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BRAC WASH programme

Babar Kabir, Tanzeba A Huq, Rezaul Karim and Mizanur Rahman
BRAC WASH Programme

Abstract

The Government of Netherlands supported BRAC WASH initiative is a scaled up programme to bring sustainable water and sanitation to over 37 million people in a range of locations across the country. It is based upon carrying out a census of the existing situation and an intensively supported hygiene education based approach to encouraging lasting behaviour change. The case study describes the general approach and early progress in one location.

Background

Safe water, sanitation facilities, and hygiene are pivotal for life. They touch every aspect of human activity, from environmental protection to safe drinking water and from empowerment of women and education of girls to the reduction of productivity losses. More than a quarter of all people in the developing world lack access to safe drinking water sources, and more than half lack sanitation facilities (WHO and UNICEF, 2006). Lack of safe drinking water and sanitation has a profound effect on health, especially waterborne or diarrhoeal diseases, which have a significant impact on children. It is estimated that around 3,900 children die from waterborne diseases every day (WHO and UNICEF, 2004).

In recognition of these facts, the Millennium Development Goal (MDG) targets include halving the proportion of people without sustainable access to safe drinking water and sanitation between 1990 and 2015. Table 1 shows the water supply and sanitation (WSS) coverage in Bangladesh from 1990 to 2006. It highlights the fact that the lack of basic sanitation and adequate

hygiene knowledge contributes to child mortality, which could be curtailed through behavioural change in hygiene practices such as access to sanitation and safe water. For example, hand washing alone can reduce mortality by 42%.

TABLE 1 Water and sanitation coverage in Bangladesh

Coverage	1990	2000	2005	2006
Safe water	85.2%	97%	74%	74%[1]
Sanitation	21%	41%[2]	39%[3]	39%

Sources: UNDP 2006, JMP 2006, SDNP 2005, UNICEF Bangladesh 2006

The Government of Bangladesh (GoB) has set an ambitious goal of achieving full sanitation coverage by 2010. This requires a 12% per annum increase in coverage whereas the average annual increase since 2003 has been 4%. However, GoB has taken initiatives to achieve this national sanitation target in collaboration with development partners and NGOs. One of these is the BRAC Water, Sanitation and Hygiene (WASH) Programme.

BRAC WASH, the Bangladesh element of the Government of Netherlands funded programme, will support extending access to safe, reliable and sustainable drinking water and sanitation for 50 million poor people. It aims to initiate a holistic approach incorporating hygiene promotion and education to 37.5 million people, ensuring access to sanitation services to 17.6 million people, and providing safe water services for 8.5 million people[4]. It will ensure proper maintenance and management of the existing water supplies by the community. Fulfilling BRAC's commitment to the poor, the programme incorporates sustainable and appropriate services to the poor and hardcore poor, and particularly to women.

Justification of undertaking WASH programme

In Bangladesh, unsafe water, poor sanitation and improper hygiene practices contribute to the death of thousands of children less than five years old. Therefore, every family in the community should know the risk factors that result in diarrhoeal or waterborne diseases. Contributing to these risks are unfavourable sanitary practices such as faecal disposal in open places, improper waste disposal, absence of latrines, lack of proper hand washing and poor food handling, and lack of access to protected water. Hygiene incorporates healthy habits or practices that ensure disease prevention and a healthy environment. Hygiene practice is integral to a healthy life, an environment free from diseases, and prevention in the spread of various waterborne diseases.

Similarly, safe water, sanitation and improved hygienic practices play an important role in poverty reduction. The WASH programme also pursues the goal of achieving a sustainable influence in health by reducing maternal, child and infant mortality rates by improving the health status of children, adolescents, women and men. In spite of concerted efforts to provide safe water over the preceding decades, approximately 25 to 30 million people are affected by arsenic contamination in drinking water. Coverage has decreased from near universal

[1] Reduced due to arsenic contamination
[2] Includes non water seal latrine
[3] Fixed defecation is considered by GoB as latrine coverage which is 84% in 2006
[4] Where 7.5 million people will have access to safe water through the repair of existing water facilities and 1 million people will get access to safe water supply through new water supply facilities

access to around 74%, as shown in Table 1. Sanitation coverage is also less than four in ten. Through direct and indirect support, BRAC will raise the sanitation coverage to 80% in 150 Upazilas, including at least half of the uncovered households below the poverty line. There is no reliable countrywide data on hygiene practices; however, the lack of hygiene practices deprives the community from the benefits of safe water and sanitation.

