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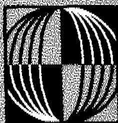
COMMUNITY PARTICIPATION IN THE LATE `90s

Water Supply and Sanitation in Bangladesh



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BUET, Dhaka, Bangladesh

822 — BD03 - 18141

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Water Supply and Sanitation in Bangladesh

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Water Supply and Sanitation in Bangladesh

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*ITN Research Series **04***

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Water Supply and Sanitation in Bangladesh

Published by

ITN-Bangladesh
Cente for Water Supply and Waste Management
(A project financed by DANIDA)
Civil Engineering Building (3rd Fl.)
BUET, Dhaka-1000
Bangladesh

June, 2003

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Centre for Water Supply and Waste Management

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Cover Design by: Mr. Khairuzzaman Biplob

Printed by : Mati ar Manush, 173 Fakirapool (1st. Fl.), Dhaka-1000; Ph.- 0171 661841

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ABBREVIATION AND ACRONYMS

BRDB	Bangladesh Rural Development Board
DANIDA	Danish International Development Assistance
DPHE	Department of Public Health Engineering
DSW	Department of social Welfare
EPI	Extended Programme on Immunization
ITN	International Training Network
MoH&FW	Ministry of Health and Family Welfare
MoH	Ministry of Health
MoLGRD&C	Ministry of Local Govt., Rural Dev. and Co-operatives
MoWR	Ministry of Water Resources
NDWSSP	National Drinking Water Supply and Sanitation Policy
NGO	Non Government Organization
NWMP	National Water Management Plan
NWP	National Water Plan
RWSSP	Rural Water Supply and Sanitation Programs
SOCMOB	The Social Mobilization
TW	Tube Well
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UP	Union Parishad
UWC	Union WATSAN Committees
VDP	Village Defense Party
VSC	Village Sanitation Center
WatSan	Water Supply and Sanitation
WHO	World Health Organization
WSS	Water Supply and Sanitation

FOREWORD

Mere provision of physical facilities of water supply and sanitation (WSS) is not enough to attain envisaged objectives of WSS interventions. Lessons learned so far, indicates that clear perception about WSS and closer participation of the end users in WSS affairs are a prerequisite for sustainable development of this sector. In Bangladesh, other than development of almost universal habit of drinking tube-well water, virtually very little other behavioral changes related to water and sanitation have taken place. The situation thus demanded a close look at the user participation aspect in recent water and sanitation programmes.

In this context ITN Centre undertook this study to assess the degree of community participation in all aspects of water supply and sanitation, particularly in rural Bangladesh in late nineties. Methodology of the study entailed desk review on the secondary sources of information, interviews with community members, community survey, community case studies and field study of cause-effect relations. Study findings have been analyzed and finally conclusions have been drawn.

I hope this report will provide a reference point with regard to the level of community participation in WSS sector in Bangladesh prevailing in late nineties.

M. Feroze Ahmed
Centre Director
ITN-Bangladesh

ACKNOWLEDGEMENT

Throughout the study the author received immense support from various persons at all stages. This certainly made the sometimes-tedious tasks both easy and enjoyable.

I would like to thank all the members of the community who gave selflessly their time for their willingness to listen me, answer my lengthy questions and inquiries and to thoroughly discuss the relevant matters with me.

Thanks must be extended to all the people of the various government departments and the NGOs community who in spite of their busy schedules gave me patient hearing. They made the scarce documents accessible to me that have certainly enriched this assignment.

Thanks are due to ITN personnel and members of the project selection committee for giving me this opportunity to be a part of an important component of the national water supply and sanitation program of Bangladesh.

Special thanks are due to Ms. Shahanara Akter, all through the writing of this report I have repeatedly sought her assistance in organizing the information and composing some of the lengthier documents.

Though many people have not been thanked individually they are not forgotten.

I hope that this effort will be taken in the sprite in which the situation has been analyzed. I also hope that they will also be used to modify and improve the existing situation towards a more intensive community participation in the water supply and sanitation sector in Bangladesh that will bring the fruit of our joint efforts.

Afsana Wahab
Principal Investigator

EXECUTIVE SUMMARY

1. Background

Prior to and immediately after the liberation, the rural population of the country (60 million, 1971 census) was served by 185,000 tube-wells (hand pumps), that covered 325 persons per tube-well. Access to sanitation facilities was less than 1% of the population. Periodic outbreak of cholera caused thousands of death and the annual child death rate due to diarrhea ran into quarter of a million.

The Ministry of Local Government, Rural Development and Co-operatives (MoLGRD & C) has the statutory responsibility for water supply and sanitation together with its policy formulation. The Ministry of Water Resources (MoWR) is responsible for the water management and the Ministry of Health (MoH) looks after the general health. The functional responsibility of providing drinking water and sanitation facilities has been delegated to the Department of Public Health Engineering (DPHE) in all rural and urban areas of the country except Dhaka and Chittagong cities.

The government's objectives for injecting resources into this sector is to improve the overall health status through improved access to safe water and sanitation.

In spite of considerable efforts, the concept of community/users participation i.e., involving the ultimate program beneficiaries at all stages of the program thus transferring a sense of ownership and responsibility has still not taken root in the community. The fact remains that the contribution of the consumers/ultimate users particularly in the rural areas is confined to the cost of sinking tube-wells and installation of latrines.

