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For Discussion Only

Programme Communication

for

Water and Sanitation

in

The Socialist Republic of the Union of Burma

Draft Report by
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INTRODUCTION

1. The present consultant's report is the result of a one month (June 1985) study and review of the UNICEF programme of cooperation in Water, Sanitation and Health Education Services in the Government of the Socialist Republic of the Union of Burma. The consultancy was undertaken at the invitation of the UNICEF Representative to Burma, Mr. Antonio A. Hidalgo, and in close collaboration with the Programme Officer for Water and Sanitation, Mr. Steven R. Allen, and the PSC Officer, Mr. Samphe D. Lhalungpa.

2. The consultancy was also undertaken with the consent and support of government officilas with responsibility over Water, Sanitation and Health Education Services in rural and peri-urban areas of Burma, namely: U Myint Maung, Director General, Agricultural Mechanization Department (AMD); U Khin Maung, Director, Rural Water Supply Division (RWSD) of the Agricultural Mechanization Department; U Than Htaik, Director General, Cottage Industries Department (CID) in the Ministry of Co-operatives; U Ba Tun, Director, Public Health, in the Department of Health (DOH); U Lun Wai, Director Planning, Finance, Admin. & Training in the Department of Health; U Myint, Assistant Director, Environmental Sanitation Division (ESD) in the Department of Health; and U Min Swe, Assistant Director, Central Health Education Bureau (CHEB) in the Department of Health. These officials are mentioned here in gratitude for their co-operation.

3. The report is based on information gathered through discussions with UNICEF officers, government officials at central and peripheral levels, extension officers of the

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Department of Health, and participant villagers in the Water, Sanitation and Health Education programmes. It is further informed by readings of relevant documents and personal observations of on-going Water and Sanitation projects in rural and peri-urban settings.

4. This report is by no means an exhaustive document on Programme Communication, Water or Sanitation. It is rather a preliminary reconsideration of some such projects as factors in the pursuit of health objectives, which means, in UNICEF terms, the enhanced survival and development of children and mothers in the Union of Burma. The task is made easier by the fact that there exists a consensus between UNICEF and the Government of Burma on the leading health problems for the population in general and the relationship of these problems to inadequate or unsafe water, poor sanitation and hygiene practices is well-understood.

5. From the UNICEF perspective, programme cooperation in Water, Sanitation and Health Education must ultimately lead to a palpable reduction in mortality and morbidity among the client population. With this in mind, the report identifies some constraints and suggests some possible adjustments in the current practices of programme implementation. One must add that the views expressed in this report do not necessarily reflect the views of United Nations Children's Fund.

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BACKGROUND

6. The UNICEF programme of cooperation with the Government of the Socialist Republic of the Union of Burma covers programmes in the service of Basic Health, Nutrition, Water Supply, Environmental Sanitation, Primary Education and Social Welfare. These programmes are intended to address the priority problems of children and mothers in the country, especially among the rural population. The pursuit of these priorities is delimited by the framework of national development policies and sectoral priorities set out by the Burmese Socialist Programme Party as detailed in the Government's quadrennial development plans.

7. UNICEF assisted programmes by nature and design address problems in the social sector. As is the case in many a developing country, the social sector in Burma has a decidedly low priority for capital expenditures. This much can be gathered from the current fourth four-year plan covering the period 1982-83 to 1985-86. In the allocation of limited resources, it is not unusual for developing countries to favour the agricultural, industrial and trade sectors over others and this is certainly the case in the Union of Burma. One consequence of collaboration within the resource-starved social sector is that UNICEF assistance may be valued - in fact overly valued - as a source of scarce foreign exchange for capital expenditures.

8. UNICEF assistance in Burma as elsewhere includes a substantial allocation for off-shore and local supplies in line with the specified needs of programme and project plans of operations. But the aim has always been to try to arrive at a

healthy mix of supply assistance (SA) and non-supply assistance (NSA) giving some consideration to such factors as organisation, training, communication, monitoring and evaluation in the proper execution of programme and project objectives. As a rule, the programme objectives should create and define the problems and the problems thus defined should determine the appropriate mix of supply and non-supply inputs necessary for their resolution. This is the guiding principle for the following analysis of the Water, Sanitation and Health Education/Programme Communication activities in Burma. The principle is valid - mutatis mutandis - for all other programmes and projects.