Among the constraints to improving water and sanitation are the lack of hygiene knowledge and practice, insufficient and inadequate financial resources, and inappropriate adaptive approaches in design and implementation of drinking water sources and sanitation systems. The community led approaches in the BRAC WASH programme (and others) may help to conceptualise the water and sanitation situation, leading towards a solution overcoming these constraints. It will help the community to understand the necessity of integrating safe water, sanitation and hygiene practices, which might be a more effective measure than providing only complimentary hardware.

This approach is expected to assist in reducing the burden of disease, relieve human suffering and ensure considerable economic benefits. The Government of Netherlands has helped the BRAC WASH programme to emphasise interventions that will improve the health of the population in an affordable, equitable and sustainable way, with particular focus on reducing child morbidity and mortality.

WASH programme device

BRAC is implementing the programme in 150 sub-districts of Bangladesh with an innovative and education-focused approach. It is composed of a preparation phase of six months followed by a start-up period of 1.5 years. The BRAC WASH programme was launched in May 2006 and currently has a staff of 5,360. It has a target population of 37.5 million in a total programme area of 1,468 unions and 89 municipalities.

The programme focuses on multiple challenges such as:

1. reaching the poorest people to ensure consistent hygiene practices
2. issues related to water quality and water management
3. improving pro-poor sanitation technologies, especially for high water table areas.

WASH programme goal

The WASH programme aims to help, in partnership with the GoB and other stakeholders, to achieve the MDGs and national objectives related to water, sanitation and hygiene for all – especially for underprivileged groups in rural Bangladesh – thereby improving the health situation of the poor and enhancing equitable development.

Specific objectives

Within the programme area (in rural parts of the country) to:

- Objective 1: Provide sustainable and integrated WASH services.
- Objective 2: Induce safe hygiene behaviour to break the contamination cycle of unsanitary latrines, contaminated water, and unsafe hygiene behaviour.
- Objective 3: Ensure sustainability of and scaling-up of WASH services.

The WASH programme is divided into three parts, or *'phases'*. Each phase consists of 50 sub-districts. Within each phase are three stages of work activities where hygiene education, sanitation and water aspects are addressed respectively. The WASH programme has five major components:

- **Water** (renovation of existing/traditional water sources, small piped water supply schemes by bore holes/surface water, capacity development, innovation and technological options; coverage: 8.5 million).
- **Sanitation** (installation and maintenance, micro-enterprise development, revolving fund for poor, subsidy for hardcore poor, capacity building; coverage: 17.6 million).
- **Hygiene practice** (behaviour change communication, advocacy, hand washing, social marketing, formative research; coverage: 37.5 million).
- **School sanitation and hygiene education** (hygiene promotion and education, installation and maintenance of tubewell/latrine, separate latrines for girls, school compound cleaning and disposal of solid waste).
- **Public-Private Partnership** (partnership with soap companies, local sanitation entrepreneurs, Local Government Institutions (LGIs), Department of Public Health Engineering (DPHE) and other stakeholders such as the Watsan committee, Rural Electrification Board, Power Development Board and an advisory committee comprised of relevant specialised organisations.

While accomplishing WASH activities, BRAC will coordinate with influential stakeholders and community leaders, religious leaders, and union members in the local context to influence and motivate towards WASH activity.

The basis of the targeted water and sanitation coverage

The BRAC WASH programme has taken the present structure from a series of lessons learned over the years in providing various, water and sanitation services at grass roots level. The programme developed with the changing demands and needs of the poor. It is estimated that the proposed 100 pipe water systems will serve 0.25 million (pipe water system 100 X 500 HH X 5 person /HH = 250,000) and the proposed 3,000 deep tubewells will serve 0.75 million people (deep tubewell 3,000 X 50 HH X 5 person /HH = 750,000). Thus, WASH will provide safe water to 1 million people through new water interventions.

The targeted sanitation coverage has also been delineated from the following estimation:

1) Total population	
250,000 /upazila X 150 upazilas	= 37,500,000
2) Target in WASH programme 80% HH	= 30,000,000
3) Existing latrine coverage	
33% HH (base line survey)	= 12,375,000
Therefore, accomplishing target for sanitation in WASH	= 17,625,000

Upazila selection criteria

While selecting 150 upazilas, the Bangladesh sanitation task force has ensured harmonisation between other donors and WASH activities by allocating different project areas for BRAC-WASH according to three selection criteria (poor area, low sanitation coverage, arsenic contaminated area) of the WASH programme. There is a sub Local Consultative Group (LCG) forum on WSS, which coordinates to harmonise the programme and to avoid duplication of development work in the same area through regular review meetings.

