Community action for health in 'Ontevrede' community

PRA PROJECT REPORT

Produced by University of Namibia and the Ontevrede community
With the Regional network for equity in health in east and southern Africa (EQUINET)

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Through institutions in the region, EQUINET has been involved since 2000 in a range of capacity building activities, from formal modular training in Masters courses, specific skills courses, student grants and mentoring. This report has been produced within the capacity building programme on participatory research and action (PRA) for people centred health systems following training by TARSC and IHRDC in EQUINET. It is part of a growing mentored network of PRA work and experience in east and southern Africa, aimed at strengthening people centred health systems and people's empowerment in health.

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Executive summary

The nursing students at the University of Namibia initially lacked a participatory community approach in their work and training. Without engaging them to explore their knowledge, harboured perceptions that communities are ignorant regarding their health needs and need advice. After engaging in a participatory reflection and action (PRA) process in 2006, the mindsets of the students completely changed and they realised that the community was capable of identifying their health needs and also know which actions to take for identified health needs. However, the community thought that they were not able to act on some of the identified priority health needs, such as the problem of lack of toilets in the area. They realised after stepping stones exercise that they too are powerful and could do things without the help of others. Building communal toilets was the own initiative of the community living in Ontevrede settlement area.

In the second phase, the community working group and UNAM team held meetings with various stakeholders and presented the previously identified health needs and related health risks. This aspect resulted in change of mindsets of the local authorities and they are currently in the process of negotiating with the community to give them possible assistance. This study aimed to learn about processes for strengthening community action in health using a PRA process to steer their own implementation plan to construct pit latrines cohesively and effectively own the project. It aimed in the process to also:

- strengthen the communication between the local community and their public health and local authorities so that they are able to take forward other health programmes;
- widen the participation of UNAM teaching staff in the PRA process work to enable its spread in the University; and
- involve students as a learning experience of PRA and community roles in health.

The intervention used participatory research (PRA) methodologies to achieve these goals. It was implemented in the context of the EQUINET programme on PRA training for people centred health systems. It drew support from EQUINET institutions in the region, namely TARSC Zimbabwe, Ifakara Tanzania and CHESSORE Zambia. Twelve nursing students of the University of Namibia participated in this study, together with the community of “Ontevrede” informal settlement area around Katutura.

Permission was obtained from the community leaders and community participants. The PRA team (Community working group and UNAM team) completed an attitude checklist before their work on the community. Students and communities jointly held negotiation meetings with the Councillor of the area prepare and deliver position paper that could serve in the meeting with City Council for permission to build the pit latrines. In meantime, while waiting on the position paper to serve on City Council meeting, other activities such as “health day’ was held in the community to give them health education on issues raised during the initial phase of the PRA work in this area. PRA approaches including transect walks and community mapping, brainstorming and discussions were done. The findings from the pre-test questionnaire, various meetings with the Councillor, transect walks and community mapping and activities such as health day were then synthesized, and report compiled.

The PRA team (UNAM and Community) almost unanimously agreed on the ability of the community of Ontevrede settlement area to assess and plan actions on health improvements it sees as important (like building of pit latrines). However, most disagreed or were not quite sure that the community could build pit latrines on its own. Most of those who believe in the ability of community to act on own health issues were those students and community members that participated in the previous participatory work (2006) in this area. There were also a significant disagreement and doubt about whether the community in

Ontevrede settlement area and local authority had a good supportive relationship on health issues. Similarly, the PRA team expressed significant doubt on the issue that the community would be able to ensure that all households would have a pit latrine by end 2007. Although doubt on the ability and possibility for the entire settlement area to have access to pit latrines by end of 2007, there was also a significant agreement that the community would ensure that at least one in ten households would have a pit latrine by end 2007. The PRA team agreed that there is a good working relationship and support with learning institutions, such as UNAM.

However, a significant difference was observed in the new PRA students of 2007: they showed more trust and confidence in the ability of communities in assessing and implementing their own health issues, compared to the previous group (2006). The community PRA team learned that waiting for projects to kick start discourages people (wider community members). The facilitator learned that PRA process is not in the hands of the facilitator, thus s/he cannot rush it, but only do what is practically feasible at that time.

We met one of the three objectives fully - widening the participation of UNAM teaching staff in the PRA and community process work to enable its spread in the University. We incorporated one lecturer and four new students, while the final year students (2006 group) are phasing out. The objective on 'involvement of students as learning experience of PRA and community roles in health' was partly met, but not completely because the whole PRA process was not completed as planned. Thus they did not gained a full understanding of the PRA process. The first and most important object of construction of pit latrines was not fully met, but the PRA community gained access to their Councillor and were free to negotiate during the meetings we had. However, it was difficult for the PRA team to schedule appointments with the Councillor, due to his busy schedules.

Implementing community empowerment for health actions in informal settlement areas faces many challenges, as community members have weak access to decision making on their services. The PRA process needs to respect context and facilitators cannot force the pace of interventions. Actions to implement even the most basic PHC interventions take time to build the co-operation and responses from necessary stakeholders.

The PRA team proposes to continue with the process in 2008 and support the 'Ontevrede' PRA team until their paper is presented to the City Council and a workable alternative solution found to their problem of lack of toilets.

1. Background

In Namibia, issues of the informal settlements are entirely handled by the Regional councils, who own the land. The Public Health section of the city council deals with health promotion and prevention services. The Ministry of health provides for general functions like curative, specialised and rehabilitative health care services. Therefore, the City of Windhoek (municipality) relocated this community of "Ontevrede" settlement area in 2000 from other suburbs because the City of Windhoek wished to extend those areas. Some of the community members were brought from other settlement areas due to overcrowding in those areas. Generally, this community is youthful: mostly school dropouts, with young men in the majority. Some of the youths ran away from homes and live with friends in this area. These community members came from all over the country, but mostly from the Northeast, in search of jobs in the City. Most of the community members were unemployed, while those who were employed earned low salaries, ranging from N$100.00 to N$500.00 per month. (=US$16.60-$83.30). Many of those employed were security guards (men) or domestic workers (women). Most of community members were unmarried, but cohabitant with children. The settlement area is 20-25 kilometres from the City centre and 5-6 kilometres from the nearest suburb where the health facilities are located. There is no official public transport in this area, due to the gravel roads, not suitable for public transport. Therefore, most community members go shopping only once a month. On their return trip by taxis, usually they are being overcharged, as the area is considered to be outside the taxi zone.

Regional Network for Equity in Health in East and Southern Africa (EQUINET) through TARSC and Ifakara Health Research and Development Centre (IHRDC) has begun a programme of work to develop materials for training on participatory training and research for community based mechanisms. This training programme aims to strengthen the community voice in planning and implementing primary health care and health services at primary care level. Research, implemented in a participatory manner, can itself raise community voice and strengthen more collective forms of community analysis and organisation to take up their interests in health. TARSC and the Ifakara initiated work in 2005 to develop this programme of capacity support for research and programme implementation. In 2006 University of Namibia implemented and reported on PRA work that this proposal builds on (Hofnie-Hoëbes et al, 2006).