WATER SUPPLY AND ENVIRONMENTAL SANITATION

9. UNICEF is one of a number of collaborating agencies in Burma's ambitious programme for the provision of safe water and sanitation facilities during the current International Drinking Water Supply and Sanitation Decade (IDWSSD) 1981-1990. It is the Government's aim to provide access to safe water and sanitary waste disposal facilities to as many as 50% of its population by 1990 and 100% by the year 2000. As of 1980, less than 15% of the rural population of about 27 million and less than 35% of the urban population of about 8 million were said to have reasonable access to such facilities.

10. At the heart of the Government's strategy for IDWSSD is the physical construction of water and sanitation facilities utilizing a variety of technical innovations dictated by the prevailing medley of climatic and hydrological conditions of the country. The mix of technical innovations for water facilities includes gravity flow systems, deep tube-wells,

shallow handpump tube-wells, village group reticulated systems, rain-water collection systems and the rehabilitation or sanitization of old wells. The technical systems for sanitation facilities are similarly varied and include water poured latrines with septic tanks, back pit and direct pit latrines with or without chutes, with or without PVC pans and ferrocement slabs.

11. The government has deployed a large number of national agencies and/or departments belonging to no less than ten different Ministries as implementing, supporting and collaborating agencies in this ambitious water and sanitation programme. It has also secured external support from a number of bilateral and multilateral agencies including OPEC, ADAB (Australia), JICA (Japan), Netherlands, WHO, UNDP, AsDB and UNICEF. The beneficiary communities mobilized through their various State/Division, Township, Village and Ward Councils are expected to play a substantive role in implementing and meeting the decade objectives. A financial measure of the seriousness of this partnership between the government, the external donors and the community is provided in Table 1 of estimated costs for the rural components of the IDWSSD programmes. For comparative purposes, the local currency costs to the Government and the community are represented here in equivalent US dollar figures. One may gather from Table 1 that the total cost for the rural water and sanitation projects estimated at about 172 million are to be shared between the partners in the ratio of 12% from the government, 37% from the communities and the balance or 51% from the donors.

Table 1

Projected Costs for the Rural Components of the IDWSSD Programme in the Union of Burma (1982-1990)

Rural IDWSSD Programmes	Total Costs		Govt. Costs		Community Costs		Donor Costs	
	US$	%	US$	%	US$	%	US$	%
Water Supply	119,579,970	100	18,873,870	16	26,008,200	22	74,697,900	62
Sanitation	52,896,480	100	1,483,000	3	38,072,800	72	13,340,680	25
Total	172,476,450	100	20,356,870	12	64,081,000	37	88,038,580	51

Source: National Meeting on Strategy and Detailed Planning for the IDWSSD, January 6-11, 1982, Rangoon, Burma. Vol. I.

The communities are expected to carry the bulk or 72% of the costs for sanitation projects and the donors will contribute the larger share or 62% of the water projects. A similar breakdown for the urban components of the IDWSSD programmes is not available but total estimates are given as follows: 194 million dollars for water supply and 138 million dollars for sanitation projects. The donors are expected to contribute 180 million or 54% of the total cost which adds up to 332 million dollars. In sum, the combined costs for the IDWSSD programmes in the rural and urban sectors in the country are expected to be in excess of 500 million US dollars. It is massive by any measure and may well take beyond the year 2000 to accomplish.

12. What has been demonstrated so far is the seriousness with which the government, the communities and the donors intend to pursue the IDWSSD objectives in Burma. In fact, there is already considerable progress made in the physical construction of safe water and sanitation facilities. However, it is quite feasible that the achievement of the physical targets i.e. the proliferation of water and sanitation facilities may not result in a proportionate reduction in water, sanitation and hygiene related diseases in the country. Quite simply these facilities are necessary but not sufficient for health. This point will be further elaborated.

13. From a systems perspective, the essential features of the current IDWSSD programme may be reduced to the following inputs, processes and outputs represented in our Model 1. The overall impression may be characterised as a technological determinist's approach to water supply and sanitation problems. If the primary objective were just to increase the

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number of water supply and sanitation facilities, then one would have little argument with the approach. But if the ultimate objective is to reduce the number of water and sanitation related diseases in the country, then, the approach should look more like our Model 2.