It is now appreciated both by the government and the implementing agents that to transform the concept of community participation in water supply and sanitation into a reality the shortfalls of the program must be identified first. With this objective the International Training Network (ITN) commissioned a study to assess the level of community participation in water supply and sanitation sector in Bangladesh.

This study is no way exhaustive in its contents. It has attempted to assess the situation through a number of participatory methods and has highlighted some of the gaps that need to be minimized if community participation in its true sense is to be flourished.

2. Community participation in water supply and sanitation sector

Keeping in lines with the National Water Management Plan (NWMP), the National Drinking Water Supply and Sanitation Policy was formulated in 1998. The strategy adapted to implement the NWMP was full participation of user beneficiaries in

planning, development and maintenance through community based and other organizations.

Clear understanding of community participation is one of the important tools that can be used to compare the implementation of the above policies with achievements. Considerable resources have been invested in the recent years in Bangladesh to promote community participation in the sector. However, the expected results are not yet obtained. Wrong interpretation of the meaning of community participation is one of the main reasons for this.

3. Study Findings

One of the main findings from the field study is that other than development of almost an universal habit of drinking tube-well water, virtually very little other behavioral changes related to water and sanitation were seen. Personal and household behaviors and sanitation practices by the majority of the population to a large extent are unhygienic.

The access to a sanitary latrine does not guarantee its use. Some latrines – particularly in areas where the provision has been forced or linked to a subsidy, which the consumer wanted – has fallen into disuse. Some school children prefer defecation in the open due to convenience. Most of the people interviewed continue to defecate in the open – near the pond from where they fetch their water for cooking, and in which they take bath.

A more focussed approach is needed for effective promotion of the use of sanitary latrines. Public media like radio spots, television spots etc. which is increasingly reaching the villagers in Bangladesh may prove most cost-effective than social mobilization campaigns. For children the example of adults such as parents and teachers may prove cost-effective compared to class room teaching.

4. Lessons Learned

In-depth interaction with different groups and levels of stakeholders brought to the light that the program designers of community participation in water and sanitation sector advocated planning from below, they failed to listen to the grassroots when actual planning came about.

Thus program planning, even if it is for the installation of a latrine, or sinking of a tube-well, it must always takes into consideration the needs of the ultimate users.

When development becomes donor driven the delivery system may not be sustainable after the withdrawal of the donor assistance.

Therefore responsibilities of implementation must be allocated according to the capabilities and sustainability must be the first consideration.

NTRODUCTION

1.1 BACKGROUND

Prior to and immediately after the liberation of 1971, 60 million rural population of the country was served by 185,000 tube-wells covering 325 persons per tube-well (TW). Access to sanitation was less than 1% of the population. Periodic outbreak of cholera caused thousands of death and the annual child death rate due to diarrhoea ran into quarter of a million.

The Ministry of Local Government, Rural Development and Co-operatives (MoLGRD & C) has the statutory responsibility for the water supply and sanitation together with its policy formulation. The Ministry of Water Resources (MoWR) is responsible for the water management and the Ministry of Health and Family Welfare (MoH & FW) looks after the general health of the people. The functional responsibility has been delegated to the Department of Public Health Engineering (DPHE) in all rural and urban areas except the cities of Dhaka and Chittagong. The National Policy for Safe Drinking Water Supply and Sanitation was approved in late 1998. While the policy framework is in place, practical aspects of its implementation are still to be worked out.

The government's objective for injecting resources into this sector is to improve the overall health status through improved access to safe water and sanitation. In line with its objective the government in collaboration with United Nations Children Fund (UNICEF) formulated and implemented a number of rural water supply and sanitation programs (RWSSP) from 1972 to 1998. Local government authorities, NGOs and the private sector have actively been involved in the implementation activities. According to the government documentation, Bangladesh has made a commendable progress in the provision of basic level of water supply and sanitation to its population. Rural water supply coverage is recorded at 91% and rural sanitation coverage as 44%. In the urban areas, coverage is estimated at about 50%.

To achieve this level of success considerable donor supports have been given to the sector. The main development partners are UNICEF, WHO, UNDP-World Bank, DANIDA, SDC, Islamic Development Bank and the NGOs.

However, the fact remains that the contribution of the consumers/ultimate users particularly in the rural areas is confined to the cost of sinking of tube-wells and installation of latrines. To involve the beneficiaries more actively in all aspects of the RWSSP, a lions share of the allocated resources has been directed towards social mobilization and greater community participation in WSS. An increasing thrust to encourage private sector participation is also noticeable. In spite of considerable efforts, the concept of community participation i.e., involving the

ultimate program beneficiaries at all stages of the program has still not taken root in the community.

In the field setting community participation has been perceived as a set preconditions to be met before a TW application is approved. The expected organization of applicant groups in communities surrounding a TW has not been successful. Time and again the "desire for community participation" has been sacrificed at the altar of the "need for speed in implementation". Thus, speed has been achieved at the cost of community involvement!

In spite of the program designers advocating planning from below, the reality is far removed. Records show that many stakeholders and external consultants have been involved in the development of the WSS strategy while the needs of people was not considered. Instead of a demand driven approach, the program adapted, to a large extent, donor driven in mobility.

Community participation is the minimum, as far as cost sharing is concerned; and it is absent where policy development is concerned, even at the local level. The scenario is more disquieting when the ultimate consumers of the program are women. Even they are representing their communities in public forums such as the WatSan Committee, they are only 'seen' but never 'heard'.

