we have the threat of cholera and it’s not good for self and his action has no positive impact for the environment.

**C: Self OD, Other ODF**
The sanitation environment is the third best for self and the worst for others, if we actually need 100% compliance with ODF. The rule doesn’t seem to apply.

D: Self OD, other DO, All OD

It’s the Worst situation: the entire community suffers of this harmful status with the increase of the threat of diarrheal diseases with the spread of shit in the immediate surroundings communities.

4. Strategies for not Open Defecation

To move from the current situation to the ideal situation, UNICEF supported sanitation programme has launched the Community Led Total approach that is one of the 3 priorities of the WASH Programme Component result (Water treatment, water and sanitation in schools, Scaling up CLTS approach).

The following strategies will contribute to get the social norms.

- Pre visit for the selection of the 25 communities out of the 40-50 identified. Quick review of data to be integrated in this research action as a pilot project, a laboratory in terms of validation of criteria’s that should be the most relevant in case of scaling up this pilot project (no sanitation project, presence of community based organization and leadership, interested in the community approach…). UNICEF will hire an NGO working in the area and very familiar with the conditions of the selected communities;
- Rapid assessment for data collection will be combined with the first pre visit: the quantitative and the qualitative data are required for ensuring a better understanding of the indicators in one hand and in another hand the motivations of such communities. The data collection will namely include questions related their conditional preference, empirical expectation and what individuals thinks the community expects of them. These actions should confirm the behavioral rules and the news norms established;
- A pre triggering visit organized for the preparation of the training for trainers and the triggering of the 25 communities: this visit will ensure the presence of the whole communities including all core groups (women, young, schoolchildren, leaders of community based organization) for a full attendance of all. They have ensured the leadership by adopting the new rule;
- Service delivery through the construction / renovation of water points where population can have socialization meeting and the reinforcement of the construction of Water Sanitation and Hygiene (WASH) facilities; all the core Group can find payoffs with these new community WASH facilities.
- Capacity building of stakeholders through the organization of the a 5 day-workshop with the training 30 CLTS trainers and the triggering of the 25 selected communities during which all steps of the community approach has been implemented. This is a direct communication based on social and emotional issues. Such approach is based on the disgust demonstrated during experiences of the bottle of water and/or the bred besides the feces with flies. It helps to have more evidence and the earlier first adopters to push for changes. Thus, each community during this general have ensured their commitment tu use latrine in the context of cholera outbreak. With a technical support of NGO and the government partners, local problems has been solved through
local solution. It’s also ensured the training of natural leaders trusted for their credibility, involvement and commitment for reinforcing the sensitization at community. Communities with their action plan will ensure themselves the monitoring the status of the not OD. This can contribute to punish, sanction members of communities as agreed in the onset. At district level the partners will contribute to reinforce activities led by local leaders and other core groups re-categorized according their status and respective objectives.

- Empowering of natural leaders, NGO partners and DINEPA: facilitating the adaptation of the mechanism and method of sensitization described in a Manual within the Haitian context. This activity is a way to better collaboration between respective staff who ought to be bridges and partners with communities. The community relays ensure also the role of bridge between the intermediate level and the communities for following the social norms. Communities are also self-organized to set their own rules and modalities of sanctions and payoffs avoiding the discomforts of the bush; gaining prestige from visitors; and avoiding dangers at night and improved dignity and status, women’s security, children’s safety and comfort. In some rural areas and provisions of sanitation materiel for poor people and shame for others who do OD;

- Monitoring and evaluation of the triggered communities: to ensure that the pressure on communities such as sanction with the local committee launched in each communities, supporting the household ready to construct and utilize latrines, a monitoring mechanism shows that at local level 3 identified leaders and 2 community based organization members ensure in each village five visits per week to following the behavioral changes and the respect of the rules. For sustainability and truthfulness reasons, communities do their monitoring.

- Capitalization/Knowledge management with the organization of visit exchanges and workshops with the participation of community leaders for learning more lessons and addressing Reinforcement of the partnership with other local and international NGOs Organization and technical and financial partners for further eventual funding.