Model 1: When facilities are the objectives

INPUT →	PROCESS →	OUTPUT
government resources community resources donor resources	hydrological surveys drilling construction installation	water facilities sanitation facilities

Model 2: When health is the objective

INPUT →	PROCESS →	OUTPUT
safe water facilities sanitation facilities programme communica- tion/health education	utilization utilization new water and sanitation related practices	reduction in water and sanitation related diseases

Granted, the Models 1 and 2 are simple and meant only to demonstrate the possible consequences of the confusion between intermediate and ultimate objectives/outputs, the confusion between means and ends. In Burma as elsewhere, there is present danger that the oversubscribed physical targets of water and sanitation projects will fall short of the ultimate objectives of Health for All (HFA) or for that matter the Child Survival and Development Revolution (CSDR) by the year 2000. It is too easy to loose sight of the health objectives behind the imposing profile of a Failing drilling rig.

THE UNICEF ROLE

14. Given the scale of the IDWSSD programmes in the Union of Burma, it does appear that UNICEF is, but a junior partner and its contribution relatively small to afford significant leverage over the direction of the overall programmes. To illustrate, the UNICEF Plan of Operations for 1982-86 sets aside less than 21 million from general resources and noted funds to cover the expenses for water and sanitation projects over a four-year period. This amount probably represents the outer limit and the actual level of expenditure will finally be determined by the rate of implementation of the planned targets. A summary picture of the UNICEF programme of assistance for water supply and sanitation planned for 1982-86 in presented in Table 2 below in sufficient detail.

Table 2 Summary of targets and estimated cost of activities to UNICEF by source of financing

Technology/Activity	Implementing Agency	Number of systems 1982/83	1983/84	1984/85	1985/86	Total	Source of UNICEF Financing (In thousands of US Dollars) General Resources	"Noting"	Total
1. Rainwater Collection	ESD	10	50	150	300	510	326	-	326
2. Water Supply to Rural Health Institutions/ Schools & nearby communities	ESD	60	60	60	60	240	690	-	690
3. Household & School Latrines	ESD	40,200	80,300	120,500	161,000	402,000	1,491	345*	1,836
4. Gravity Flow Systems	RWSD	1	5	14	15	35	725	546*	1,271
5. Gravity Flow Schemes (Expansion)	RWSD		to be finalised					3,000	3,000
6. Shallow handpump tube wells/manufacture	RWSD	250	750	1,500	1,500	4,000	41	792*	833
7. Handpump Manufacture (Expansion)	AMD/RWSD							1,000	1,000
8. Community Sanitation & Shallow Co-orp wells								1,700	1,700
Deep Tubewells with Power Pumps or Handpumps									
9. Lower Burma Phase I (Rehabilitation)	RWSD	500	500	375	335	1,710	-	666*	666
10. Lower Burma Phase II (New wells)	RWSD	-	-	450	450	900	240	1,906*	2,146
11. Dry Zone (New Wells)	RWSD	600	600	150	150	1,500	6,428	-	6,428
12. Dry Zone Rehabilitation	RWSD	-	-	125	165	290	-	1,008	1,008
TOTAL							9,941	10,963	20,904

* Already approved by the UNICEF Executive Board, but only partially funded to date. Implementation is covered by this Plan of Operations.

Source: UNICEF Plan of Operations 1982-1986

15. In keeping with its rural bias UNICEF collaborates primarily with those government agencies and departments active in rural Burma. The bulk of the assistance for water supply projects is channelled through the Rural Water Supply Division (RWSD) of the Agricultural Mechanisation Department (AMD) in the Ministry of Agriculture. RWSD is a specialised technical agency with a characteristically narrow engineering approach to the problem of water supply. Undoubtedly, it is an efficient agency able to move well-equipped and mobile teams of engineers, drillers and mechanics from village to village with a single aim: to bring the water to the surface. RWSD, like other agencies in Burma is centrally administered from Rangoon though it does maintain outlying stations to support its mobile teams. It maintains a training centre for its staff in the town of Meiktila and sends a few abroad for further training courtesy of the Governments of the Netherlands and Australia. Virtually, all RWSD sponsored training programmes are designed to enhance the technical skills of the staff.

