Livelihood of latrine builders and sustainability of sanitation programmes in Lesotho

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1. Introduction

Proper sanitation provides not merely health benefits, by preventing the faecal contamination of the environment and water, but also psycho-social benefits such as maintaining privacy, dignity and safety, especially for women. Sanitation also encourages female students to continue their education. In spite of its importance, access to sanitation in the world is poor. Around 2.6 billion people have no access to improved sanitation worldwide and 1.1 billion people still continue the custom of open defecation1. Sanitation policies should address both sustainable access and the use of sanitation. They need to include how to establish a sustainable service supply system, how to generate demand for sanitation, and how to change people’s behaviours. Conventional sanitation programmes in many developing countries have been supply-led, subsidy-driven types2, which have focused on subsidies for hardware and the number of latrines built in a certain period, but not on how to motivate people to actually use latrines or on the needs of communities. Although health education has sometimes been delivered with the intention of changing people’s behaviours3,4 most of those sanitation programmes have failed to establish sanitary behaviours, and latrines have been unused or utilized in other ways2.

As a result of this failure, sanitation programmes have shifted to demand-led community-based approaches. The ‘Community-led total sanitation (CLTS)’ model and sanitation marketing are now becoming a trend in current sanitation programmes. CLTS, which was initiated in Bangladesh, aims to decrease open defecation, build toilet facilities through community mobilisation, encourage people to recognise problems related to poor sanitation, and find solutions on their own. Sanitation marketing is a method of increasing demand for sanitation by using marketing techniques, which tries to understand people’s motivation to change their behaviours and buy latrines2,3. Sanitation programmes have involved local latrine builders, who are potential resources to improve sanitation. However, few studies from their perspectives have been conducted, in particular, regarding their livelihood, which is considered to influence the sustainability of their job and, eventually, sanitation programmes. The purpose of this study is to investigate the livelihood of latrine builders in rural Lesotho, where several sanitation programmes, involving local latrine builders, have been implemented since the 1980s.

2. Methods

This study describes the livelihood of latrine builders in Lesotho in order to explore factors that influence the sustainability of sanitation programmes in rural Lesotho. The research took place in Mafeteng district, which is located in the south-west of Lesotho and is the third largest district in the country. The National Rural Sanitation Programme (NRSP), which launched in 19875, was implemented in the district from 1993 to 2003. The total population is around 193,000 and 83.3% of people live in rural areas. Five villages were purposively selected based on information from the former sanitation coordinators. Twenty-three informants were recruited by local healthcare workers from those who had attended at a two-week training course to become latrine builders during the implementation of the NRSP. The total number of ex-trainees in

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the target villages is estimated at around 110.

The principal investigator and Lesothian field workers collected quantitative and qualitative data on-site. All the recruited latrine builders responded to a self-administrative structured questionnaire, with the help of the field workers, on their general characteristics and livelihood. To obtain more detailed information, in-depth interviews to 10 out of the 23 respondents were conducted by the principal investigator through verbatim Lesotho-English interpretation. Criteria for selection for the in-depth interviews were those who made smaller and larger (but not always the smallest and largest) numbers of latrines in each village. Data from the structured questionnaire were descriptively summarised. The in-depth interviews were recorded and transcribed by the principal investigator, and then qualitatively analysed by thematic analysis.

3. Results

3.1 Responses to the structured questionnaire

The average age was 48.5 years and there was only one female builder. The average time after the completion of training was 12.4 years. All 23 latrine builders received income from another job besides latrine building, for example, building houses. Ownership of improved sanitation facilities, pit latrines, and no facility was 61%, 35% and 4% respectively. Of the respondents, 65% had completed primary school, and 78% had a friend or relative who worked as a latrine builder.

As shown in Figure 1, the longer the period from the last work, the lower the number of latrines ever built. It was observed the total number of latrines ever built differed among villages. Of the respondents, 61% found customers by themselves through health education or self-advertisement, and 52% were introduced to a customer by family or friends or health workers. The majority of the respondents (57%) found customers beyond his/her village and its neighbouring villages. Only 13% of the respondents were satisfied with the number of customers while 52% were not satisfied at all. Likewise, only 13% of the respondents were satisfied with the profit from latrine building while 65% were not satisfied at all.

Nearly 40% of respondents answered that they attended the training because they had needed a job. All respondents suggested that they were happy with the job and hoped to continue working as a latrine builder. A good income and feeling of contribution to the health of the community were suggested as positive points of latrine building, while low income and difficulties in gaining customers were suggested as negative points.

Table 1. Attitudes towards latrine building

| Main reason for undertaking the training | 9 (39%) |
| I needed a job                                    | 7 (30%) |
| I was interested in the job.                     | 6 (26%) |
| I was recommended by family/friend.              | 1 (4%)  |

The best point of latrine building

| Contribution to the health of the community | 11 (48%) |
| Income                                      | 9 (39%)  |
| Respect                                     | 2 (9%)   |

The worst point of latrine building

| Difficulties in gaining customers | 9 (39%) |
| Low income                      | 9 (39%) |
| Hard work                       | 5 (22%) |

Future plans (multiple answers allowed)

| To make more efforts to gain customers | 11 (48%) |
| To teach latrine building to my family member | 11 (48%) |
| To work at the same pace             | 5 (22%) |
3.2 In-depth interviews

From the in-depth interviews to ten selected respondents, the following themes were identified: 1) difficulties in finding customers, 2) feeling of contributing to the health of the community, 3) financial satisfaction / dissatisfaction, and 4) desire to continue to work.