It has been appreciated both by the government and the implementing agencies that to transfer the concept of community participation in WSS into a reality the shortfalls of the program must be identified first. With this objective the International Training Network (ITN) commissioned the present study to assess the level of community participation in Bangladesh in water supply and sanitation sector.

This study is no way exhaustive in its contents. It has attempted to assess the situation through a number of participatory methods and has highlighted some of the gaps that need to be minimized if community participation in its true sense is to be flourished.

1.2 OBJECTIVES

The primary objective of this study was to assess the degree of community participation in all aspects of the water supply and sanitation sector, particularly in rural Bangladesh.

Since the women in the family are the primary consumers of the program the second and more important agenda was to assess the level to which the women in the family and in the community are participating in the activities related to the program.

The most important objective, however, was to listen and learn from the stakeholders, especially the women, their understanding of the concept of community participation in general, and in the RWSS in particular, how they approach it and how far they are able to apply it in their own communities.

The study was thus designed to assess whether the involvement of the ultimate program beneficiaries occurs or not at various stages of the program.

Assessment of development of sense of ownership and responsibility through community participation was another agenda of the present study.

1.3 METHODOLOGV

The methodology of the present study was divided into the following steps:

Desk study and Planning
Keeping in mind the objectives of the study a number of relevant documents were studied. One of the important documents was the DANIDA Project Completion Report of March 1998. This report provided a detailed background information and an account of the history of the rural water supply and sanitation program from 1922 to 1997 including the achievements of the program in relation to the targeted outputs.

An informal meeting was held with the consultants who prepared the DPHE/UNICEF Rural Water Supply and Sanitation Project Completion Report to learn about the gaps and the reasons of lack of community participation in the water supply and sanitation program.

A field visit was made to two villages in Jessore where DPHE water and sanitation program was undertaken with the aim of obtaining the first hand knowledge about the existing situation of community participation in such programs and also to conduct the field testing of the interview schedule.

Interviews with Community Leaders
A series of meetings were held with various stakeholders such as Donors, DPHE personnel, concerned officials of UNICEF, DANIDA, NGO Forum officials. A total of 10 one on one interviews were taken with the representatives of the stakeholders.

At the Thana level, discussions were held with members of the WatSan committees, NGOs, and BRDB, DPHE. Thana and field staffs, school teachers and students. A total of 12 such discussions were held.

Opinions of the community leaders, senior citizens, beneficiaries (particularly women) of the government and non-government water supply and sanitation programs, tube-well mechanics, caretakers and private producers were also sought. These meetings were conducted in a participatory manner. 12 such focus group discussions were held one in each of the selected Thanas.

All three groups of meetings were targeted to a community for self-appraisal. The purpose was to determine the existing level of participation in the water supply and sanitation sector by the end users. The study team focused on an approach involving systematic consultation with the community members. It was designed to provide qualitative input by focusing on the factors that have affected the situation of the end-users, the incentives and constraints to behavioral changes among them and their reactions to service delivery and institutional responsiveness.

Community Survey

Based on document review, available BBS and UNICEF data and consultation with some of the concerned stakeholders, a matrix of high and low water supply and sanitation coverage districts was drawn up.

The following criteria were considered in selecting the districts for conducting the study:

- Existing water supply and sanitation program
- Coverage or level of service delivered by government or NGOs.
- Rich and poor districts
- Accessibility of the areas.

Within each district the team selected two Thanas, one poor and one rich, on the basis of percentage of households having dwellings with roofing of straw or bamboo type and having no agricultural land. Selection of unions was made on the basis of percentage of households having sanitary latrines. In the two Thanas of a district, the team selected one union with low and the other one with high coverage of sanitation. Two villages in each union were selected for carrying out structured questionnaire survey. In selecting the villages it was ensured that there were WSS program intervention and had a good percentage of the mentioned population groups.

A simple, open ended questionnaire was developed for facilitating discussions with respondents at various levels and a reporting format used for recording the responses and findings from each study village. A total of 256 structured questionnaires were administered. After validation 240 of these questionnaires were used to draw a quantitative profile of the situation. Individual interview sessions were held with 120 formal and informal community leaders. 120 general members of the public (60 females and 60 male) were also interviewed.

Community Case Studies
An important part of the study was collection of in-depth information from 8 of the 48 communities visited. The purpose of this exercise was to closely observe the behavioral pattern and the practice of water supply and sanitation and to cross check the information obtained during interviews at various levels. The communities were selected in such a manner that the socio-economic characteristics considered in this study were reflected in one or more of the coml11unities. However, the selected communities were not the representatives of the whole country in a statistical sense. They are merely illustrative examples and lesson learned from them form a qualitative information base rather than a quantitative one.

Field Study of Cause-Effect Relations
The total field study was designed to provide useful information on beneficiary's experiences and perceptions regarding WSS initiatives provided by the public and private sector. It also dealt with the extent of community's involvement, mechanism and arrangements for such involvement, the extent willingness to take responsibility for improved services, the types of organizations for potential involvement and the common obstacles to effective participation in WSS and possible means of reducing them. The study team was thus in a position to systematically and continuously track the cause-effect relationships and in establishing the lessons learned.

