Participatory strategies in water, health and rural development programmes

by K. Balachandra Kurup

Water supply and sanitation schemes, hygiene education programmes, and operation and maintenance strategies will never work unless they have been developed with the community.

DURING THE last decade, global policies and strategies have evolved, and a new approach for progress in the water supply and sanitation programme has emerged. Many countries, including India, adopted the goals of the International Drinking Water Supply and Sanitation Decade (IDWSSD) and were committed to providing clean water and sanitation to all by the year 1990. India has decided to pursue comprehensive coverage, and the Decade period has been extended beyond 1991.

It is not enough, however, to plan for 'coverage' of the population with facilities; we must also plan for the sustained functioning of these facilities, such as feasible operation and maintenance, cost recovery, etc. In providing safe water and improved sanitation facilities to poor rural communities, slum dwellers, and other vulnerable areas, the so-called appropriate facilities such as public standposts, handpumps, or public latrines are often specified according to standard designs. Moreover, the community as a whole must be educated to realize that clean water is a scarce and costly commodity, that they must pay for what they use, and that it should be used with little or no waste. Further, they must also understand the precautions necessary to avoid polluting the water before use, and the ways of ensuring that there are protected water supplies and safe water for drinking. It has generally been noticed that improvements in water supply and sanitation play a crucial role in reducing the high mortality rates in many poor countries.

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The principal objectives behind the Socio-Economic Units (SEUs) are:

- To help foster community participation and mobilization in all activities under the SEU umbrella.
- To involve the communities, especially the women, in the selection of standpost sites, coverage studies, rural water-supply schemes, and the operation and maintenance of schemes.
- To monitor the implementation of the schemes, with the participation of Ward Water Committees, and be directly involved in working out detailed designs for providing 90 per cent coverage to the community.
- To introduce meaningful, cost-effective, and appropriate hygiene education activities with more focus on traditional and local media.
- To implement cost-effective sanitation programmes (household and institutional latrines) in the selected pilot areas.
- To develop a systematic built-in monitoring and evaluation mechanism for periodically assessing the progress, weaknesses, and failures of the schemes.
- To strengthen the capacity of existing government departments and local organizations to plan and implement their drinking-water supply and sanitation activities.

Community participation

The core element of the project is ensuring community participation through the involvement and mobilization of the communities in the selection of public standposts, the location of sites for latrines, and the organization of hygiene education programmes and beneficiary meetings at the ward (local) level. To improve living conditions and implement activities effectively at the local level, some sort of organizational network or social group based at the local level is imperative.

There is still no established definition of a local area, however, and the term 'local' has a variety of meanings: settlement, village, ward, panchayat, area of a chief or sub-chief (traditional native administrators), district, even province. The local unit should be given structural identity, delegation of power in principle and practice, decision-making power on the socio-economic development of the locality, and the required financial resources to develop community consensus and commitment in the management of the social and economic uplift of the area. For practical reasons appropriate areas are to be selected based on the local need, variations, and landscape. In this programme a ward is the lowest local-level unit.

With the help of an established group, such as a Ward Water Committee (WWC), it is possible to promote effective dialogue and express the interests of the community.

'The formation of local pressure groups is necessary to bring about structural changes and reforms, to achieve a more suitable sharing of the benefits of development, to demand better services from government agencies, or to exercise a larger voice in the policy and programme decisions affecting their lives'.[1]

Community participation is regarded as the mainstay of social development, yet this is more often rhetoric than reality. One way by which practical community participation in water supply and sanitation schemes can be encouraged is by the involvement of WWCs. These are representative groups which determine the patterns by which water supply and sanitation programmes can be implemented in their locality. Selected members will be given a one-day orientation course on organizing and on other aspects of the drinking-water and sanitation programme. These committees, supported by the SEU, will work closely with other sectoral departments. WWCs are involved

in site selection for public taps and latrines, distance criteria discussions, surveys of existing water points, the identification and resolution of water problems, the provision of training and information regarding the operation and maintenance of public taps and latrines, and the establishment of links between users and relevant institutions such as panchayats, KWA, departments of rural development, and social welfare voluntary organizations. The whole process should be flexible and should incorporate lessons learned from mistakes and experiences.