The initial intervention was planned in two phases. During the first phase, health needs were identified and actions to be taken were proposed. In the combined meeting of the two groups (student nurses and community), the priority health needs and the actions to be taken to address them were discussed. The major difference was in the actions to be taken to address lack of toilets. The community did not see the need to build toilets when they did not have their own plots, while the students felt that shared toilets could be built as an interim measure. The building of communal toilets was the own initiative of the community living in Ontevrede settlement area. In the meeting through PRA approaches the community worked out a systematic plan of action to deal with the issue of toilets, and through this resolved to build one toilet for every four households (Hofnie-Hoëbes et al, 2006).

In the current second phase, the community wished to act on the outcomes of the first phase. During the first part of this second phase, various meetings were held to give feedback to solicit support for the construction of communal pit latrines on the understanding that City Council wish to listen to the community and offer hand of assistance in the start-up process of building predicted pit latrines in the 'Ontevrede' informal settlement area.
Initially the nursing students lacked a participatory community approach and harboured perceptions, without engaging them initially to explore their knowledge, that the communities are ignorant with regards to their health needs and need advice. From 23 March to 31 May 2006, the community and eight nursing students of the University of Namibia jointly identified

the health needs and actions to be taken at Ontevrede settlement area. After participating in the PRA research on 'Creating nurse student awareness on community knowledge on health in Ontevrede informal settlement in Namibia', the mindsets of the students completely changed and they realised that the community was capable of identifying their health needs and also knew which actions to take for identified health needs. However, the community thought that they were unable to act on some of the identified priority health needs, such as the problem of lack of toilets in the area. The community identified four priority health needs, ranked in order of the clinic, plots, tar roads and toilets. They realised after stepping stones exercise was introduced that they too are powerful and could do things without out the help of others (Hofnie-Hoëbes et al, 2006).

2. Methodology

The action plan for the PRA round in 2007 consisted of various activities as follows:

- A short baseline questionnaire would be completed to assess the status of each of the major outcome indicators identified above in the perceptions of the PRA community working group and UNAM team. This would be repeated at the end to assess how the process has changed these indicators as perceived by the PRA community working group and UNAM team.
- After completing the questionnaire, the PRA community working group and UNAM PRA team were to meet and reflect on their visit to the Councillor in December 2006. During the meeting:
  - the PRA community group and UNAM PRA team were to set out their expectations of the process;
  - feedback was to be given to the full community on the visit to the Councillor;
  - the community plan of constructing pit latrines was to be discussed thoroughly;
  - inputs were to be invited as to the way forward and possible discussion points during the follow up visit with the Councillor; and
  - groups of four households were to be identified for communal pit latrines.
- The community working group and UNAM team would pay a follow up visit to the Councillor as agreed upon in the prior phase. Depending on the outcome of the meeting with the Councillor, the community was to:
  - organise to plan and implement a plan to build pit latrines;
  - draw experience and ideas to organise action and identify and plan around obstacles and potentials;
  - use own ideas to engage authorities;
  - review actions to celebrate victories and reflect on areas for problem solving;
  - monitor progress according to set indicators.

The community was then to define roles to be played by different members of the four households, and work out their work plan. Follow up meetings were to be planned, focusing on the implementation coupled with monitoring progress according to the outcome indicators, review, reflection and problem solving. The households were to be empowered to use a Wheel Chart to monitor set targets. Thereafter, a spider diagram was to be used to reflect on the outcome indicators: why progress was made or identifies why there was lack of progress. This exercise was to be followed up by 'But why?' exercise to better understand the reasons of progress or lack of progress in each working group for remedial actions or to celebrate the 'victories'.

New third year students involved in the PRA ***Source****: UNAM*

The facilitators and students were to meet after each households meeting to reflect on the facilitation methods, tools, achievements and challenges for possible review. Students were to reflect and record specific lessons they learned from each PRA intervention. The new lecturer would be empowered beforehand to understand the process and then to learn through active participation in the PRA process and was also expected to record the lessons learned. A copy of the facilitation guide was given to her and she was encouraged to widely read information on PRA.

Meetings of the whole community (i.e. groups of 'four households' working in their units) were to be held once a month to share the challenges and successes. These regular joint meetings were intended to help groups empower each other and learn from others. The PRA community working group was also to:

- use their own ideas and engage local authorities;
- organise meetings with the local authority once in every two months, brief the council on progress and ask for input to keep the horizontal communication channels open and functional;
- give feedback to the entire community after each meeting with the local authorities, to gather community inputs to be taken up for at next local authority meeting;
- have continuous communication with institutions in EQUINET for back up on the PRA process; and
- meet in mid November 2007 to:
  - reflect on the whole process;
  - repeat the short baseline questionnaire to assess the status of each of the major outcome indicators identified above, based on the perceptions of the PRA community working group and UNAM team;
  - review the expectations of the process they set out in the beginning; and
  - discuss the expectations and reflect on how the process has impacted on these areas.

After the November 2007 meeting the assessment of indicators was to be compared to the baseline survey and analysed. Report writing and dissemination of results was to be done on three monthly basis, once implementation commences. The final report was to be disseminated to the City Council, participating PRA team, i.e. the community working group and UNAM team and EQUINET. The full programme was implemented between March 2007 and November 2007. A full report of the whole process and lessons learned was prepared for EQUINET. Dr Käthe Hofnie-//Hoëbes, University of Namibia, led the research team.. Those involved in the work from UNAM included a lecturer in Reproductive Health and third and fourth year nursing students from UNAM, namely: T De Almeida, S Nairenge, W Linyando, J Shikukutu, S Erastus, L Shavuka, O Amwaanyene, L Muinjo, H Uukongo, E Siteketa, P. Haita, S. Shikongo and E. Nakale. From the Ontervrede Community, those involved included J Gaingos, P Hamundjebo, T Hamunyela, M Katjikuru, C Haosemas, S Shidinge and A Bock.

This protocol guided the intervention reported in this study, using PRA methods to empower the community to steer their own implementation plan to build pit latrines cohesively and effectively own the project. The intervention used a mix of qualitative and quantitative PRA methods and tools. Four new students were recruited for continuity of the PRA project, as all eight Students from the previous year students were in their final year of university studies.

One lecturer, teaching Reproductive Health was also recruited into the PRA process for capacity building. New students and a lecturer were oriented into the PRA work and given written material on the previous work done during Phase I: 2006. They were encouraged to read through the documents to familiarise themselves with the previous work.

The UNAM PRA team met and discussed the 'way forward', including those issues to be covered during the full community feedback meeting. The agreed not to give the detailed information on expressed assistance by the Councillor to the full community as: 'If the community goes an extra mile and build these toilets, they may indirectly force the City Council to give them the plots'. The fear was that such information could create over enthusiasm on the issue of plots which they were awaiting for so long and also pertinently indicated in the first phase that they will not build toilets without having own plots. There it was decided to discuss only the purpose of Councillor's visit, that includes: acknowledging identification of their own health needs by the community and not by UNAM team; acknowledging, praising and expressing appreciation of proposed plan of action to build toilets; discussing possible assistance in clearing the area and digging of pit latrines; and possibility for links and follow up on the visit.