WASH programme concepts and strategies

The overall programme strategy has its foundation in hygienic practice and behavioural change. Capacity development, community organisation, institutional mobilisation and the availability of relevant facilities are key components of the WASH programme, which seeks to initiate, establish and reinforce behavioural change and sustainable hygiene practice. The micro-strategy is to sensitise and stimulate bottom-up participation on planning and implementation at the village level. WASH committees represent the villages. Their members are comprised particularly of poor people and women, other active committees and agencies, and other local NGOs. Thus, the programme will be reinforced through learning, reaching beyond the BRAC network. The plans were developed by adopting the Participatory Rural Appraisal (PRA) method and later at union level with a multi-stakeholder group. A standard action plan methodology is used for most villages but this is applied flexibly where the context dictates.

Specific support measures such as access to loans and grants have been included in the programme to ensure construction of sanitary latrines by the poor and the hardcore poor. Aligned with the policies of GoB, the proposed programme has allocated financial support for hardcore poor families to install slab latrines.

Programme Assistants, along with Programme Organisers, are supervised by trained Upazila Managers in each Upazila. Regional Managers of BRAC WASH local offices are responsible for overall supervision of different sub-districts under his or her jurisdiction. A Programme Management Team, with the assistance of a Programme Specialist team, manages and supervises the programme from central to Upazila levels.

During this initial two-year period, there will be different types of action research and experimental or comparative trials on various issues to develop a highly effective, community driven, large-scale and sustainable programme. At every point the key indicators are checked and monitored qualitatively as well as quantitatively. It is important to assimilate key lessons learned during the first year of the programme and to modify the programme design on a budget neutral basis for improving subsequent activities.

Scope of intervention

WASH interventions occur at six levels: ***household level,*** through individual and group education or interaction***, institutional level,*** through educational and social institutions, ***community level,*** through involving village WASH and WATSAN Committees, ***administrative level,*** through social mobilisation and advocacy at sub-district and unions, ensuring ***partnership*** with corporate sectors for promoting the use of soap, and ***reinforcement of messages*** through interpersonal, electronic or print media, folk media and popular theatre.

Activities before commencing intervention

Community census

To set targets for the programme, it is important to know the present status of water and sanitation situation. It is similarly important to know the reasons why such a vast number of people do not have latrine and safe water facilities. Community

censuses have been conducted in every household and institution to know the WASH status. The census was instrumental in sensitising people at the grassroots level about sanitation, safe water and hygiene issues.

Programme staff were involved in the "community census" which covered every household. This survey identified each and every household and determined their WASH status before starting project interventions. The objectives of the community census are:

- Identification, benchmarking and quantification of WASH indicators to measure the post-intervention impacts
- Provide a baseline against which to monitor progress
- Identify and locate groups (such as the hardcore poor) within the village that need specific attention
- Provide the background for the development of a village implementation plan in terms of number and types of latrines that need to be constructed and type of interventions that need to be made to ensure safe drinking water supply.

The following activities are carried out under the census:

- Survey method design
- Questionnaire preparation and finalisation
- Training of data collector /staff
- Field data collection
- Toilet observation
- Data entry and analysis

The community census has been carried out in all 150 selected sub-districts in three phases. Community census of first 50 sub-districts began in August 2006 and was completed in December 2006. The second phase census, consisting of the next 50 sub-districts, began in January 2007 and was completed in June 2007. The final 50 sub-districts began in July 2007 and was completed in December 2007. Findings from the community censuses along with PRA will be used to design and implement WASH intervention activities[5].

Toilet observation is one of the decisive activities during door-to-door information collection. It provides basic information about the initial latrine status, endorses and helps the WASH staff to be accepted within the community, and increases their accessibility to the community. Furthermore, the community becomes sensitised to the new information and messages being promoted. Rapport and empathy are strengthened through allowing an outsider (WASH staff) into the most private area (latrine) of any house.