1.4 LIMITATIONS

An assessment of a program, which has been implemented over a number of years, depends upon the access to an institutionalized memory. Sometimes, it becomes a difficult task due a lack of systematic documentation of information. The problem is more difficult when the subject of investigation is as fluid as community participation and changes in the behavioral patterns of a community. Often the activities explaining the outcome of a program have taken place over a number of years. Their verification is depended on properly documented or memorized information of the situation in the past. It was difficult to gain access to some of the key informants of UNICEF and DPHE and thus it was not possible to obtain their valuable insight and understanding regarding the present issue of investigation.

The overall political environment of the country made it impossible to adhere to the planned schedule. Though most of the pre-scheduled sites were visited some of the more remote ones had to be changed for reasons of travel time management and the safety of the field team.

1.5 PROGRAM AND THE STUDY TEAM

The study team comprised of three enumerators, one research associate and one principal investigator.

Four enumerators were involved to conduct the questionnaire survey at the community level. Since 50% of the respondents were women, two female enumerators were involved for the work at the field level.

The team visited communities in 48 villages of 24 unions. The unions were selected out of the 12 thanas of the 6 divisions. The sites were selected through a predetermined selection criterion. The principal investigator together with the research associate conducted the one on one interviews at the national and community levels. They also facilitated the focus group discussions and observed the proceedings of the W A TSAN committee meetings.

2. COMMUNITY PARTICIPATION IN WSS

2.1 INITIATIVES OF THE GOVERNMENT OF BANGLADESH

It is universal fact that water is central to people's way of life, which is more applicable to a riverine country like Bangladesh. The responsibility of making water available to the communities in a safe condition lies upon the Government as well as the general people of the country. Combined effort of all stakeholders is the only way in which this valuable resource can be made available to the people.

Considering the importance of water supply and sanitation sector and its impacts on health and well being of the people, Government of Bangladesh declared 1980s as "Water Decade" with the aim of delivering safe water and sanitation facilities to the people of the country. To implement the provisions of the policies the government co-opted the resources of the Ministry of Local Government, Rural Development and Co-operatives (MoLGRD & C) which has the statuary responsibility for the water supply and sanitation together with its policy formulation. The Ministry of Water Resources (MoWR) is responsible for the water management and general health is looked after by the Ministry of Health and Family Welfare (MoH & FW). The functional responsibility has been delegated to the Department of Public Health Engineering (DPHE) in all rural and urban areas except Dhaka and Chittagong.

2.2 THE NATIONAL WATER POLICY

The Government of Bangladesh formulated the National Policy for Safe Water Supply and Sanitation in 1998. One of the specific objectives of the NWP is to ensure the availability of water to all elements of the society including the poor and the underprivileged and take into account the particular needs of women and children. It is emphasized in the NWP that each individual has an important role to play in all aspects of the WSS program.

The National Water Management Plan (NWMP) addressed the importance of people's participation at all stages of the program from planning to implementation. Thus, within the macro framework of the NWMP, it was envisaged that participation of all project-affected persons would be ensured at all stages and Local Government (Parishads) would be the principal agency for coordinating these efforts. It is mentioned that the community level self help groups and NGOs would also be relied upon to assist in the participatory process and social assessments would be mandatory in all plan development.

The policy, recognizing that women have a particular stake in water management as the main users of domestic water, stated that they would be allowed to play a key role in local community organizations for management of water resources. The lack of access to safe water supply in rural areas and its impact on the health and productivity of the population in general, and women in particular, was identified as one of the root causes of household poverty. Through this policy the local government had the mandate to educate the people for checking water pollution. Thus arose the need for water distribution with equity and social justice.

The most important learning from the policy was that stakeholder participation is an integral part of water resource management. For this a complete reorientation of the institutions for increasing the role of stakeholders in decision making and implementation of water projects was a must.

2.3 THE NATIONAL POLICY FOR SAFE DRINKING WATER SUPPLY AND SANITATION

Keeping in line with the NWMP, The National Policy for Safe Drinking Water Supply and Sanitation was formulated in 1998. Community participation at every stage of project cycle from planning to maintenance was the strategy of implementing the NWMP.

No particular program or project has been designed to achieve the development objectives as set out in the government policies regarding WSS, but over the years, specific activities have been initiated with capacity building as a specific objective. Other activities, which may have had service provision as the primary objective, have directly or indirectly contributed to the establishment of national capacity in the government, NGO and/or the private sector.

Along with the introduction of the local government structure, the Union Parishads and the Union WATSAN Committees (UWC) were intended to play a key role in the promotion of sanitation and personal hygiene practices and in the site selection process.

If the implementation of the above polices are to be measured against achievements one must first be clear as to what exactly is meant by community participation. One definition is the empowerment of people. The community must engage in some of the following: identify problems, decide how they can be overcome, make plans and seek solutions. It also involves capacity building of communities to organize, manage and sustain services. Some of the activities necessary to bring this about are group formation, community management, planning and assessment. Communities must be able to take a conscious and informed decision about their needs and how to achieve them, They must be

aware of the processes required and be able to access sources to satisfy those needs in a manner that is equitable and socially justifiable.

The government's initiatives motivated donors and program implementers to strengthen their ongoing efforts. The positive steps taken to make safe water and sanitation facilities available at the community level and the physical distribution of tube wells and sanitary latrines is well documented.

However, it is seen that though resource investments have been made to promote community participation, the results so far obtained fall far short of the targets set. Some of the reasons for this which came to light during the study are mentioned below:

The meaning of community participation is wrongly interpreted by development workers.