The facilitator visited the community PRA group in December 2006 after the meeting with the UNAM PRA team and held a short discussion on the way forward. The joint meeting (PRA UNAM and PRA Community group) to prepare for the broader community feedback meeting and a meeting with the Councillor were both organised for April 2007.

The joint meeting was held as planned; the new students and lecturer were introduced and welcomed by the PRA community group. The community PRA group consisted mainly of the area committee members who are in leadership and serve as the link between the wider community and the Councillor. Suggestions were made during the previous meetings with the Community group to feel free to identify additional members if they wished to do so, as the implementation phase may require some innovation. Thus two new community members were introduced to the UNAM PRA team, both men. One of the section leaders explained the purpose of the PRA working group meetings to one of the new community members: '*…this is not a political meeting. It has nothing to do with the party politics, but we are here to work together for our development in this area…'*

The meeting reflected how seriously people understood and valued this PRA work, and sought to protect it from sabotage by others. One of the regular community group members could not attend the meeting, as she was at work the particular day; and delegated her husband to attend the meeting on her behalf. These leaders were respected by the wider community, and were informed of any meetings or activities within the wider community.

The way forward was discussed. The PRA team perused the twelve point plan of action for constructing pit latrines, developed during 2006, after the 'Stepping Stones' exercise, viz:

1. Call a community meeting to discuss the issue;
2. Elect a committee;
3. Community to pledge cooperation in whatever they are planning to do;
4. Find out cheaper and easy way to construct pit latrines;
5. Consult municipality for permission;
6. Provide feedback from municipality to the community;
7. Agree on rules with regards to cooperation among the community members;
8. Four households to build one toilet;
9. Pledge contributions for the construction of toilets among four households;
10. Solicit cleaning material among households and later from Ministry of Health on monthly basis;
11. Health education regarding maintenance of hygiene;
12. General maintenance of the whole project by households.

The community group elected to continue with their existing committee one with additional member. The new developments in the area since 2006 were reviewed. The committee indicated that the City council had erected two spray lights in the adjacent settlement, but not in their area. The meeting thus discussed the interaction with the Councillor, and agreed that it was better to ask the Councillor or his delegate to be present during the full community meeting to give it more meaning, and show the Council's support for addressing lack of toilets. The community members agreed that they would solicit building material in their own resource constrained capacity.

A brief baseline questionnaire was administered to members at the end of the meeting to explore the status of the major areas of outcomes, including perceptions of:

- community capacities to plan and implement its own plan of action on a health intervention, specifically toilet construction;
- strength of links between the community and the local authority towards supporting the implementation of health interventions;
- community access to sanitation; and
- learning, capacities and organisation within the community to address other priority problems raised by the community on health..

The questionnaire was designed in English and administered in local languages. The students were categorised into two groups to assess differences between them - 1) students who participated in the first phase (2006) and 2) four new students and the additional lecturer. Seven students from 2006, all five new UNAM PRA members and six community PRA group members participated in the exercise.

The PRA team implemented a transect walk that aimed to identify the number of households and sanitation needs in Ontevrede settlement area. The PRA team was also encouraged to observe and enquire about other relevant issues such as water sources, waste management, etc. The focus was on:

- number of households
- the structure of the households such as: nuclear families, extended families, etc.
- number of inhabitants of each household
- availability of toilet and bath facilities, and its conditions
- proximity of households to each other
- any space for pit latrine between households
- proximity of places used for toilets to the houses such as riverbeds or bushes
- areas where the children play.

The transect walk was conducted by the whole PRA team (UNAM team and community group). Almost 90% of the entire area was covered during the survey. The only houses that were not physically surveyed were those without people at the specific day of survey, although some information on the number of inhabitants of such absentee households was obtained from neighbours and the team observed the outside sanitation facilities. The survey was conducted in one day, as the PRA team members were many.

The various other meetings and activities held are discussed in the results.

3. Results

3.1 Results of the pre-test questionnaire for PRA team

The results of the pre test are shown in Table 1. The PRA team (UNAM and Community) almost unanimously agreed on the ability of the community of Ontevrede settlement area to assess and plan actions on important health improvements (like building of pit latrines). However, most disagreed or were not quite sure that the community could implement the

building of pit latrines on its own. Those believing in the ability of community to act on their own health issues were those students and community members who participated in the previous participatory work (2006) in this area. Their views were probably shaped by the learning from the PRA work in 2006.

Table 1: Baseline PRA team pre-test results on outcomes

Outcome Assessment	UNAM		Community	
	Answers	**Results**	**Answers**	**Results**
1. Community can assess and plan actions on health improvements it sees as important (like building of pit latrines)?	Agree Disagree Don't Know	92% 8% 0	Agree Disagree Don't Know	100% 0 0
2. The community can itself act to implement these health improvements (such as building pit latrines)?	Agree Disagree Don't Know	33% 25% 42%	Agree Disagree Don't Know	17% 83 0
3. The community and the local authority in this area have a good relationship on health issues.	Agree Disagree Don't Know	25% 42% 33%	Agree Disagree Don't Know	17% 83% 0
4. The local authority is giving guidance to communities on their health activities.	Agree Disagree Don't Know	33% 17% 50%	Agree Disagree Don't Know	17% 83% 0
5. The local authority meets as needed with the community.	Agree Disagree Don't Know	8% 33% 58%	Agree Disagree Don't Know	17% 83% 0
6. The community will be able to ensure that all households will have a pit latrine by end 2007.	Agree Disagree Don't Know	28% 39% 33%	Agree Disagree Don't Know	28% 39% 33%
7. The community will be able to ensure that at least one in ten households will have a pit latrine by end 2007.	Agree Disagree Don't Know	58% 25% 17%	Agree Disagree Don't Know	83% 17% 0
8. The community meets regularly to discuss and share experience on health issues.	Agree Disagree Don't Know	25% 50% 25%	Agree Disagree Don't Know	17% 83% 0%
9. All households in the community are involved in health activities.	Agree Disagree Don't Know	8% 67% 25%	Agree Disagree Don't Know	0 100% 0
10. The University and the community understand and support each other's work in health.	Agree Disagree Don't Know	67% 8% 25%	Agree Disagree Don't Know	83% 0% 17%
11. The University has adequate lecturers who have skills in using participatory approaches.	Agree Disagree Don't Know	58% 25% 17%	Agree Disagree Don't Know	50% 0% 50%
12. The University students respect community experience.	Agree Disagree Don't Know	67% 8% 25%	Agree Disagree Don't Know	67% 0% 33

Participants generally disagreed that the community in Ontevrede settlement area and local authority have a good supportive relationship on health issues, particularly in the community. The PRA team – UNAM and the community - expressed doubt on whether communities would be able to ensure that all households will have a pit latrine by end 2007. While it was doubted whether the entire settlement would have access to pit latrines by end of 2007, there was agreement that the community would ensure that at least one in ten households would have a pit latrine by that time. The PRA team observed that there is a good working relationship with and support from learning institutions, such as UNAM.