Programme Intervention

WASH programme intervention started its field level activities in January 2007 given completion of the census, along with the following assumptions. WASH will continue its programme activities (new constructed toilet observation, social mapping, and formation of village WASH committee) systematically. Hygiene promotional activities are

[5] There are 9.5 unions on average in each upazila and WASH has three staff at each union. Altogether, that makes 28.5 staff in one upazila excluding four staff at upazila level, thus around 32.5 staff members are in each upazila for the WASH programme. One staff member is able to complete at least 30 questionnaires a day (sometimes more depending on the distance). It was found that on an average, 35 questionnaires (ie households) could be completed in a day per staff member and 1,137.5 households per day per 32.5 staff members. WASH has 1,625 (50*32.5) staff at 50 upazila and therefore 56,875 (1625* 35) household's information can be collected in a day. So, an estimated 2,736,434 HHs in the first 50 upazila can be completed in (2736434/ 56875) 48.11 working days.

initially the primary focus, followed by messages on sanitation practices and safe drinking water.

Assumptions

- Every household should have its own or shared sanitary latrine
- Only two families should share a joint latrine, as per government policy
- Newly constructed sanitary latrines need to be technically safe and sound to the users and environment
- Hardcore poor are identified and selected households will receive materials and install sanitary latrines
- Annual Development Programme (ADP) block grants will be mobilized for proper use by Union Parisad for sanitation coverage under programme area
- Poor families, identified by the Village WASH Committee, will receive loan support to install new latrines and replace latrines
- WATSAN committees in all unions will be active or have reactivated
- Ensure representation of Village WASH Committee, BRAC WASH in the Union WATSAN committee.

Social mobilisation, and hygiene and sanitation promotion through social mapping

The aim of PRA is to help strengthen the capacity of villagers to plan, make decisions, and to take action towards improving their own situation. It also involves BRAC WASH staff learning together with villagers about the village. The lessons are designed to provide staff and villagers with a better understanding of (a) the bio-physical, socio-economic, and institutional characteristics of the village through PRA, and (b) the use of PRA information as a basis for designing, implementing and managing village WASH (water, sanitation and hygiene) activities.

In the WASH activity areas, BRAC forms a Village WASH Committee that consists of clusters of between 50-300 households, depending on the location of the households in a union. For the formation of the Village WASH Committee, each cluster consists of 10 households. Before the cluster meeting takes place, the Programme Assistant (PA) ensures that female members from all 10 households participate in the meeting. To conduct initial WASH activities, 3.5 to 4 days are needed.

PAs remind community members of previous BRAC interventions involving oral rehydration, or drinking saline, as a health measure for diarrhoea. It is emphasised that the WASH programme is a continuation of the initial interventions, currently undertaken to prevent the spread of diarrhoea and other waterborne diseases. BRAC staff members disseminate information about WASH to the villagers in half a day and extend an invitation for the next meeting.

During the first day of the meeting, respective staff members ensure the presence of local elites and other general people. The staff members provide five messages on hand washing: three on hand washing before taking food, and two on washing after defecation; then they review, with their feedback. A participant is also invited to demonstrate the difference between hand washing with water only and proper hand washing with soap. Then a map is drawn on the ground showing all the houses in the cluster. This map is only within the small women cluster to sensitise. Availability

of sanitary latrines and tubewells are also portrayed in social mapping. BRAC-WASH staff members record which people have drawn the map, demonstrated the hand washing and the number of male and female members who participated in the meeting.

Apart from the cluster meeting for women, the village is split into six clusters taking 50 households each for male members, adolescents and children aged between 9 to 11. They are informed in separate meetings as organised before.

A house that is acceptable to all and located at the centre of the 300 households or the village is selected as the "centre house" and, after consultation with its owner, a time and date is chosen for the next meeting. To assist the formation of the WASH committee, one or two acceptable, active community leaders are invited to draw the social map in the next day at a designated time and place. The next day, people are divided into two groups that walk the whole area of the village and return to the same spot. After the visit, the participants comment on what they have seen and discuss steps to overcome the situation. Initiative is taken to create a sense of competition among the clusters.

With active participation from all, a map is drawn on the ground. Then a social map is drawn on a big piece of paper using code and symbols. The interpretation of using code and symbols are explained in detail. The names of the people who have participated in drawing the map are recorded on the map.

The map is a pictorial tool, illustrating the entire sanitation system, especially the location of latrines, problems in safe drinking water supply, location of the tubewells, water drainage system and the socio-economic condition of the inhabitants. At a glance, one can glean the information of the respective village motivating discussion to resolve the apparent problems. A comparative analysis is made between this data and the data collected initially by BRAC during household survey or census. Before ending the session, everyone is thanked for their participation and asked to join the next day's meeting.