- There is no involvement of all the users in the decision making process from the different groups.
- Lack of commitment.
- Inactive committees.
- Lack of understanding about their roles by the committee members (WATSAN committees).
- Inability to access technical options.
- Lack of ownership of facilities and dependency syndrome.
- No control of the system.
- No women involvement in decision making process.
- When focusing more on women and their needs, men think that it is only women's program and start to ignore it. This increases burden on women and they need supports from male community.
- Interference by the local influential people in the process of community participation.

2.4 COMMUNITY ORGANIZATION: CARETAKER FAMILY AND USER PARTICIPATION

The concept of community or users participation, i.e., involving beneficiaries in site selection, installation and maintenance of water supply options, thereby transferring a sense of ownership and responsibility, is a part of the Integrated Approach philosophy and should be evaluated against the field staff capacity. The objective of this program component of the government is to develop capacity at the household level and the level of the community to participate in the planning, implementation and operation and maintenance of physical facilities. International experience shows that the participation of users is a pre-condition for sustainable provision of water supply and sanitation services.

2.5 ANSAR & VDP: PARTNERS IN THE INTEGRATED APPROACH

Ansar and Village Defense Party (VDP) is a large voluntary force which has proved to be effective in a number of social mobilization efforts in Bangladesh. They have been actively collaborating in the implementation of a number of national program such as EPI, Mass Literacy, Family Planning, Tree Plantation etc. During early 90s, their involvement in promotion of village sanitation program yielded good outputs in a short span of time. Due to confusion at the donor level regarding the participation of VDP, involvement of this large group of community members could not be used optimally. According to the Union Parisads, WatSan committees, community opinion leaders and DPHE officials, this has been a missed opportunity for institutionalizing the program efforts at the village level.

2.6 OTHER GOVERNMENT INITIATIVES

Bangladesh Rural Development Board (BRDB) co-operatives are playing a significant role in rural sanitation. The efforts of the Department of Social Welfare for improved sanitation and safe water provision particularly focused towards the poor is also important. The field level health family planning field workers are other prominent allies from Govt. departments. Potential and need for coordinating with these Govt. bodies have been mentioned in a number of DANIDA/SDC joint missions reports. In practice the program has not succeeded in establishing any effective collaboration with these other GoB departments.

2.7 NGO FORUM FOR WSS

The objective of the social mobilization training program implemented through NGO Forum for Water and Sanitation during 1993-1996 in the selected 20 diarrhoea-prone thanas did not have capacity building of NGO Forum as its explicit target. Nevertheless, the program has resulted in interaction between the district and thana levels and has no doubt contributed to DPHEs networking capability. However, other than a limited number of contractual agreements with few international and national NGOs, the strengths of local NGOs for social mobilization and reaching the poor have not been explored and utilized.

In spite of all efforts to bring women into the mainstream of the development platform, no tangible progress has been made to maintain a gender balance in decision at any level. This is mainly due to the lack of a comprehensive integration of women's needs in development planning and inadequate co-ordination and monitoring at different stages of any such endeavors. This is also because the need for coherence in the thrust on Gender between various agencies is not clearly perceived.

3. STUDY FINDINGS

The research team visited 48 communities in the 6 divisions of the country to study the changes in the community behavioral patterns in relation to water and sanitation.

Other than development of habit of drinking tube-well water, virtually very little other behavioral changes related to water and sanitation were observed. Personal and household behaviors are unacceptable and sanitation practices by the majority of the population to a large extent are unhygienic.

3.1 MAJOR FINDINGS

The main observations regarding the prevailing behaviors and practices of water supply and sanitation are as follows:

Almost universally, people now drink tube-well water. There has been distinct change among large number of population from drinking river and/or pond water to tube-well water. The habit is established so well that efforts for carrying water from even long distance are now considered necessary.

There exist considerable number of tube-wells (both private and publicly owned) without platform having possibility of water pollution by dripping of polluted water. Some tube-wells are very close to latrines and water from these tube-wells is being used without considering the possibility of contamination.

Majority of the households uses pond and river water for cooking and other domestic purposes. The reason is not necessarily access or proximity.

Majority of the households does not use any types of latrine and open defecation is still common mainly amount adult males and children.

About 25% of the latrines under use are not sanitary and the general cleanliness condition of the majority of these latrines is poor.

Some households are using in sanitary latrines that cause environmental pollution.

People's practices related to personal hygiene, by and large, is still very poor. Some of practices are as follows:

Children's excreta is considered less harmful and not disposed of in a sanitary manner.

Hand washing after defecation is not followed seriously.

3.2 THE PROVISION OF SANITARY LATRINES

All the 48 communities visited had access to a Village Sanitation Center (VSC), but to some communities the closest supplier of latrines was a private producer. The Government, together with the non-government organizations, has been successful in creating a demand for sanitary latrines through their social mobilization programs. It has been estimated that at present (late 1998) as much as 90 percent of the latrines in the rural areas are supplied by private producers.

The study team interviewed the members of 240 households and found that very few had invested in sanitary latrines. Of the 240 families interviewed in 48 communities, less than 20 percent had access to a sanitary latrine at home. The children attending school, in most of the cases, had access to – but do not use – the latrine at the school.

The well educated and more affluent of the rural population are buying latrines from the market in which a large range of products can be found at affordable prices. The private sector is responding well to the emerging demand from private households, but at the moment a sanitary latrine is not a priority of middle income and of poor rural households. The Team interviewed customers, who preferred the latrines produced by the private sector. They were cheaper, located closer to the home, and had a product range from which the customer could make a choice in accordance with his/her priorities. The water sealed latrines produced by the VSCs are not popular with all customers. They prefer less expensive solutions.