The new PRA students of 2007, in their responses on the first two questions, showed more trust and confidence in the ability of communities to assess and implement interventions on their own health issues, compared with the same assessment implemented in the prior

assessment in 2006. This 2007 group of students were possibly informed and influenced by the prior orientation they received regarding the PRA work done in 2006, before their participation in the current exercise.

3.2 Scheduled follow-up visit with the Councillor

The six community PRA team members, (three males and three females and two UNAM PRA team members (facilitator and the additional lecturer) visited the Councillor in April 2007 by appointment. This visit was to receive guidance from the Councillor on the way forward for the community project of constructing pit latrines. Students could not attend, as the appointment was given during their instruction hours. While one of the community members requested to speak in the local language, the Councillor felt that those working as community leaders should attend literacy classes, which are free of charge, to communicate in the official language, noting that communication skills were vital.

He informed the community of the video session on AIDS, and Violence Against Women and of the workshop facilitated by Ministry of Gender and Child Welfare and invited participation from the group. He seemed to want to empower the community leaders in Ontevrede.

PRA team meets with the area Councillor Source: UNAM

The meeting reviewed the background to the work and the purpose of the current meeting, as a follow up to the 2006 work identifying community needs and plans for improving health in their area.

One of the community leaders indicated that there are no toilets in their area and that they are just using of nearby bushes. The Councillor confirmed this, noting that people had complained of the stink of faeces in that area during a school meeting. The City Council, which is in control of public health, is fully aware of this lack of toilets.

This is why the Municipality constructed 300 toilets in 2003 in an adjacent informal settlement area, but with inadequate planning for what would happen when the pit latrines filled and the consequences for hygiene. The community realised these problems and refused to use the pit latrines, particularly when they filled, were poorly cleaned or in poor condition. The municipality had hired a contractor to clean and empty the toilets, but his tender expired: He explained that when the polio outbreak occurred, the municipality had revisited the issue of toilets, but had not taken this forward after the polio outbreak. According to the Councillor, the municipality gave plots to some community members, but with poor supervision from the municipality, so some built toilets too close to their kitchens. He further informed the PRA team that a delegation from the municipality visited Cape Town to look at the type of toilets people are building in some areas such as Gugulethu and that a report on this visit was in the progress. When the results were out, he said probably Namibia could use and implement some positive examples in areas such as Ontevrede settlement, to improve the community's public health.

The Councillor indicated that the big issue was how to convince the municipality of the need for toilets, given their limited flexibility. He suggested that the PRA team survey the number and environmental conditions in the households and write a brief and strong paper to serve as the motivation for the building of toilets in Ontevrede settlement.

He enquired what type of toilets community envisaged building. One of the community leaders then explained to him that they prefer the pit latrine with a deep pit, with proper toilet seat with cement. He was in support of the type as commonly in use, but reiterated that he preferred flush toilets as a more sustainable option. He encouraged the community to go ahead with their idea, however: "*Go ahead until municipality provides you with the alternative. But we have to take up your project. They have to give you an alternative solution. Something needs to be done*."

One of the community leaders indicated that they do not want municipality to give them everything: "*We want to help ourselves. We need only some assistance, but not everything. If we are quiet, they will think we are happy*". The Councillor confirmed this and endorsed partnerships with the community, with business, government and international agencies.

The PRA team thus agreed to return and survey the households in "Ontevrede" settlement area, and prepare a well formulated paper for the Councillor to review for motivation of the health intervention. The Councillor would make an appointment with the City Council for he and delegates from the PRA team to present the case. He observed that the Council may have already made plans to build toilets in the future in which case the community would be asked to wait for these to be implemented, or advised to implement the project in the 2007-2008 budget in small phases. He advised the team to advocate implementation by arguing the public health issues and the Council's encouragement of community initiative to address identified problems.

After leaving the meeting, the PRA planned the follow up survey, agreeing that the PRA community group would liaise with the heads of 20 households each in their area to get cooperation for the survey, excluding illegal settlement dwellers. The UNAM team would design a simple questionnaire and communicate a survey date to the PRA team members. The team agreed to complete this exercise before the next full community feedback meeting. With this scheduled for after the meeting with the City Council, it was noted that clear information needed to be given before this to households on the purpose of the envisaged survey.

3.3 Results of the household survey

The survey gathered evidence on:

- the number of households
- the structure of the households such as: nuclear families, extended families, etc.
- the number of inhabitants of each household
- the availability of toilet and washing facilities, and their conditions
- the proximity of households to each other
- any space for pit latrines between households
- proximity of places used for toilets to the houses such as riverbeds or bushes
- areas where the children play.

3.3.1 Household's structure and living environment

The inhabitants of most households were extended families. However, nuclear families were found in some few cases. Some households only consisted of men who live together as friends or families. Sometimes, three to four houses were built on the same plot, shared by different family members. This implies that too many people were living on the small portion of land, resulting in overcrowding, with some small plots with nineteen people each. Some houses were used for business (shebeens). According to our observations, there was hardly place for a pit latrine between some households, as the houses were close to each other, due to some plots being occupied to maximum capacity. Overcrowding of the plots were

aggravated by planting of shade trees in some cases. However, some plots had only a single house structure, leaving enough space around it for some gardening and planting of shade trees. Most residents tried by all means to keep their houses and yards clean.

Children playing around bushes used for toilets Source: UNAM

Children were playing around the houses in the limited spaces. Some ran around in the bushes, used for toilets, while others ran around where sewerage of bathroom/urinating rooms was freely draining. Children were all over the area, as this survey was done during their school holidays.

Tenants were found at some houses, their owners being explained by a section leader as being government employees who live in this area and have other houses elsewhere in the city. He said sometimes they live in 'Ontevrede' and rent out other houses, or live in their houses elsewhere in the city and rent out the house in 'Ontevrede'. This issue is under investigation according to the source.

3.3.2 Sanitary conditions

No toilets were found, except one pit latrine at one section leaders' house. The community uses bushes or riverbeds, which were not far from the houses. Some bushes were found between two blocks of houses and used by all nearby households. At places, where the bushes were very close to the houses, faeces were found all over that place as could be seen on the above picture.

Some of the bushes used for toilets by two blocks of houses Source: UNAM

Faeces seen all over the place Source: UNAM

Night pot emptied and stored next to the house Source: UNAM

At one house, we found a bedridden woman who had chronic diarrhoea and who was also paralysed. According to the family members, the pot used during night time by the woman with chronic diarrhoea was emptied very close to the house, as other bushes were a bit distant from the house in an area that has no

streetlights and is very dark. The PRA team observed some shacks used as bathrooms and toilets, made with bags, boxes, plastics, corrugated iron and hardboard. We observed that some of these bathrooms were empty, but found washing basins in some. These places were constructed without roofs and sewerage was draining down the streets from them.