16. UNICEF cooperation with RWSD/AMD includes a mix of water supply systems spread around the country. Prominent among these are the gravity flow system in the hills of Chin State, the so-called "3100" deep tube wells in the dry zone comprised of Sagaing, Mandalay and Magwe Divisions and the shallow tube wells in Irrawady and Pegu Divisions of lower Burma. Progress against planned targets in all of these projects is slow but steady. The critical factor is said to be shortage of manpower in RWSD/AMD. UNICEF has employed about ten engineers to work on the gravity flow systems. It is, however, understood that such an arrangement is rare and replication in other areas would run counter to prevailing government policy.

17. In a recent expansion of the water supply and sanitation programme, UNICEF has begun collaboration with the Cottage Industries Department (CID) in the Ministry of Co-operatives. In view of the strategic position occupied by the Co-operatives in Burma, UNICEF alliance with the CID is potentially a productive one. The CID project, still in its early stages, is meant to provide shallow tube well water supply systems and sanitation facilities in a compact and crowded area within the perimeters of Rangoon. The compactness and proximity of the project area to Rangoon proper, the development capital of Burma, contribute to its suitability for an integrated social marketing approach to service delivery. Mere proximity to Rangoon is likely to make it one of the more visible development models of the UNICEF programme of cooperation in the Union of Burma. It would be irresponsible to equate visibility with replicability and one hopes the project will not become another showpiece of development tourism.

18. UNICEF's leading partner in the implementation of sanitation projects is the Environmental Sanitation Division (ESD) of the Ministry of Health. ESD too is a technical agency that concerns itself mainly with the physical design of latrines. It does not have its own field staff to speak of and relies on the extensive network of health personnel from Township Health Officers to village level Basic Health Staff to mobilize the community to construct their own latrines with ESD supplied PVC pans and ferrocement slabs. Though the ESD makes a valiant effort to develop even more effective designs to enable communities to build fly-proof larines, the emphasis at the village level appears to be of quantity rather than quality. In a rush for quantitative targets, the harried health staff may at times resort to methods of coercion to

secure village cooperation in the construction of latrines. That is the hard-sell approach, but conventional soft-sell methods require the health staff to first convince the villagers of the superior health benefits to be derived from the use of latrines. They seem to have no such responsibility with respect to water supply.

19. The Central Health Education Bureau (CHEB) would be the logical counterpart for UNICEF collaboration in Programme Communication for water supply and sanitation and given the general tendency for government agencies in Burma to steer close to their legal boundaries of turf and territory, there may not be an alternative. The CHEB has the onerous responsibility to provide health education support for all of the health programmes and projects in Burma. As a small unit within the Department of Health it is best described as long on enthusiasm and short on staff and finances. The CHEB staff of 50 or so health educators are thinly spread throughout the 14 States/Divisions of the country. They are expected to work with and through the various levels of the hierarchy of Health Officers in support of the health education activities carried out by the Basic Health Staff at the village level. It may be to their credit that the term if not the substance of "health education" occurs frequently in conversations with health officers and community members. But it is difficult to draw comfort from this observation for it is also widely known that health officers and communities alike continue to share in the belief that health ultimately comes from the barrel of a syringe.

20. CHEB's diffuse mission notwithstanding, it may yet be possible for UNICEF through its Programme Communication Unit to seek agreement on priority objectives, methods of operation and measurement of results and begin a serious collaboration in support of water supply and sanitation projects. Already, CHEB has some indeterminate access to the national media -- radio, television and the press. It has a demonstrable capability in pretesting and production of printed matrials -- posters, pamphlets, charts and books translated from external sources such as WHO. It has sponsored research on community practices in relation to water and sanitation and has from time to time organised training in behavioural research for its staff.

21. From the preceding outline of the UNICEF role in the IDWSSD programme in the Union of Burma follows the inevitable conclusion that its Water and Sanitation programme is not quite in step with the community based and (community) demand oriented school of development in today's UNICEF. But in many ways it is an excellent example of country based programming shaped by country specific constraints and opportunities. It is one of UNICEF's high profile programmes in Burma and seems to have engendered a considerable amount of goodwill for UNICEF in general and the Water and Environmental Sanitation Section in particular. This may have contributed to the government officials' surprising receptivity to this consultant's voiced concern about the programmes apparent failure to show any significant health impact. In fact it is fair to say that there were already some positive indications to some of the following recommendations first raised in our meetings with the government counterparts.