The success of private latrine production in recent years relates to the hygiene awareness, as well as to a demand for privacy-particularly among young women. Social status also matters. Among the more wealthy rural families a latrine has become a status symbol.

3.3 THE USE OF SANITARY LATRINES AND SANITARY PRACTICES

The access to a sanitary latrine does not guarantee its use. Some latrines – particularly in areas where the provision has been forced or linked to a subsidy, which the consumer wanted – has fallen into disuse. Some school children prefer defecation in the open due to convenience. Most of the people (adult males and

children) interviewed continue to defecate in the open – many near the pond from where they fetch their water for cooking, and in which they take bath.

Children under 5 years are not considered to be targets by either the families or the development organizations working in the areas. No attempts have been made to make appropriate technology and related information available to parents of school age/going children. Due to a complex set of cultural and socioeconomic factors organizations have been unable to reach the majority of the population.

Regarding the use of sanitary latrines experience shows that it must be based upon the expressed needs and priorities of the households. To change these priorities is a long-term process.

A more focussed approach is needed for effective promotion of the use of sanitary latrines. Public media like radio spots, television spots etc. which are increasingly reaching to the villagers in Bangladesh may prove more cost-effective than social mobilization campaigns. For children, the example of adults such as parents and teachers may prove cost-effective compared to class room teaching.

3.4 PERSONAL HYGIENE AND SANITARY PRACTICES

The study revealed that (assuming all the tube-well water was safe) the benefit of drinking tube-well water for healthy life has been well understood by the majority of the population. However, the need for keeping tube-well root area free from polluted water dripping through the pipe bore-hole or maintaining a safe distance from latrines have not been rightly perceived by most of the of the consumers. It was learnt that these have simply not been adequately explained to them by anyone in the past.

Other than adapting to the habit of drinking tube-well water, very little positive changes could be seen amongst the majority of the population regarding personal hygiene and sanitation practices. Traditional cultural values and perceived conveniences are still the decisive factors. Change in behavior has occurred within a small proportion of the population (mostly rich and educated) although most likely not as an impact of the awareness raising sessions attended but largely due to the economic solvency of the users. Even among the rich and educated families, privacy and social status have received more importance over health benefit.

3.5 TRAINING COVERAGE

The coverage of personal hygiene and sanitation training given by the government or any allies mobilized by them, at the beneficiary level is very insignificant. Most of the community members and tube-well caretaker families interviewed have not received any training or orientation on personal hygiene and sanitation. Students acquire some health knowledge in school from the teachers and visiting health workers.

The social mobilization (SOCMOB) training program development for mobilizing the Union Parishad, informal community leaders, imams, social workers and others have not achieved the effective coverage. Only a few, less than 5%, of such personnel interviewed received some basic training.

The WATSAN committee at the union level has made half-hearted attempts at being involved with the community for promotion of WSS. This is clearly observed in the gaps in understanding the roles, functions and responsibilities of the WATSAN committees both by its members as well as by the community. The study team held meetings with 12 WATSAN committees, which were attended by about 200 participants. A hand full (less than 10% WATSAN committee members) could mention receiving any training or orientation from either the government or any of its allies in the effort. In many cases, it was the first time the committee member learnt the existence of a WATSAN committee. Even the name WATSAN is not understood by many of the members. In one place the committee was found with the understanding that the WATSAN committee's role as carrying road construction projects.

3.6 IMPROVED ACCESS TO SAFE WATER AND ITS USE

Government statistics show physical achievements of TWs installed and rehabilitated after floods to be 97% (in 1996). It should be noted however, that this figure is based upon an average calculated as the number of people per installation for each location. Such a figure misleads the assessment of improved access to safe water because of many reasons.

It includes pumps to which access is not free to the general public because it is privately installed, owned and maintained. It assumes, that the TW is installed in a place where it serves the community in an optimum manner in the sense that it minimizes the distance which members of the community have to travel to fetch water.

It includes pumps installed by the Department of Public Health Engineering (DPHE) but financed (contribution) by one household and located within its

compound and effectively privatized by the same households. The user group does not contribute to the O & M and collect water at the discretion of the "caretaker cum de facto owner" of the public TW.

These three factors account for the difference in access to TW water between different socioeconomic groups. During the mid 80s the cost of installation of a hand pump (# 6) had become affordable to most non-poor households, and those with the highest need bought pumps from the private sector to be used by themselves, family and friendly neighbors. Some rich families even installed more TWs, some of which were sunk in the yard where water could be used in private. Only the poorest 30-50 percent of the households lack access to a private TW, but very few would have to travel more than 100 meters for fetching water from TW.

However, use of TW water for all purposes still depends on its proximity. Households which have to fetch water from neighbors or from a distant well would limit their water consumption to what can be fetched by the available hands two to three times a day. In rural Bangladesh, this general pattern is obscured by the fact that many people have a preference for bathing in rivers and ponds. This may be out of habit or simply part of a social event, which brings its own pleasures and which is continued in spite of the fact that people are well aware of the health risk.

In the 90s, villages with a good political leadership and/or with an active Member of Parliament were able to increase coverage substantially by getting more than a fair share of the Tara TW allocation given to the districts. Thus, the study team found significant differences in coverage between neighboring villages. Detailed investigation revealed that villages well served had a leader who was either Member of Parliament or chairman of the Union Parishad. Discussions with local leaders in three villages confirmed the relationship between village representation in political bodies and the average service level.