Bath/urinating rooms *Source: UNAM*

House with built-in urinating pit and bath
Source: UNAM

We also came across one house with a bigger bathroom, built with better temporary material, a bath inserted and a floor covered with a carpet. This was the only house where we observed a built in urinating pit.

3.3.3 Waste management

At some places we observed accumulated waste in the riverbeds or sometimes closer to the houses. It was reported that the City Council removes the waste at regular intervals at agreed upon collection sites, but that some residents do not cooperate with the City Council and put their waste at places that were not agreed upon. The City Council does not remove this waste at unauthorised places.

3.3.4 Water sources

Four taps were observed. The community makes use of pre-paid water metre system. Each household buys a card according to affordability. Some households spend up to N$80 (U$13.30) per month, but mostly it depends on the usage of water. Water sources were found to be much closer to some households (about 1-2 metres), while these taps were far from some households (about 800 metre)**.** According to them, those households that were very far from the taps requested their section leaders to bring this issue under the attention of the City Council for an additional water outlet closer to them.

3.3.5 Total households and inhabitants in 'Ontevrede' settlement area

There is doubt about the accuracy of the household numbers, because some households were not present at the time of survey, and the PRA team relied in these cases on neighbours for some information. This was in about 10% of the households. Face-to-face interviews were conducted by the members of PRA team (Community and UNAM). Heads of households were targeted. However, in some cases where the head of households were not present, any other adult member of the households were interviewed. *Table 2* shows characteristics of the area.

Table 2: Area characteristics

Characteristics	Frequency		Frequency	Grand total
Households	503			
Adults		**Children**		
Male	804	Under 5 years	318	
Female	595	Attending school	317	
Pregnant women	32	Out of school youth	43	
Total	**1431**		**678**	**2109**

Most households reported experiences of diarrhoea and tuberculosis among adults. Diarrhoea, malaria and flu were reported as the most common conditions among children. It was not clear how many of these community members were hospitalised. We came across one woman who reported being diagnosed with tuberculosis, who was also bedridden.

The PRA team observed that some community members deliberately withheld some information, such as that of pregnant women. At two different occasions, when it was enquired whether there were pregnant women in the households, the respondents answered negatively – just as pregnant women came out of the houses! We can assume, therefore, that the information on health status is not entirely accurate. In some cases the team was invited into the houses to see the sick persons.

PRA member interviewing out of school youth who was also a head of household *Source: UNAM*

We found household heads who were out-of-school youths. Some girls were partnered by adult men and having children or were pregnant. One girl indicated that she was an orphan and has nowhere else to go. Another young woman interviewed who was carrying a baby in her hands was found to be a youth out of school.

Accuracy of data is a general problem in any research, and we certainly report this problem in the quantitative data in this survey as we did not employ rigorous mechanisms to cross-validate the data. This is a gap to be addressed in future work. However despite this, we assert that the findings of our transect walk, survey, photographic images and interviews provide reasonably robust information on environments and health in "Ontevrede" settlement area that has not been previously reported or are poorly monitored due to the informal nature of the settlement. We found a number of social and environmental problems, including extremely young mothers and accumulated waste in the riverbeds or close to the houses. Our survey confirmed the community priority concern, particularly noting a serious lack of sanitation, with no toilets in the area, children playing in areas used for bush toilets, and freely draining sewerage from bathroom/ urinating rooms.

3.4 Position paper prepared for council

A paper was compiled by the UNAM team, and discussed and agreed upon with the community PRA team who were happy with it, particularly the pictures. According to them, the visitors see only the pictures that are taken from the air by the City Council and do not really see how dirty some areas of the City are, so it is expected that the pictures will give better view to the City Council. The issue they particularly wanted to stand out in the paper

was that City Council 'has to do something regarding this issue of lack of toilets'. The exercise was an extremely important once for the community representatives and the UNAM team to document the conditions in the area, and give formal status to experience of the community. It gave the community a format with which to back their discussions with the council on ways of improving a problem that they felt to be a priority for them.

However, when we came to take the paper forward, the Councillor was out of office to fulfil his other council responsibilities. We had difficulty getting input from him to finalise the paper, despite the community PRA team emphasising the urgency of this document to serve on the Council.

The position paper was finalised by the PRA team and is shown in *Appendix 1.* It outlined the background, what was done to examine the conditions in the community and the findings on the community profile, and particularly the lack of sanitation. The following conclusion was given:

> *The Millennium Development Goals emphasise the importance of intersectoral collaboration and partnership in addressing crucial issues affecting the health and development of the Namibian citizens. The University of Namibia, in partnership with the community of 'Ontevrede' settlement area works toward the realisation of above goals, by empowering the community to take ownership of their health, through identification of health needs in their environment and act on it. The Health for All citizens in the Republic of Namibia is the main goal of the Ministry of Health and Social Services. To achieve Health for all citizens in the country, sanitation is one of the crucial components and also a basic human need. This basic need also superimpose on poverty, which is currently on the international agenda. It is against this background that the community of 'Ontevrede' settlement area initiated this project of building pit latrines to improve their own public health. Thus this humble beginning of this community needs constant support from all sectors.*
> *PRA team Position paper, 2007*

3.5 Follow up activities in the community

While waiting on the feedback from the Councillor, the PRA team planned other health activities to implement in the community, responding to issues raised in the PRA work in 2006 and the survey findings.

3.5.1 Health Day

Health education was identified as a need both by the students during the first phase PRA work in 2006 and by the community in their plan of action, with request to the University for assistance. Against this background a health day was planned to give health education on issues such as HIV and AIDS, hygiene, nutrition and hypertension. The aim was to maintain contact and communication with the community and provide a service which shows sense of interest in the community work. The expected outcome was active participation of the community and direct dialogue between UNAM team and the wider "Ontevrede" community on common health issues. The health day was an initiative of new third year students (2007) who were very eager; the final year students were too busy. They planned a weekend to hold a "Health Day" in Ontevrede settlement area, to:

- provide health education on general health issues like HIV/AIDS, nutrition, hygiene, first aid;
- take blood pressure of the community members and refer if necessary.

The PRA community team informed the broader community of the envisaged 'Health day' and what it could entail. When the UNAM PRA team arrived, some of the community members were already waiting at the house of one of the area leaders. Initially, it looked as if

not enough people would attend, but as we put up posters against the fence of the leader's house, more people arrived. Some did not know what was happening; others who knew were waiting for us to start.

The facilitator explained the purpose and it was translated by the students in most spoken languages in the area. Thereafter we started with the health talks with different posters. These chosen topics blend nicely into those health needs identified by students during the first phase of the PRA work in "Ontevrede" community (Hofnie-Hoëbes et al, 2006: 15-16).

The first poster consisted of healthy foods, followed by hygiene and HIV, particularly on use of alcohol and drugs while on anti-retroviral therapy (ART). The students explained in different languages and community members listened with keen interest and asked questions. Community members complained about taking ART on an empty stomach as they sometimes do not have enough food, and of problems with transport to collect ART from the relevant health facilities, two are commonly reported problems in Namibia among clients taking ART.