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CONCLUSIONS/RECOMMENDATIONS

22. Going back to an earlier stated principle, objectives define and create problems and problems in turn determine the mix of interventions. UNICEF objective for water and sanitation projects everywhere is to reduce water and sanitation related diseases among children and mothers and perhaps in the process also reduce the drudgery of hauling water that is the lot of many rural women. The problem more often than not, has to do with contaminated drinking water and logically the interventions will include the provision of safe water and sanitation facilities but in the end the best guardians against contaminated water are the educated/informed consumers.

23. Starting from this basic assumption, it would seem that the IDWSSD programme in Burma, of which UNICEF is a part, has placed much too much emphasis on the provision of safe water and sanitation facilities and to little effect. For, there is yet no substantive research evidence in Burma that, other things being equal, villagers with safe water and sanitation facilities are somehow better off than those without. The conclusions of just such a study by Nyi Win Hman (1984) "Study of Dry Zone Rural Communities", do suggest otherwise, but these have been found to be extra data conclusions.

24. UNICEF may be in a position to correct this obvious imbalance to some extent. There is some suggestion in Burma that the level of contribution by the external agencies, the bilaterals in particular, is sufficient to sustain the pace of the physical construction of water and sanitation facilities for some time. The question arises whether the level of

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contribution is considered sufficient enough to allow UNICEF to attempt a strategic shift of its assistance to water and sanitation away from supplies and facilities and towards the equally critical area of change in water and sanitation related practices among the communities in Burma. The shift need not be sudden and disruptive but gradually achieved it may prove indispensable for the realisation of the Country Office objectives.

25. To this end UNICEF Rangoon's objective for its Water and Sanitation programme of cooperation with the government will need to be re-examined and re-stated differently than it is now in the Plan of Operations for 1982-1986. It now reads: "To reduce the incidence of water related diseases including trachoma, and of leprosy through the provision of safe water supply and sanitation facilities and through specialised campaigns." To begin with "specialised campaigns" which can only mean health education campaigns should be so changed and given a prominent position within the statement of the objective. The particular mention of trachoma and leprosy within the statement defies understanding. According to the Department of Health, trachoma and leprosy are not among the top ten disease conditions in Burma. The DOH top ten list does contain the following water related disease conditions: diarrhoea, viral hepatitis, ARI and dysentery. Thus, if a particular disease condition is to be mentioned at all within the statement of the objective it should be diarrhoea. The implications are perhaps too obvious. For one, it would be more consistent with the priority disease conditions established by the Department of Health in Burma, not to mention the worldwide UNICEF priorities. What is more, the ORS/ORT strategy to combat diarrhoea depends for its success on

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the communities' proper handling of water and sanitation to prevent diarrhoea from occurring in the first place.

One important result from this symbolic manipulation of the statement of objective for the water and sanitation programme may be that it establishes a shared responsibility between the UNICEF Rangoon Sections -- PSC, WES, Health -- for ORS/ORT as well the water and sanitation interventions in Burma. Similarly, the functional link between the various counterparts DOH, ESD, CHEB, RWSD/AMD and CID begins to become apparent.

26. The solutions to the problems that arise as a result of a more focused objective for the Water and Sanitation programme of assistance will require changes of behaviour/practice among the various participants in the IDWSSD programme:

1. the Communities;
2. the Service Delivery Staff;
3. Planners and Decision Makers;
4. the Donors.

One hopes that UNICEF will be able to assume the role of a key change agent among all the parties concerned. It is a role that, among other things, demands a comprehensive communicataion/education agenda. The contents of this agenda will be discussed under each heading beginning with the communities.

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26.1 The Communities

Most remarkably, there is a very high level of community participation in the IDWSSD programmes in Burma. A financial measure of this participation has been given earlier in Table 1. Under the leadership of Village Councils, they raise funds, construct water tanks and latrines and establish water committees to maintain the systems. They freely admit that they need health education and they do look up to the health workers and teachers to provide such education. And yet there is some evidence that such health education as may be provided has not resulted in any fundamental change in their water and sanitation practices.

UNICEF directly and/or indirectly has been involved in two studies among the communities of the dry zone to try to establish some health impact from the introduction of the new water and sanitation facilities. One is the longitudinal study by Dr. Thein Maung Mint (1982 --) of the Department of Medical Research and the other by Dr. Nyi Win Hman (1984) of the University of Rangoon. If the studies prove anything at all it is that the attempt is premature. But those studies and some new additional ones, if necessary, may be used to identify the prevailing water and sanitation related practices of the villagers, especially those that may lead to the contamination of safe drinking water. These practices may be grouped under the following headings:

1. water use at or in the home
2. water use at the pump
3. water use at traditional sources
4. sanitation.