On the next (third) day, a person is selected among the participants to preside over the meeting. Those who participated in the preparation of the social map and cluster-based information present the findings gathered. A competitive environment is created among clusters to develop the situation.

Formation and orientation of the Village WASH Committee

With upfront participation from all, the Village WASH Committee is formed for the 300 households for a period of two years. The president of the committee is elected from the respected people and local leaders. After electing a representative from female youth as member secretary and one village society or BRAC village organisation member as treasurer, the Village WASH Committee is formed. It consists of 11 members of various groups and trade. To emphasise women participation, the committee must have six women members and five men among the total 11 members. The person elected as president must be able to dedicate enough time to the committee for improvement of safe water, sanitation and hygiene in the village. Union Parishad members and women members in their own area are selected as advisers of the

Village WASH Committee. In other places, two advisers are selected from the qualified and respected people of the village.

After the meeting, a resolution for the meeting is adopted and names and signatures of the participants are recorded. The president keeps the social map, register and file to enable him or her to record future activities.

The committee will usually initiate the following steps to execute WASH activities:

- Identify problems and resolve them by using existing resources
- Mobilize local resources to assist the local poor and hardcore poor people
- Undertake actions considering the significance of public health and develop human resource
- Establish a sanitary latrine in every household and ensure its use
- Repair, maintain and properly use safe water technology
- Hand over responsibilities to the village committee for further improvement after certain period of implementation of activities has passed.

Before forming the committee, a social and professional rapport is built with villagers, which is important to communicate to everyone irrespective of social class, and to assess their interest and strengths.

The members of the committees are empowered by orientation and play a significant role in promoting WASH activities in their respective villages. The first meeting is held within seven days after formation of the committee. An orientation session is organised within 15 days after formation of the committee, where the members are told their duties and responsibilities. The advisers and committee members create a specific yearly plan to ensure safe water and total sanitation in the village.

In the reporting period (until December 2007), 20,835 Village WASH Committees were formed and orientation sessions were held for all the committee members. The active and enthusiastic facilitation, combined with regular follow-up and monitoring by the WASH committee members, will help to reinforce community participation and mobilisation regarding water, sanitation and hygiene practices.

Challenges at this stage of programme activities

The following challenges have been identified:

- Ensure hygienic practices irrespective of age and socio economic class
- Ensure alteration of unhygienic latrine to sanitary latrine from 66% to 100%
- Ensure installation of sanitary latrines by all, irrespective of socio economic class
- Ensure use of sanitary latrine by all age groups
- Ensure sanitary latrines at atypical areas e.g. *char* (low-lying river islands) land.

Impact indicators

Through home visits, discussions at mosque, religious or education institutions, the committee works to improve awareness, ensure safe water and use of sanitary latrine at every household. WASH also involves school children to make them aware them on these issues. In addition, the village committee – in coordination with the Union

BOX 1 Chornilokhiya Union - a case study from the WASH programme

Since it is difficult to elaborate on the impact of the WASH programme in all the programme areas and give detailed information of changes in all the sub-districts, this case study will focus on one sub-district.

Mymensingh Sadar sub-district, located in northern Bangladesh, has been chosen because WASH has been implemented there for more than 16 months. Given the volume of data available for the entire sub-district, the data of one union (about 10 unions to one sub-district) will be used in the case study. Chornilokhiya, which had the lowest sanitation coverage (total latrine coverage 34%, sanitary latrine coverage 19.57%), is a union under the first phase of the WASH programme and is being considered for this analysis. It will provide an overview as well as fresh insight into the process being followed by BRAC WASH to change the general sanitation situation of this area.

Study area: Chornilokhiya; Mymensingh, Village 11
Study population: Total sample size was 43,285 people
Sampling technique: For the intervention group, all eligible inhabitants (those who are not resident to one area for more than six months and/or not visitors are eligible for the survey) of the pre-intervention area were surveyed.
Objective: To reveal the difference in perceptions and knowledge on safe water, sanitation and hygiene practice at baseline (pre-intervention) and after the intervention implementation phase began.
Study design: longitudinal panel study (ie the same individuals at base line and after the intervention implementation started were observed).
Data collection tools: For the quantitative part, a structured questionnaire was used. For qualitative data collection, observation techniques were used and triangulation was done for effective evaluation.
Pre-testing the questionnaire: Pre-testing was also one of the important steps in preparing the final questionnaire. The purpose of the pre-test was to evaluate the level of success in obtaining the objective and goal of the intervention. The pre-test further sought to indicate the clarity of the instructions and the questions, which influenced and motivated the respondents to answer.
Training for the Data Collectors: There are two Programme Assistants, who are selected locally to perform the programme activities and collect data. Training for the Programme Assistants and Programme Organisers is given to ensure consistency of data collection.
Quality control: There is a quality control check in the data collection procedure by Monitoring and Research and Evaluation Departments to ensure the quality of data attained. The Research and Evaluation Department and the Monitoring Department cross check the collected data through an independent random sampling of homes initially interviewed by WASH.
Data analysis: During the survey, which is carried out during the inception period, data is preserved to see the impact after the intervention, and strategies of intervention are designed depending upon the survey findings (sanitation and water situation).