Correct use of male condoms was demonstrated. Some men looked on very shy, while others actually enjoyed watching the demonstration and asked relevant questions. The community also had a chance to demonstrate this back to the students and those who did it correctly with the very first attempt got a big applause. The community participated actively and gained some insights, particularly on correct use of condoms

Male condoms were distributed after the demonstration, although the number of condoms was inadequate. Femidoms were only used for demonstration. Some women took male condoms for their partners. The PRA team promised to bring further boxes of condoms the following week and distributed five boxes then to community members, mostly young men.

3.5.2 Waste management

Work on waste management was also discussed as an interim issue between the facilitator and the section leaders. It was observed as an issue and also raised in the survey by community members, as shown by the quote below:

> *"Plastic carry bags are been used, particularly during the night time for elimination (stools) and just thrown at the places for waste removal. City council do not approve that idea and the workers just leave those plastic bags with faeces, or sometimes burn it at those places that are also not far from the houses, consequently the bad fumes are coming back to the nearby households".*
>
> Community member

While acknowledged that it was a good idea that needs attention next, the section leader thought at this stage it would bring confusion among the community members, as they were asking what happened with the household survey results. The section leader guided the PRA team to focus on the issue of building pit latrines and keep trying to obtain feedback from the Councillor. This suggestion was followed, and discussion only held by the PRA team on how the problem of waste may be taken forward in future. It was suggested that a meeting to discuss the problem of waste management that came out during the transect walk for household mapping would map out the way, by discussing the problem with the community, soliciting cooperation from different section leaders to promote cooperation with the City Council, such as in using pre-assigned and agreed upon places for waste removal and section leaders assigning specific people to be responsible for supervising waste dumping sites on daily basis and on a rotational basis. Incentives might also be discussed, as well as penalties for households who do not cooperate with the plan of action.

It was also suggested that PRA tools be used for the above activities when they are implemented, such as:

- transect walk through the area to locate the agreed upon places for waste removal to see the scope of the problem;
- mapping areas, identified by the community members, as some community members complained that the waste is been put too closer to their homesteads;
- discussions on incentives for those who will be supervising the waste gathering sites and possible penalties to those members who will found not to be cooperative; and
- ranking and scoring might be used for consensus agreement on how to proceed.

The PRA team showed through this that they had internalised participatory approaches as a means of addressing future issues in the community, to work out solutions with community members, rather than impose these on them.

3.6 Follow up meeting with the Councillor

The PRA team made several attempts to have an audience with the Councillor, but he was too busy. When the facilitator at last got hold of the Councillor in September and enquired on the progress on the position paper he was due to submit to the City Council, he reported that he was still waiting to be invited to the Council meeting to speak in the paper, and invited the team to a meeting to further strategise. The UNAM PRA team could not attend the meeting as it was during their instruction time, but the facilitator and the community PRA team met with the Councillor on the agreed date.

The Councillor asked for the name of the project, and the community named it as “Pit latrine project in Ontevrede settlement area”. He asked what assistance the community needed from the City Council and the team explained that the community needed:

- permission to build pit latrines; or any workable alternative solution for lack of toilets;
- guidance as to where and how to dig pit latrines as the City Council has rules how this could be done; and
- assistance with clearing bushes.

The community pledged labour and soliciting of building material from each four households.

The Councillor again reiterated the importance of the project, commended the effort made and indicated that it was long overdue. He informed the PRA team that he will submit the position paper before end of September and called the team to accompany him. The community leaders in turn reiterated that the project was long overdue and commended the Councillor his promise to speed up the process.

There was also dialogue in the meeting on other health issues: The councillor informed the team of an activity by Namibian defence force members studying environmental sciences to clean up another settlement area with community members. He reported that he had heard of the ‘Health day’ initiative in “Ontevrede” community and received report on the day from the team. He raised some concern about the disposal of used condoms and the team promised to communicate the message on safe disposal of condoms. The PRA team and councillor discussed the reported the sale by some community members of condoms received in the shebeens. There was concern as to whether these were condoms received free of charge from Ministry of Health or those obtained through the private sector, with community members reporting that they were not from Ministry of Health.

However, the political situation changed in Namibia around end October/ beginning November 2007. A new political party was formed by some prominent members of the ruling party. It was first reported that our Councillor found himself on the ‘wrong’ side and lost his position in the Council, but later that this decision was withdrawn. While the exact events were not clear, it interrupted the dialogue with the major channel for communication with the council. The PRA team is evidently very dependent on the area Councillor to assist in

obtaining the permission to build the pit latrines in Ontevrede settlement area. While this process is bureaucratic and potentially frustrating to the momentum and participation built a participatory process within the community, it has to be followed, as do the Council guidelines on building of toilets. When the information was received that the councillor was still in place, the PRA team contacted him and he responded positively to look into the project as early as possible. At the time of writing this report this process of dialogue with the council is still ongoing.

4. Discussion

In the discussion we reflect on three major areas of the process:

- the UNAM team perceptions, capabilities and changes;
- the community team perceptions, capabilities and changes;
- the process and outcomes in the environment

4.1 The UNAM team perceptions, capabilities and changes

Unlike students who participated in PRA activities in 2006 who doubted the ability of the community to assess and plan health improvements, all five (100%) of the new PRA team members agreed that the community was able to assess and plan health improvements. There was a significant doubt that the community would be able to ensure that all households would have a pit latrine by end 2007. The learning from the PRA work in 2006 possibly led the team to understand that with many actors involved, community work is not very easy and fast. The same experience also indicated that the community in "Ontevrede" settlement area and local authority did not yet have a good supportive relationship on health issues, critical to progress on health issues. The PRA team agreed that there is a good working relationship and support with learning institutions, such as UNAM. As the work unfolded it was clear that the good relationship with UNAM was important to support the community to build its relationship with the council, as a means to addressing health problems. While building this relationship was not easy to plan or predict, and is ongoing, it was recognised as essential to taking forward plans developed by the community.

The household survey, despite being elementary, helped in obtaining baseline data of "Ontevrede" settlement that was not already available. The students gained observational and interview skills during the transect walks and community mapping, and experienced directly the difficult conditions facing communities in informal settlements. The serious lack of sanitation was evident, as a central issue to the public health of people. This was an eye opener for the students, who saw how these communities are trying to cope under their circumstances. They reflected themselves on this,

- on the poor environmental conditions: *"Through the research I realise that life is so difficult for people living in that area, although it seems they adapted to those conditions … there is no toilets; houses were built without windows and there is no electricity in the area."*
- On the social response to these conditions: *" It appears to me that the community are in need of people they can talk to about their social problems, because despite answering our questions, they further raised complains that we as researchers were not aware of."*
- On the extent to which people are already taking health actions: *"Important experience is that this community, even they are far behind the standards of living and also seems to be disadvantaged in many ways, they are willing to come up to the standard by keeping their houses and yards clean, selling some items to make living bearable. Most of the children are currently attending school. They are also trying to improve their health conditions by intending to build toilets."*
- On the roles to address problems: *"The people in that area are eliminating in the valleys and bushes, which put them also at greater risk for snake bites, kidnapping*

and even murder. According to my opinion, the City Council needs to help the community to build pit latrines."