Among the community practices, there will be some that need to be encouraged with modifications. A case in point is the Burmese preference for tea rather than raw water for drinking. The conventional wisdom is that tea water is made safer by boiling. Further investigation of this practice may, however, reveal that the water is not boiled long enough to make a difference. One may also find that the practice of drinking tea instead of raw water is limited to adults only, leaving unprotected the more vulnerable of UNICEF clients - the children.

There will be some practices to be discouraged. For example, it seems that in Burma as in many other countries, villagers demand that their drinking water be of good taste. It is a legitimate demand, but the water from the new tube wells may not always be as tasty as it is safe and the villagers may well continue to dip into their traditional, tasty but unprotected water holes for their drinking water. This is but one example of the kinds of values, beliefs and practices that can frustrate the technological interventions in water supply and sanitation. Hence the first suggested step is to develop an inventory of the more prevalent of these practices and then proceed to formulate a set of messages to encourage or discourage the practices as necessary.

The message formulation process should ensure, to the extent possible,the involvement of a cross-section of the partners in the IDWSSD programme. The objective is to develop a set of standard health messages understood if not agreed upon by community representatives at the village level, by experts (as in planners, health officers, teachers, communication officers, engineers, etc.) and by sponsors (as in government

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officials and donor representatives). Broad participation at this stage may enable subsequent collaboration in the widest distribution of the messages in whatever form, personal or mediated in print or audio visual materials.

There are a number of channels of influence in Burma for these and similar health messages addressed to the villagers. There are the conventional channels, the schools, the health centres, the co-operative markets, etc. One observes also that water drilling cites tend to attract village people in numbers, if nothing else to watch the progress of the mechanical contraptions, the oversized tools, drill-bits and rigs. It would seem that the engineers/drillers of RWSD are in fact best placed to carry the health messages, suitably framed, from one drilling cite to another, from one village to the next as part of their normal gear.

There may be other channels of influence in Burma who like the engineers and drillers have yet to realize their full potential as messengers of health. It would be sensible to compile a list of these potential channels as part of the research on community behaviours and practices.

26.2 The Service Delivery Staff

The health messages or statements of desired practices with respect to water and sanitation in the villages provides a suitable framework for the development of training and retraining modules for the service delivery staff including the health workers, the primary school teachers and the water and sanitation engineers/drillers. To date the engineers/drillers of RWSD/AMD, CID or even those employed by UNICEF for the

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gravity system projects and who have been working extensively on the pilot project up in the Chin hills may not clearly understand the health consequences of their designs. Among the most telling examples of water contamination by engineering oversight is to be found in one of the peri-urban water projects of the CID. The reticulation pipe from an elevated water tank is laid in the gutter. The customers have to attach plastic hosepipes at various points of distribution along the length of the pipe, something like bung-holes below the surface of the effluent in the gutter, to get their "safe" water. This extreme example is cited here in order to press home the need to extend health education training to the engineers and drillers.

The health workers and teachers are already converts to health education at least in theory. Additional training, however, might help them distinguish in practice what is and what is not desirable behaviour in handling water and sanitation facilities. In this connection one might mention the case of a new water storage ground tank located across the residence of a Station Medical Officer. It appears that some of the villagers have started the unhealthy practice of dumping refuse hard by the fence surrounding the water tank. That the practice is allowed to continue may suggest that the SMO does not recognize the adverse health consequences of this practice. It may also be, as suggested earlier, that the health establishment as a whole is biased towards curative rather preventive care.

The primary responsibility for training and retraining of the heath workers, the teachers and the engineers in these matters may be in the hands of DOH/CHEB. It may be necessary for UNICEF to encourage and persuade the DOH/CHEB to extend

their training assistance across the well-known sectoral boundaries that separate one government agency from another.

UNICEF may also contact directly the centres of learning in the Netherlands and Australia that provide water and sanitation engineering courses to Burmese nationals as part of the IDWSSD programme. One gathers from a couple of the returnees that the courses may be too narrowly defined to include health education of the preventive type. This is important in as much as some of the returnees will end up as trainers in the training centres, Meiktila for example.