In the SEU activities, great emphasis is placed on promoting the role of women, since they are the main users and managers of water resources and therefore influence family sanitary habits and effect changes in basic hygienic behaviour. The time taken and effort made by women in water collection and storage can affect socio-economic and health conditions in many ways. Proper community involvement has enormous potential and there are conditions under which local people can indeed be in charge of successful rural water-supply projects. Handpump projects in several countries have promoted the concept of Village Level Operation and Maintenance (VLOM) as a means of overcoming some of the obstacles to sustainable water-supply schemes. Sustainability is more often dependent on the support provided for the operation and maintenance of the facilities: people do want improved services, but only if these meet their perceived needs. The members of the WWCs will be selected democratically after considering their competency, dedication, and motivation. The SEU has developed a manual and curriculum for training the selected members. The experience with more than 300 WWCs over the past year proved that with their support and involvement it is feasible to implement the anticipated activities. In order to provide adequate support to these committees, panchayats and district level committees have also been established, and this system will be strengthened simultaneously.

Location study

SEU has added a social dimension to its engineering activities: the central involvement of the people in selecting their public standpost locations. The SEUs, in consultation with the WWCs and Kerala Water Authority (KWA), introduced the process of socio-economic site selection to cater better for the needs of the poor sections of the population. This process involves the community in the planning and design of their water-supply scheme. It is also the point to prepare a local maintenance and fault reporting programme.

In order to facilitate the process, a meeting will be held with the panchayat authorities along with the concerned KWA staff as a first step. The KWA distribution design map will be discussed with each panchayat ward member, and during the process the panchayat members will identify the main areas left out in the design. WWC members visit all the wards with the map and later a sketch map will be prepared for each and every ward. Following this the field staff will visit all the areas to demarcate the deserving areas (where a concentration of people below the poverty line is dwelling) in the maps. During this exercise the number of potential beneficiaries (households) for private connections (middle-income and above), and those who need the service of a public tap (people below the poverty line), will be listed on the map.

Hygiene education

Effective hygiene education requires the combined use of different approaches, like interpersonal communication and group discussions. There is no inherent contradiction

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between these approaches; each has its own advantages and limitations. The main goal is that the workers should be able to select the right approach or combination of approaches for each situation, and use them effectively. It is easy to make changes in technological and other hardware aspects, but appropriate changes in attitudinal and behavioral practices have to be developed. This involves more than simply explaining the importance of hygiene education to the people. Local women are selected for neighbourhood committees and are trained to implement effective hygiene education programmes. Adequate provision will be made to study and understand how beliefs and attitudes influence behaviour (especially hygiene practices), and thus affect disease transmission. Such feedback may provide useful information about community organization, participation, and education.

Supportive systems are required both to strengthen the communities and to enable them to respond by organizing themselves for active involvement implementing the hygiene practices promoted by health education efforts. Action-oriented and pragmatic health education programmes, carried out with the help of local youths (both men and women), have been used to promote health-supportive behaviour. Similarly, most of the field activities and production of materials have been carried out through participatory approaches.

Targetting schools

School Health Clubs have been formed in twenty-one selected schools. Through their activities they have improved children's health and awareness. The main objectives of the School Health Clubs are:

- To increase the awareness of pupils about the value of water, water management and other associated factors.
- To educate them about how to use and safely handle drinking-water.
- To educate them about the hazards of gastro-enteritis and other water-borne diseases, and about the need to use sanitary latrines.
- To make them aware of the fact that the health of a person is the health and wealth of the family and society.

Improved water supply and sanitation are considered to be a prerequisite for better health and socio-economic development, and this goal would not be possible through water-supply schemes without adequate sanitation coverage. Several institutions, the government, and some voluntary organizations are involved in the rural sanitation programme in Kerala. A clear picture of the involvement of various bodies in the sanitation programme and what their impact is, however, is not available. When SEU considered a sanitation programme, it was realized that in spite of all the efforts the coverage of rural sanitation in Kerala was only about 22 per cent.[2] The challenge was to equip as many households as possible with proper sanitation, but in such a way that the beneficiaries understood and appreciated the facility, and used it properly. Right from the beginning, we came to the conclusion that a different approach was required to construct cost-effective and technically sound latrines on as large a scale as possible. So, depending on their need and importance, and with assistance from SEU, a pilot sanitation programme was carried out in selected needy panchayats. Through this programme, SEU introduced appropriate technologies and built in moni-

toring procedures for measuring the effectiveness of the pilot programmes. Another aim was to involve the beneficiaries and the local people directly in the programme as well as the governmental and non-governmental agencies.