- On the methods used: *"I learned how easy it is to get information from the community by asking them questions about their health and also observing ourselves objectively. Observation is really a good tool."* and *"It was a fun and educational… This survey broadens my understanding of quantitative methodology we are doing in Sociology at UNAM."* and
- On the difficulties they faced in implementing these approaches: "*Language was a problem to me, because most commonly used languages are Rukwangari, Afrikaans and Nama."*

The also observed problems with their own perspective, for example seeing overcrowding as an underlying problem: *"I think this need improvement, since transmission of various communicable diseases is rapidly transmitted in such situations."*

While building the relationship with the council was a key determinant of progress on this health intervention, it was not straightforward. While the Councillor was willing, had an open door policy and communication was open between the Councillor and the community, it was difficult to organise meetings with the councillor due to his busy schedule, and the range of individual issues he had to deal with in the community. For example, the Councillor also told us one day of one of the community members' shack which burnt down, where he was writing letters to well-wishers to support the person.

While the Councillor acknowledged the importance of the project, and the City Council encourages community initiative, there were barriers experienced to implementation. From the community side, the weakness identified of not having a concrete position paper with evidence to support the argument was addressed by the PRA team conducting a household survey on the Councillors advice, and producing a report for the City Council through the Councillor. From the council side there were barriers in the bureaucracy, in long waiting periods for issues to be attended to, and in political events that interrupted the channels of communication. These barriers were less easy to address, and the process is thus still ongoing.

The health day was the initiative of the new PRA (2007) students, while the PRA team was waiting for the process to proceed with the Councillor. It was fairly well attended, encouraged active community participation and it was encouraging to note a slight change in the response from the communities. Previously at such events, community members were very shy or unwilling to take condoms. However, this is changing. The young men were just grabbing the condoms. Some women also took male condoms for their partners. This may be a reflection of communities realising that AIDS is real and that they have to do something about it.

4.2 Lessons learned on using a PRA process

We realised that while a PRA process builds involvement in the community, it doesn't necessarily go smoothly from point A to point B when engaging outside the community. While the PRA team assumed that the Councillor's support in 2006 when the issue was raised would lead to relatively quick next steps for construction of toilets with the Council assisting in technical issues of how to do this, this was not the case. There is a longer process to negotiate permission to build the pit latrines from the City Council and the follow up steps. Fortunately the facilitator chose to not be too over-enthusiastic on what would be achieved during the first interactions with the community, and the team was guided by the community members on being cautious about what was shared with the wider community, to avoid expectations and frustrations. It was fortunate in that respect that a big community feedback meeting was double booked and cancelled.

It is easy to feel as though movement in this process takes one foot forward and five feet backwards! These processes are not predictable, there are no quick, focused solutions and complex problems need both strategic responses and time for responses to succeed. By keeping to a participatory process the team has sustained the intention to advance the plan of action and the learning around this, building insight in the process. This does, however, call for patience, courage, open-mindedness, flexibility and perseverance.

4.3 The community team perceptions, capabilities and changes

The community members in the PRA team were unanimously confident of the ability of the community, motivated by the achievements from the previous PRA exercise in drawing the plan to build pit latrines. They were also correctly clear on the weaknesses in the relationships and guidance provided to the community on these issues by the authorities. Not surprisingly therefore they doubted whether the community would be able to ensure that all households have a pit latrine by 2007, although they felt that at least one in ten households have a pit latrine by end of 2007. This indicates that there was perhaps some underestimation, similar to the UNAM team, of the complexity of taking this issue forward with the City Council.

The transect walk was an eye opener for the community team members. It not only confirmed and documented the sanitation issue, but also raised the problem of accumulated waste in the area. At this stage they agreed to do something about it and came up with a plan of action to explore, discuss and address this problem. Included in this were proposals for specific people to be responsible and given incentives for correct management of waste collection areas, in accordance with municipality rules. This affirmative approach signals a mindset change on self driven approaches to tackling problems in their area, as accumulation of waste was not a new problem. However, it was proposed by community leaders to hold on processes for discussing and acting on this problem until the work on building pit latrines was in progress, given community expectations.

The community members of the PRA team reflected on the issues learned in the process:

- On how eager the wider community was to have changed, but unclear about how to produce this change: *"The broader community is tired of the unhygienic conditions, mostly aggravated by lack of toilets and wants solution. People are interested and pledge cooperation and support for the envisaged project."*
- On the scepticism of community members when the process is long, that change will take place.
- On the potential of the approach to raise new health issues, such as the accumulation of waste, and
- On the frustrating barriers to action, such as bureaucracy: "*…Waiting on projects to kick start makes the people (the wider community members) disillusioned, while the Council is encouraging us to come up with ideas to solve our own problems in our areas…"*

4.4 The environment

The City Council is responsible for the public health (meaning, promotive and preventive services) of all citizens in their respective regions, while Ministry of Health and Social Services caters for curative, specialised and rehabilitative services. The City Council is also the custodian of informal settlement areas. They decide when informal settlement dwellers should vacate, and to which areas. This PRA work was thus implemented in a community which is particularly disadvantaged in terms of self determination over health issues.

Ontevrede settlement dwellers were relocated in 2000, and since then have had no sanitation facilities. While this led to a clearly identified problem, prioritised by the community, for which a public health intervention (pit latrines) exists, it was not simple to take the next step of meeting the set objective of the community cohesively planning and building their envisaged pit latrines.

From the PRA team's consultation with colleagues in Ministry of Health we confirmed the right channels to address the sanitation problem. We observed that the City Council is aware of the situation of informal settlement areas in Windhoek, including Ontevrede. However we also observed that this correct process faces bureaucracy, time to deal with the Council, and to negotiate the meetings and consultations. We have not yet completed this process, a year after starting. However we are aware that context matters and that there are no shortcuts if we seek lasting solutions. The situation on the ground, policies and institutional processes in a particular setting determines the route that process takes, and facilitators of PRA processes need to respect this and do what is practically feasible. This also means that part of the skills in facilitation is examining and identifying ways of advancing processes that face barriers or appear dormant.

At the same time we were able to meet more fully objectives that were more under our control. We were able to widen the participation of UNAM teaching staff in the PRA and community process work to enable its spread in the University. We incorporated one lecturer and four new students, while the final year students are phasing out. While the whole process did not progress to the end, limiting understanding of the PRA process as planned, the UNAM team learned through transect walks, community survey and discussions, and strengthened their understanding of work with the community and the methods for this. They were also able to apply this in planning future work on waste management with the community.