26.3 Planners and Decision Makers

Coordination across sectoral boundaries is perhaps the most difficult to achieve among planners and decision makers in the Union of Burma. UNICEF might begin by reviving the PSC committee as a working task-force and enlarge this committee by invitation of the key counterparts to its deliberations. The task-force should be chaired by the Representative or the Programme Coordinator with the PSC Officer as its executive secretary following up on recommendations for action. The task-force should consider a whole range of issues and not all limited to communication and information matters.

The following are some examples that could be fruitfully addressed by such a task-force:

(a) The water storage tanks, ground tanks of cement and galvanized iron roofing of the Dry Zone project may not be the best technological option. Cement is hard to come by and so are the roofing

materials. Even so, the communities tend to alter the design withthe addition of open cement troughings. In many cases the drainage system around the ground tanks is inadequate. Would a reticulated system with an elevated storage tank be a better option?

(b) Sanitation facilities should be,as far as possble fly-proof. Current installation practices, however, are not of standard quality. In the interest of credible health impact among the communities, may it not be better to slow down the pace to achieve higher standards?

(c) The interventions of health education, water facilities and sanitation facilities should as much as possible reinforce each other and preferably be undertaken at the same time at the same place. But the agencies for water and those for sanitation and health education tend to move according to their own separate plans and their own separate criteria of selection of areas for their activities. What gives?

26.4 The Donors

UNICEF's contribution to the IDWSSD programme has been described as relatively small compared to that by other donors. Still, UNICEF's concern with the lack of a palpable health impact from the provision of water and sanitation facilities is thought to be a widely shared concern among the donors. It is therefore suggested that UNICEF pick up on this

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concern and seek the donors' support to lobby among government officials for a renewed strategy that will highlight the role of health education along the lines suggested here, as part and parcel of the IDWSSD programme. Equally important is to assess their readiness to pick up some of UNICEF's commitments in the construction of facilities as it moves to support the health education initiatives so critical to the whole programme. This strategic shift in emphasis is likely to succeed if carried out with the least disruption in the progress of the on-going programmes and projects.

27. The conclusions and recommendations as they are will entail a number of activities that need to be carried out by the UNICEF Burma country office in consultations with the host government and other interested parties (the donors) and the following pages present in table form the range of activities/results/responsibilities envisaged by this consultant.

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PRELIMINARY RECOMMENDATIONS FOR WATSAN

ACTION	RESULT	RESPONSIBILITY
1. Review current UNICEF and counterpart agencies' WATSAN programme objective and emphasize health education/ programme communication as an integral part of WATSAN projects.	. A statement of objective more consistent with DOH priorities in Burma and UNICEF priorities world-wide i.e. to reduce water and sanitation related diseases, diarrhoea in particular. . Adoption of health impact (reduction in incidence of diarrhoea for example) as a key measure of success for all WATSAN projects.	UNICEF-DOH-CHEB-ESD-RWSD/AMD, CID and other donor representatives.
2. Review UNICEF staff and budget commitments in the light of the renewed emphasis in Health Education/Programme Communication for WATSAN.	A gradual shift of financial assistance away from facilities to health education/programme communication and the recruit-ment of WATSAN officers with experience on Health Education/ Communication/Training.	UNICEF with government counterparts.

ACTION	RESULT	RESPONSIBILITY
3. Establish a body to coordinate the separate activities of the participants in WATSAN by expanding the role of the in-house UNICEF Rangoon PSC alternative.	. Coordinated planning for the implementation of water projects, sanitation projects and health education in a designated area concurrently. . Appointment of local persons for health education/programme communication in each participation agency in the WATSAN programme. . A permanent WATSAN Task Force made up of the above focal person to oversee health education, programme communication activities for WATSAN. . A model of collaboration for State/Division, Township and Village level representatives of the relevant agencies in the implementation of WATSAN objectives.	UNICEF and Government agencies in collaboration with donor agencies.