Intervention period

After 10 months of the implementation stage, it was revealed that around 522 latrines were installed and/or transferred to latrines with water seal, and that the ***sanitation coverage increased to 25.13% from 19.58%.*** It has also been revealed that after formation of the Village WASH Committee, VWC (July 2007), people are more motivated, inspired and become more conscious to change their sanitation and water situation. Hygiene

TABLE 2 Chornilokhiya Union details - pre intervention

HHs	Population		Sanitation								Tubewell					
		hard core poor	total latrine	own latrine	shared latrine	with water seal	without water seal	pit/open defeca-tion	sanitation coverage (%)	total tube well	funct-ional	non funct-ional	own	shared	tubewell coverage (%)
9,404	43,285	1,163	3,290	2,916	374	1,841	1,449	360	20	5,148	5,088	60	3,541	1,607	54

promotional activities have influenced the installation and the repair of tubewells in the locality, though messages on safe water-related issues have not yet been disseminated at this programme stage. Table 3 shows the status of sanitation and water coverage in Charnilokhiya until November 2007, which can be compared with the initial situation, shown in Table 2.

In the case of Chornilokhiya in Mymensingh, it is apparent that WASH activity in the area has increased sanitation coverage as well as accessibility to safe water. In a comparison between the initial data gathered on Chornilokhiya in Table 2 and the subsequent data reflected in Table 3, the increase in numbers indicate behavioural change and demand creation – two objectives of the WASH programme. The percentage of those who defecate in a pit or in the open has been reduced by more than 16%. Similarly, the percentage of people with their own latrine has increased by nearly 15%. These two statistics in particular are, as previously stated, indicative of positive change aligned with the goals of WASH. The decrease in the percentage of individuals who defecate openly or use a pit latrine demonstrates a behavioural shift resulting from the hygiene education and promotion approach employed by WASH. Once individuals are informed of the environmental and sanitation hazards associated with certain behaviours, the activity is encouraged to end.

Furthermore, the community approach places pressure on individuals in the community to conform to the agreed behaviours and standards. The increased number of individuals with their own latrine demonstrates the steady progression of the bottom-up demand approach that WASH seeks to promote. Having been educated about issues of sanitation and given the knowledge and means to attain higher sanitary standards, the numbers show that over a ten-month period there has been growth in the demand for sanitation. Given the ways and means, and with the support of the community, individuals have been able to mobilize to secure their demands. Similar inferences can be made of the data regarding tubewells and access to safe water. While the change is gradual, the percentage increase for a sub-district with the lowest sanitation standard shows a marked improvement.

TABLE 3 Chornilokhiya Union details - after 10 months intervention (where after formation of VWC, last 5 months were more constructive)

Sanitation							Tubewell				
total latrine	own latrine	shared latrine	with water seal	without water seal	pit / open defecation	sanitation coverage (%)	total tube well	functional	non functional	own	shared
3,792	3,418	374	2,363	1,429	300	25.13	5172	5,122	50	3,565	1,607

Parishad – will play an important role by helping the hardcore poor population of the village to construct the infrastructure.

The WASH committee also works on arsenic mitigation in the arsenic prone programme areas, safe water management, initiating funds to help the hardcore poor, and the installation and repair of latrines and tubewells. Through constant monitoring on the proper management of the infrastructure and their efficacy, sustainable and integrated hygienic practices, the WASH committee firmly believes that overall improvement of the public health situation in Bangladesh through safe water supply, proper sanitation and hygiene is not an impossible dream. Thus, WASH is ambitious and looks forward to seeing the impact on morbidity and mortality from faecal and waterborne diseases, sustainable access to safe drinking water and basic sanitation, and sustainable behavioural change regarding hygienic practice in intervention areas.

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