The local leaders explained that the DPHE guidelines for siting of TWs could not be followed because only rich people can afford the investment and O & M cost of Tara TWs. Hence, all the Tara TWs in the visited villages had been located in the private compound of a rich and /or empowered family such a members of the UP, their relatives and the political supporters.

The above are in direct contradiction to the Government's TWs siting criteria and the concept of community participation in WSS. Though they were aware of the procedure for TW application the community in these cases were powerless to voice their needs and gain access to the scarce resource.

3.7 COMMUNITY AWARENESS AND KNOWLEDGE

It was assumed that the staff of DPHE, NGOs and others, who received training on SOCMOB activities, would be able to conduct water and sanitation awareness orientation courses for community members, mobilize potential allies from the society and be instrumental in bringing about positive changes in health and hygiene behavior. Unfortunately, this assumption has proven to be too optimistic. The reasons are, firstly, the low priority attached to these software interventions and secondly, the lack of adequate supports (training aids, staff and petty) in carrying out SOCMOB activities.

The impact of the available training has also been limited due to the low education level of the majority of the recipients. The most important drawback of the social mobilization efforts has been its failure in transforming the real essence of SOCMOB i.e. using effectively the local allies and partners to its field functionaries. Importance of creating local support groups and networking with other departments for promotional and mobilization activities have not been understood and taken seriously.

3.8 WSS PROBLEMS AND THEIR LINKS WITH HEALTH

The findings from the communities visited with regard to changes in water use and sanitary practices are in general in line with the findings of studies undertaken by previous studies and evaluations.

Most people are using TW water for drinking. When the taste or smell and appearance of the food becomes acceptable, TW-water is also used for cooking. For all other purposes most people continue to use pond/river water. Defecation practices have not changed for the majority of the rural population. They mostly defecate in the open. However, the situation appears to begin to change.

Children are not given hygiene information by their parents and the habits of children under five has not changed. No activities have been specifically targeted towards them.

The impact on improved health follows logically from the changes in the behavior.

The diseases related to the drinking of unsafe water have greatly been reduced i.e. diarrhoea and cholera etc.

There has been no effect on water born diseases related to defecation practices and personal hygiene i.e. parasitic infestations such as worms and skin diseases.

These findings are significant. They contradict a widespread perception – that awareness raising efforts at the community level has had limited health impact. Though the above may be true the information must be cautiously used for the below mentioned reasons:

Only reported cases are analyzed – but in fact most cases were/are never reported.
SOCMOB campaigns may have resulted in an increase in reporting.
The reporting system has been improved over time.
It is uncertain if the increase in the rural population is properly taken into consideration.

It is important to note, however, that the improved health benefit is unevenly distributed among socioeconomic groups due to the non-adherence to the site selection criteria of the Union Parishad and the DPHE. The poorest of the poor are not enjoying the potential positive health impact of the massive investment in hardware and research. They are still suffering from general poor health conditions. They are therefore less productive than what could have been, loose more labor days than need to be and indirectly are unable to improve much upon their economic status. Empowered people, quite on the contrary, not only enjoy most of the potential positive health impact. They have also in some cases been able to use the allocation of TWs to enhance their power-base in local politics.

Impact studies on rural water supply and sanitation in other developing countries in the region have detected a positive unintended impact in terms of increased production. The improved access to water made it possible for some of the households to increase the production of vegetables and livestock. Some households were even able to start non-agricultural activities such as brick making. In Bangladesh the impact on such production activities seems to have been limited.

To reduce the incidence of diarrhoea and parasitic infestations particularly among children is an important objective of the NWP. Provision of safe water, improved sanitation and promotion of personal hygiene are the outputs of the program floated under the policy. The assumption is that the 3 outputs together are sufficient to result in a behavioral change of households with regards to the use of water and sanitation.

It is an accepted fact that use of safe water for all domestic purposes is not sufficient to reduce the incidence of diarrhoea and parasitic infestations. Only when combined with improved sanitary practices are the planned, health impact likely to be achieved. Sanitary disposal of excreta and appropriate personal hygiene like washing of hands after defecation is also required.

Combined, the use of safe water for all domestic purpose and improved sanitary practices will reduce the risk of rural families contracting the so-called water born and water related diseases. But other risks, for example, related to the consumption of contaminated food will remain. It is a misconception that a successfully implemented WatSan program in itself will result in a reduction in, for example, diarrhoea or cholera. The prevalence of diarrhoea or an outbreak of cholera, hence, is not an indication of an unsuccessful WatSan program.

3.9 COMMUNITY EFFORTS FOR IMPROVED WSS

Weak attempts have been made by communities to access resources that will improve the water supply and sanitation status of their respective communities. Repeated failures in the attempt to translate their needs to availability have discouraged many communities to opt for personal acquisition where it is possible. Where financial capacities are limited, members of the public use their influential connections, however distant, to gain access. The communities neither take the responsibility of improving the situation nor 'wasting' their time in a fruitless chase.

The willingness of the community members and leaders to take the responsibility for improved WSS in their communities is still not common. Though for the poorer families cost sharing would improve their chances of access to safe water it is a rare happening. The provisions within the government framework does not provide any subsidies for the poor nor is there a "safety net" for them to fall back on in cases where financial contribution is the only criteria required to access the resource.