We were also able to strengthen the relationship between the community members in the PRA team and the Councillor, essential for taking the health interventions forward. The meetings and dialogue held were open and constructive. We were able to respond to advice to prepare more formal reporting for the Council, and learned more about the process for taking matters forward. While this involved numerous meetings that not all PRA team members could attend, by working as a team we were able to meet these commitments, share the learning from each meeting and sustain the process. The obstacles we faced in taking the matter forward from the Councillor to the full Council are yet to be overcome.

We thus end this phase with the process incomplete, but ongoing. The process will be pursued with the Council. We have also not implemented the post intervention assessment, as the intervention is not complete.

5. Way forward

Community development is not a simple task, and is particularly difficult in under-served and economically disadvantaged groups. The Namibian government is striving towards the Millennium Development Goals, including that communities access safe sanitation. However, taking forward community 'owned' initiatives such this envisaged plan of construction of pit latrines to improve community's public health faces various bureaucratic and institutional hurdles encountered in the process. There is also evident caution from authorities on the most effective way to respond to sanitation interventions in communities where tenure is not permanent. These barriers can potentially impede or delay the realisation of these goals for the most disadvantaged communities.

We propose to continue with the process in 2008, now that the Councillor is back in his position. The UNAM PRA team will still support the 'Ontevrede' PRA team until the PRA paper is presented to the City Council and a workable solution found to their problem of lack of toilets, when we hope that the outcomes planned will be achieved or partly achieved. We hope this will not only produce the toilets the communities have prioritised, but also enhance our learning and understanding with the community of the relationships and processes needed for this.

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Appendix 1: Paper prepared by PRA team (Community and UNAM) for the Council on the sanitary conditions in 'Ontevrede' settlement area (May 2007)

PAPER PREPARED FOR THE COUNCIL ON THE SANITARY CONDITIONS IN 'ONTEVREDE' SETTLEMENT AREA

PREPARED BY PARTICIPATORY, REFLECTION AND ACTION (PRA) RESEARCH TEAM (COMMUNITY AND UNAM)

DATE: MAY 2007

Introduction

Initially the nursing students lacked participatory community approach and harbour perceptions that the communities are ignorant with regards to their health needs. The nurses feel the community needs to be advised without engaging them initially to explore their knowledge. The community and eight nursing students of the University of Namibia jointly identified the health needs and actions to be taken between 23 March and 31 May 2006 at Ontevrede settlement area (Okahandja Park D in Tobias Hainyenko Constituency). After participating in the participatory, reflection and action (PRA) research, the mindsets of the students completely changed and realized that the community was capable of identifying their health needs and also know which actions to be taken for identified health needs. However, the community thought that they were not able to act on some of the identified priority health needs such as the problem of lack of toilets in the area. They realized after the stepping stones exercise was introduced that they too are powerful and could do things without the help of others, or in collaboration with others.

The biggest challenge the community of this settlement area is faced with is serious lack of toilets. There is no toilet in this area. However, the community has realized that they could do something to improve their public health, as prevention is better than cure and that they also clearly understood that curative remedial actions are expensive, if someone has fallen ill. Such curative actions do not only put extra burden on the Ministry of health, but the government as a whole. It is against this background that the community of 'Ontevrede' settlement area (Okahandja Park D in Tobias Hainyenko Constituency). came up with this initiative of constructing communal pit latrines (one for each four households) in their settlement area to improve their public health. The specific support they require from the City Council includes: permission to build pit latrines; possible assistance with locating ideal places for pit latrines and digging of pits. The community offers to solicit building material and share labour amongst each four household members. Thus the community aims to negotiate a possible alternative solution with the City Council, if their initial request for permission to constructing pit latrines is not favourable.

Community profile

The City of Windhoek relocated the community of 'Ontevrede' in 2000 from areas such as Okuryangava and Ongulumbashe because the City of Windhoek wished to extend those areas. Some of the community members were brought from other settlement areas such as adjacent Okahandja Park, because the area was overcrowded, according to the City of Windhoek. Since then, this area has considerable number of inhabitants, including children. See tables below:

Table 1: Area characteristics

Characteristics	Frequency
Households	503
Adults	
Male	804
Female	595
Pregnant women	32
Total	1431
Children	
Under 5 years	318
Attending school	317
Out of school youth	43
Total	678
Grand total	2109

Main Problem Area

There are no toilet facilities in this area. The community is making use of nearby bushes or riverbeds. However, the piece of land on which the community lives, is densely populated that the bushes and riverbeds were not far from the houses. At some places, these bushes are between two blocks of houses and are used by all nearby households.

At places, where the bushes were very close to the houses, faeces are all over that place

At one house, the pot used during night time by a bedridden woman with chronic diarrhoea is emptied very close to the house, as other bushes are a distance away from the house and that the area has also no streetlights and is dark.

Children are playing around the houses as well as same bushes, used for toilets as the small piece of land is densely populated.

Some children are running around places where sewerage is freely draining from the bathrooms, also used for urinating.

The lack of toilets poses health hazards, not only for the children, but to the entire community. The community is aware of health hazards caused by such unhygienic conditions. These unhygienic conditions become endemic and have financial implications for the Ministry of health and the Government at large. The Health for All is thus at stake. Therefore it is imperative that the community act on their identified health need to construct pit latrines for households. Although many chronic diseases could be responsible for diarrhoea in this area, some of the contributing factors could be above unhygienic conditions, caused by lack of toilets. It is also clear from above mini household survey done during May 2007 that diarrhoea was common among this community. However, diarrhoea is one of the most common causes of death in children under 5 years old in Namibia. Observing the status and trend of the Millenium Development Goals, there has been a reduction in infant and under-five mortality by an average of 2.5 and 2 % annually, which is a significant progress but still too slow to meet the national targets of 54%. Access to safe drinking water and basic sanitary conditions can prevent childhood infections, including diarrhoea. It also transpires that some of the community members from this settlement area were treated with polio related symptoms during the polio outbreak that was experienced by the City of Windhoek during 2006.

Conclusion

The Millennium Development Goals emphasize the importance of intersectoral collaboration and partnership in addressing crucial issues affecting the health and development of the Namibian citizens. The University of Namibia, in partnership with the community of 'Ontevrede' settlement area works toward the realization of above goals, by empowering the community to take ownership of their health, through identification of health needs in their environment and act on it. Status of The Health for All citizens in the Republic of Namibia is the main goal of the Ministry of Health and Social Services. To achieve Health for all citizens in the country, sanitation is one of the crucial components and also a basic human need. This basic need also superimposes on poverty, which is currently on the international agenda. It is against this background that the community of 'Ontevrede' settlement area in Tobias Hainyengo Constituency initiated this project of building pit latrines to improve their own public health. Thus this humble beginning of this community needs constant support from all sectors.

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in the region:

- Public health impacts of macroeconomic and trade policies
- Poverty, deprivation and health equity and household resources for health
- Health rights as a driving force for health equity
- Health financing and integration of deprivation into health resource allocation
- Public-private mix and subsidies in health systems
- Distribution and migration of health personnel
- Equity oriented health systems responses to HIV/AIDS and treatment access
- Governance and participation in health systems
- Monitoring health equity and supporting evidence led policy

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