- Communication in various manners with core groups : interpersonal , utilization of supports such as drama, poetic, songs, theatre …this communication will take into account the social mobilization by showing ‘’champions households and/or neighborhoods ‘’ to communicate with illiteracies : one or more working group talk with others for comparing various deliberations for a rapid shift from the OD behavioral to the new social norms. That combats pluralistic ignorance and brings Knowledge. It would not be only the official message but the popular and positive messages from the main stakeholders in charge of their own future;

- Programming the triggering of 200 communities supported directly by UNICEF through agreement with NGO. This will be done in the perspective to create a national demand on the perspective of following the social norms rules: no to open defecation that can be a normative expectation for these communities and beyond for all the country;

- Advocacy for supporting the CLTS national alliance for a wider dissemination of the not OD in Haiti. The finality is reaching every community by following the social norms approach.

5. Achievement
As we are in a process, the goal is not fully achieved. However, some important steps have been fully met:

- The renovation of 10 existing water points (an 10 other planned for construction) as entry point to reinforce the behavioral change related the use of latrines at household levels;
- The 25 communities selected on the basis of the criteria set up prior the beginning of the pilot project. Populations participated on the rapid assessment lead by the NGOs and during the triggering 12,000 household ready to construct their own latrines. On month after the general assembly, 80% of populations are using latrine shifting to the ideal situation. The number of cholera cases has been reduced by half in 2 months.
- 500 monthly visits in the 25 communities: the objective of these visits is to monitor the trend of the utilization of latrines in the communities. This is a self-monitoring done by the community where the discussion and the dialogue are the added values;
- 250 natural leaders (10 leaders/communities with at least 5 women for gender approach) trained on monitoring and supporting the sensitization towards their respective communities: theses leaders are bridges to support and to highlight progress achieved;
- 2 radio programs broadcasted monthly by the community radio on the importance of utilization the latrine for getting the valuable payoffs. Intensive and no cost ideas exchange towards all the communities of the areas; populations gain incentives and payoffs by being heard at the local radiobroadcast;
- Partnership launched with other group such as NGOs (OXFAM, Plan, CRS, … and DINEPA) and the Mayor and Municipal Council to disseminate this social norms approach in the country in order to contribute to overcome the cholera outbreak;
- Coordination with the DINEPA that plan to enact the construction and use latrines within a large sanitation programme with the provision of 500,000 slabs in the country;
- The advocacy has contributed the get the commitment of the new President who pledges to make more efforts on sanitation issues: populations are awarded with their commitment recognized by the President;

6. **Constraints to be considered**

- Is disgust a challenge after the traumatism of the January 12 disaster? What is the cholera outbreak with more than 5,600 deaths (700 deaths/week) should be considered a visible sanction, evidence showing the necessity to stop open defecation.
- With the extreme poverty. Is this initiative sustainable? Populations under a certain level of poverty will be supported through the provision of small materiel ale to catalyze their energy for the use of their utilization;
- How does these strategies should be integrated into the DINEPA’s strategy for the construction of 500,000 latrines; this is an opportunity to accelerate the use of latrines and it’s a pride for at least 25% of the total population;
- The role of leadership of the government is be reinforced so the very low unit cost of the CLTS approach (around $15 per latrine) should be widely disseminated and replace the high cost projects with a $500 per latrine. This classic option is definitely less sustainable due to the lack of technical and financial partners committed to fund such initiative without any significant result.
7. Conclusion and Way forward
This pilot project is an opportunity to show the sanitation issues in a poor country affected by various disasters that worsened the situation of disadvantaged populations. The behavioral change is possible by shifting it to a new social norm: to not open defecation, use the latrines to reduce the waterborne and water related diseases.

The Government will reinforce this social norm by enacting the construction of latrines and its use everywhere in the country. UNICEF plans to launch a “Formative study on Sanitation and the marketing social plan”.

This study will respond to the questions related the vision of population to design their own latrines, their motivation and initiate a plan of communication to contributing to reach the desired outcome beyond these 25 communities e.g. 100% of ODF in all Haiti.

With the expected results, this pilot project will providing strong evidence on such approach in the Haitian context: this should enable a better understanding the link of good hygiene practices, namely the safe disposal of human excreta and the diarrheal diseases. Within a strong partnership including major technical and financial partners and the University of Quisqueya, this new social norm enacted by the DINEPA will be highlighted, documented and scaled up.