Community participation in WSS sector has still not taken root in Bangladesh. What little achievement is seen is the result of concentrated and combined efforts of the Government and the NGOs at social mobilization and installation of tube-wells. However, physical achievements have not resulted in a widespread change in water use habits of rural families. The benefits in terms of access have not been distributed in accordance with the NWP guidelines. TWs have generally been in the compounds of rich and empowered people. This has possibly enhanced the financial sustainability of the facilities, but at a cost of proximity and access for poor people, which may have excluded them benefits of using water for more purpose and from the benefits of leisure. TW water is considered to be safe, but people decide on water use on the basis of a rather complex set of priorities: Thus, though the general community members are aware of the importance of safe water and sanitation often they are unable to put their knowledge to practical use. Empowered families with good access get the full benefit and use water in accordance with their own priorities. They sometimes continue to take baths in the ponds, and sometimes they do not use TW water for cooking, if the taste and appearance is bad.

People who are not empowered buy their own TWs when technology is cheap and affordable to them. Generally, this is not possible for the poorest of the poor. In the low water table areas only the rich and the middle class can afford to buy private TWs. It is known that a version of the very cheap treadle-pump is being developed for domestic water supply with donor assistance, but this affordable technology is not yet available in the market. People including the poor, have the access to TW water that is used only for drinking.

To ensure that also the poorest of the poor get a realistic option for using TW water for all purposes, a poverty-oriented strategy should be followed. To ensure this, it will be necessary to design an implementation strategy, which empowers the poor financially as well as politically in the area of Union Parishad politics. Unless the local government is willing to step back and let the members of the public take charge for their own improvement, community participation in WSS sector cannot be expected to become a norm in the rural communities.

4. CONCLUSIONS AND LESSONS LEARNED

4.1 CONCLUSIONS

a. Focus Group discussions

Focus group discussions with different levels of stakeholders, showed that effort to involve the community in relation to application for tube wells have been minimal. Their involvement has been reduced to pure cash contribution that to for the most part has not been a joint effort by the poorer section of the community. Instead, the better off who can afford to install one themselves pay the total amount individually. As a result, they become the owners by default and others more deserving of the well are denied access. This "payment by one who can" approach has been adopted time and again to reach targets set by planners.

b. WATSAN Committees

Interactions with the members of the WATSAN committee revealed that most of the time the women members do not attend the meetings. If and when they do, on special occasions when there are outside visitors, they play an extremely passive role. Almost none of them have any idea regarding their roles and functions as WATSAN committee members. Discussions showed that they have not received any orientation or guidance in this matter from any quarters. Thus, it is not that they do not want to voice the concerns regarding water and sanitation of the women in their constituencies. It is a fact that they do not know how to do so or even what to ask for since they are in the dark as to what is available. None of the women members come from the poorer section of the community. With no monitoring of their attendance or activities from the relevant authorities they are left holding the "position" without any say either in the allocation or site selection for TW sinking. Some of the members who did want to attend the meetings and actively participate in the proceedings said that they couldn't afford the travel cost. It appeared that they expected to be paid to attend the meetings. If this is true then it is clear that all efforts to motivate them to take ownership for their own development has not been successful.

Besides the WATSAN committees at the union level, other actors in the sector are few and far between. Institutional development is one of the dual development objectives of the water supply and sanitation program and is expressed as the efforts made to help the government to strengthen the national capacity to provide water supply and sanitary facilities for rural areas and urban slums and fringes in a way that will achieve possible impact and behavioral change in the sanitation and hygiene practices. It was seen that throughout the years the poor have not been addressed as a specific target group. All the programs that have so far been implemented have not been designed to take up measures for targeting the poor. Poverty alleviation has not been an objective.

The measures proposed for the involvement of women have not been set in motion. Those, which are in place, will not actually empower them in the local decision making process concerning tube well site selection and health and sanitation promotion activities under the banner of the union parishads.

In relation to the social mobilization activities almost all the tube well mechanics are men and as such have difficulty in addressing women for dissemination of health and hygiene information.

Apart from the direct improvement in the conditions of the rural population it is thought that capacity building and bringing about behavioral change is the responsibility of the government.

Though the Union Parishad Chairmen and members were intended to act as the main channel of communication between the government and the community this has not come about. It is well known that the community must initiate the request for installation of a tube well. In practice, the selection of the site is the jurisdiction of the local influential persons.

The weakness of the system stems from a mismatch between the allocation of responsibility and the delegation of authority and allocation of resources. Though this is apparent throughout the system it affects the lowest tier of WSS programs. The reform must however begin at the highest tier to have any impact down to the chain of command.

To change existing sanitary and personal hygiene practices it is necessary, with a continued, on going effort, to target in particular women as the agents of change by passing on the habits to future generations. Observations in the field indicate that the ability of the program implementers to catalyze a behavioral change is weak..

4.2 LESSONS LEARNED

In depth interaction with different levels of stakeholders brought to light that though the program designers of community participation in WSS sector advocated planning from below they failed to listen to the grassroots when an actual planning for WSS came about.

Thus program planning, even if it is for the installation of a latrine or sinking of a tube-well, it must always take into consideration the needs of the ultimate users.

When development becomes donor driven the delivery systems may not be sustainable after the withdrawal of the donor assistance.

Therefore, implementation of responsibilities must be allocated according to capabilities and sustainability must be the first consideration.