3.2.1 Difficulties in finding customers

Many respondents found it is difficult to gain customers. They suggested that although people wanted to have latrines, they could not afford the raw materials to build one. Even so, latrine builders tried to find more customers by extending the areas they covered, providing health education, and advertising their previous work. Giving a discount was not a popular way to promote latrines since they believed that the lowest possible price was already being offered; however, a few respondents suggested lowering the price, which in fact was not successful. One complained that health workers were not very cooperative in finding customers.

3.2.2 Financial satisfaction / dissatisfaction

Some respondents reported that an income earned by latrine building was a positive point of the job. Considering the few job opportunities available, it was still considered as a necessary source of income although it did not make as much money as expected. On the other hand, some respondents indicated low income as a negative point of the job. They considered that the small income mainly resulted from the small number of customers gained.

3.2.3 Feeling of contributing to the health of the community

Respondents were aware of the importance of building latrines to live in a better environment, and felt that they contributed to the health of the community. They found it interesting and a good job, which encouraged them to continue working as latrine builders.

3.2.4 Desire to continue to work

Despite the difficulties in gaining enough customers and a good income, respondents hoped to continue working as latrine builders. In addition, they wished family members to learn the skills and had taught or would teach latrine building to somebody else. To make latrine building a sustainable form of employment, support from the government or from external funders was expected by some respondents. It was also suggested that the government could lowers the price of raw materials or sell them in local communities, not only in towns, so that people could save transportation fees.

4. Discussion

Although all respondents were satisfied with being a latrine builder and hoped to continue the job, nobody lived on only latrine building. The major reason for this was lack of clients. While their pride of contributing to community health was an important promoter, difficulties in gaining customers and consequent unstable income were major obstacles.

Interviewed latrine builders were considered capable and well motivated. The percentage of people who had completed primary school was more than double the figure in the district overall population (29%), and ownership of improved sanitation facilities among the respondents was three times higher than the district average (22%). They showed positive attitudes towards the job, such as self-esteem and professional efforts. If they can be more active with sufficient customers, they will have significant potential in the improvement of sanitation, not only as suppliers of toilet facilities but also as providers of information on sanitation and community mobilisation. Lesotho’s sanitation programmes have tried to involve communities and focused more on hygiene promotion and on training local latrine builders than on subsidising facilities. A two-week
local latrine builder training course included sessions for management and self-promotion techniques. Although CLTS was not yet a trend when the Lesothian national programme was established in 1987 for the first time, the program was based on a similar idea. Community’s demands, however, have not increased enough for local latrine builders to earn their livelihood exclusively from latrine building. It is considered that a low priority was given to sanitation in the household budget in many people’s mind. Looking at sanitation-related indicators in 1990 and in 2005, the quality of sanitation in rural Lesotho has not been improved at all: the proportion of the population served with improved sanitation dropped (from 32% to 25%); and proportion of the population who practice open defecation is the same as before (51%).

Applying social marketing ‘4P’ concepts, all components still need to be strengthened in Lesotho. Regarding ‘product’, only one type of latrine, the ventilated improved pit (VIP) latrine, is available in the programme. If simpler products were offered to customers, although they might not be ideal, barriers to sanitation would have been reduced. A VIP latrine is far more expensive than simpler types. In addition, the gap between the ‘price’ of latrines and the average income of users has increased significantly over the years. In the late 1980s, the total cost of one latrine was £15-£30. This was slightly less than the average monthly household income in rural areas. Currently, £270 is required for a latrine, while the average monthly income of a rural household is estimated at less than £90. Building VIP latrines has become more financially challenging for many households compared with the past. To obtain raw materials at local ‘places’, maximum utilisation of local materials and/or establishment of a stable supply chain should be considered. Latrine builders are supposed to exist in every village, but it is questionable when considering dropout rates. Despite initial training and personal on-the-job efforts on ‘promotion’, people’s behaviours have not been changed. Although local latrine builders were not trained as health workers, if appropriately and continuously supported by health professionals, they would be very efficient resources for health promotion. Their strength is that they are available inside the community. Follow-up training and provision of health promotion materials are possible technical support for them.

According to personal communication from the ex-coordinator of the district sanitation programme in the target area, the dropout rate of latrine builders is assumed to be nearly 95%. If this information is correct, the number of remaining latrine builders in the target villages is more than the average, and the respondents are a valuable minority. A comparison with those who drop out, who are considered the majority, will yield more knowledge of the sustainability of the job and the programme.

In conclusion, sustainable sanitation will be achieved by combining community mobilisation and marketing techniques to maximise the potential of local latrine builders as existing local resources.

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