ACTION	RESULT	RESPONSIBILITY
4 a. Begin survey of community practices and behaviours in relation to water sanitation and identify key practices and behaviours to be encouraged and/or discouraged in a new health education programme communication campaign.	. An assessment of the behavioural contraints that need to be overcome at the village level in line with the health objectives.	
4 b. Concurrently survey the current and potential channels of information for health education at the village level.	. A prioritised list of possible channels of information for the health education/programme communication campaign. These should include <u>places</u>: schools, clinics, tubewell sites etc. <u>people</u>: influential individuals, teachers, health workers, water and sanitation engineers, etc. <u>media</u>: printed materials and audio visuals.	Under the overall directions of the WATSAN Task Force, the PSC Officer, CHEB staff and a consultant, if necessary.

ACTION	RESULT	RESPONSIBILITY
4 c. Review survey findings with competent health experts and frame the content of the messages necessary to encourage and/or discourage the behavioural findings at the village level.	A set of messages endorsed by the relevant content experts and authorities with respect to water and sanitation related practices.	The PSC Officer, CHEB staff and senior health officers at DOH.
4 d. Develop a mix of channels to distribute a standard set of the messages as developed and confirmed in 3 c. above.	Prototype messages for face-to-face delivery, prototype pamphlets, posters, radio announcements, video and film clips containing the health messages developed and endorsed in 3 c. above.	The PSC Officer, CHEB staff, a graphic designer, press, radio TV, film, personnel.
4 e. Pretest and prototype media and messages for attention holding, understanding, reach, and actionability by communities. Use role playing to test messages for face-to-face delivery.	Final selection of media and messages for wide distribution.	The PSC Officer, CHEB staff in consultation with the WATSAN Task Force.

ACTION	RESULT	RESPONSIBILITY
4 f. Launch multimedia/ multichannel campaign with the standard messages and the selected media as above.	. Health education/programme communication campaign directed to communities.	The PSC Officer, CHEB staff and participating channels of information or influence.
4 g. Periodically monitor and evaluate response and make necessary adjustments in campaign.	. Gradual change in WATSAN related community practices adding up to a reduction in WATSAN related diseases.	The PSC officer, CHEB staff and participating channels of information/influence.
5 a. Review current arrangements and subject matter for training of the service delivery staff of the counterpart agencies in WATSAN related activities.	. An assessment of the training and re-training capabilities of each counterpart agency in health education for WATSAN.	Under the WATSAN Task Force, the PSC Officer, CHEB, DOH with a training consultant, if necessary.
5 b. Survey a representative number of the service delivery staff in their knowledge, ability and willingness to participate in health education for WATSAN.	. Recommendation and development of training modules for all of service delivery staff with annexes relevant to specific professional interests/bias.	Under the WATSAN Task Force, the PSC Officer, DOH, ESD, CHEB, and RWSD/AMD, CID and a consultant, if necessary.

ACTION	RESULT	RESPONSIBILITY
Test for: (1) personal communication skills with or without media aids; (2) knowledge of transmission of water related diseases; (3) knowledge of prevention of water related diseases; (4) knowledge of practical dos and donts in the proper utilisation of water and sanitation services.	e.g. For engineers, it would be important to have an annex on how to secure water sources from contamination through proper drainage systems, adequate covers etc. . Development of readers to supplement present sources of information of the service delivery staff.	
5 c. Determine the agency best equipped to train trainers for all the counterpart agencies in WATSAN who will in turn train their own staff (subsequent to 1 above).	. Appointment of a specific unit with DOH to provide such training of trainers of all counterpart agencies.	WATSAN Task Force with information provided by the respective agencies, to the PSC Officer, CHEB, DOH and a training consultant, if necessary.
5 d. Pretest all materials with trainers and trainees before launch of training programme in health education/programme communication for WATSAN.	. A gradually phased in training programme for service delivery staff in health education for WATSAN.	Under guidance from WATSAN Task Force, the training agency selected for the purpose (in 3 above), the PSC officer, CHEB.

ACTION	RESULT	RESPONSIBILITY
Review current water drilling and storage procedures to ensure water safety at the source.	. Guidelines to ensure that now water sources are not or danger from potential contaminants.	RWSD/AMD CID/UNICEF
Review current construction procedures for latrines to ensure that they are as far as possible fly-proof.	. Arrangements to provide necessary cover (roof) for ground tanks. . Fly-proof latrines.	ESD/UNICEF
Review current procedures for site selection of water tubewells and water costs to consumers from now tubewells.	. UNICEF clients (children and mothers) to have preferred access to water sources.	UNICEF/WATSAN Task Force.

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