Different approaches were used to implement the programme, and it is worthwhile comparing various technological approaches and programmes. Such comparison might indicate which factors are important in the different situations, and what the respective strengths and weaknesses of each approach could be. A detailed study of the various approaches adopted by the SEUs is presented below. The main intention of the pilot programme was to test and compare the following approaches:

- planning and implementation with voluntary organizations;
- planning and implementation with panchayat (local government);
- planning and implementation with a semi-governmental institution (Technical College); and
- planning and implementation by SEU.

In all the areas local masons were trained to build the latrines. To ensure compatability and to solve any problems, 'Sanitation Task Forces' were formed in which all partner agencies and the relevant SEU staff met as and when required. Health education, organization, mobilization, and motivation were the most time-consuming and crucial activities, and the partner agencies were not very enthusiastic or effective in carrying out this aspect. An implementation committee at panchayat level and a beneficiary committee at ward level were established (at least three months before the programme was due to start) to provide the necessary support for carrying out the construction activities as well as the motivation and mobilization work. The panchayat-based implementation committee was responsible for the procurement of materials, storage, monitoring, and supervision of the construction activities. The day-to-day managerial jobs were carried out by the beneficiary committee at the ward level.

During the pilot programme SEU experimented with several combinations of beneficiary contribution. Probably about 50 per cent of the beneficiaries were committed to dig the pit and to provide casual labour, and transportation of building materials to the site. The imputed value of the labour portion is deducted from the 25 per cent of beneficiary contribution, and the remaining portion is accepted in cash. Exceptions were, however, made for the very poor and for other deserving cases. In addition to household latrines, SEU has been involved in the construction of sanitary latrines in schools, health units, ICDS centres, and market places.

From the experience of the pilot sanitation programme, it has been proved that the panchayat is the most appropriate organization at the local level to implement a cost-effective sanitation programme. The hygiene education and awareness programme will be facilitated by the SEU in collaboration with sectoral departments, the health education sub-committee, and the WWC. The cost of the programme and the effectiveness of the programme was very satisfactory.

Through the pilot sanitation programme we learned that constant motivation and mobilization are required in all the areas at least three months before the implementation of the programme; and that for at least one year latrine use has to be monitored very carefully to achieve the expected results. The WWCs have developed appropriate procedures for effectively monitoring the use of latrines. As a result of this, 95 per cent of the households (out of 5200 latrines) are using their latrines and keeping them clean. Similarly, the incidence of diarrhoeal diseases has been considerably reduced as a result of this programme. We have recognized that in Kerala, sanitation can be used as an entry point for starting new activities.

Summary

Social and economic aspects should be given equal importance in a water and sanitation programme to get the full support and commitment of the community at every stage of the programme. This will help a great deal in solving problems connected to selection of sites for public taps or latrines, maintenance, misuse, or water management at the local level. In hygiene education and in sanitation programmes, the concurrent monitoring and evaluation of the involvement of the community is quite vital. It is, however, a virtual certainty that social information should be given prior importance in setting objectives, designing, implementing and evaluating water supply and sanitation programmes. In order to meet such requirements, a revised programme strategy has to be adopted based on our initial results. Special efforts have to be made for problem-solving in a programme by increasing the capacity of the institutions at all levels (ward, panchayat etc.) to assess their own problems, analyse the problems and identify possible solutions, and act to marshal the resources necessary to implement those solutions. More important, they must learn to reassess the results of their actions, reanalyse the solutions, and modify their actions on a regular basis. It is worthwhile noting that the SEU programme has succeeded in fostering more intersectoral co-operation and co-ordination between government departments and voluntary organizations. There has been considerable progress in this respect over the past year, and, drawing lessons from these experiences, we have incorporated new approaches while planning the activities for the future.

Efforts will be made to collect data about the sources of water-points, distances, quality, health service coverage, incidence of diarrhoeal diseases, and the Knowledge, Attitude and Practices (KAP) of the people. In the SEU programme additional emphasis will be given to the formulation of a broad policy framework with sufficient detailed decisions based on information relevant to each of the local areas of the project. Without such information there will be a danger of applying uniform solutions over the whole project area. The monitoring of the programme implementation and an evaluation of the impact will be undertaken, with a view to enhancing cost-effectiveness and achieving the maximum possible impact and coverage of the beneficiary population. During the three-year demonstration phase the effectiveness of each of the approaches mentioned above will be documented and disseminated for wider replication.

References

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