Promotion and Support for Women's Participation in the International Drinking Water Supply and Sanitation Decade

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# CASE STUDY
# ON
# WOMEN'S PARTICIPATION IN WATER SUPPLY AND SANITATION

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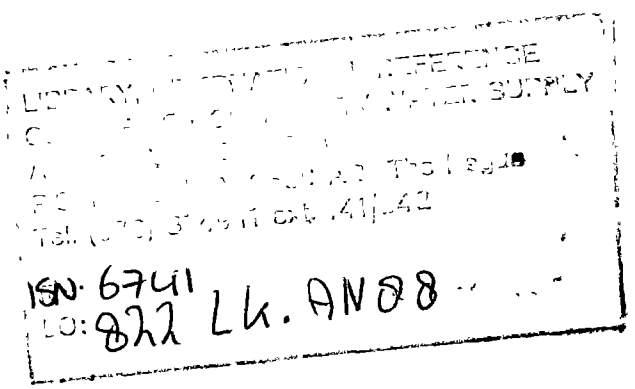
The case study on 'Women's Participation in Water and Sanitation' was conducted by IRED - Development Innovations and Networks for the World Health Organisation (WHO). The case study is directed by Sunimal Fernando (Director, IRED). The draft final report was prepared by Willie Gamage (Consultant to IRED).



# C O N T E N T S

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## MAPS AND ANNEXES



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# CASE STUDY ON WOMEN'S PARTICIPATION IN WATER SUPPLY AND SANITATION

## CHAPTER 1
## INTRODUCTION AND METHODOLOGY

### 1.1. Introduction

For a number of years UNICEF has been implementing a rural water supply and sanitation project in the Anuradhapura district. It was after this project progressed to some extent that the idea of the pilot project relevant to this study was conceived.

The basic content of the pilot project is the perception that 'if women's participation and leadership can be harnessed for rural water supply and sanitation projects those projects can be implemented more effectively'. In the Anuradhapura district the material component of the UNICEF project consisted of sinking tube wells and giving necessary assistance to construct latrines as part of rural water supply and sanitation activities. In the early stages this material assistance was provided through the participation of representatives of relevant authorities (e.g. Local Government, Water Supply, Health, etc.).

However, as the results obtained through this method were not very attractive it became increasingly necessary to think of a different arrangement. That was how the suggestion to obtain the above mentioned women's participation came about. It was also assumed that as women have to bear the major burden in obtaining water supplies for domestic use and in attending to sicknesses and problems of health in the family, that a basis exists to get women interested in water supply and sanitation activities.

Finally, it was decided to implement this scheme as a pilot project in an AGA division of the Anuradhapura district. The institutions that came in as participants were the UNICEF, WHO, UNDP and the Women's Bureau.

The function of IRED was to identify and analyse socio-economic processes that would arise in the implementation of the project. Thus the case study is intended to help the implementation process by providing sociological insights into social processes that can be uncovered through the application of social science experience and discipline.

Accordingly, IRED had to conduct the study in two stages. As the first stage beginning with the commencement of the project. IRED carried out a baseline study of the four villages selected for the case study. The report of this study was issued on 31st August 1986.

The period of collecting data for this report coincided with the initial stages of the project activities. Thus the contents of the report dealt with the following matters in regard to the selected villages, namely,geographical data, demographic information, basic economic information, information on physical and social infrastructure, available water resources, available welfare services, village level organisations (both governmental and non-governmental), the felt needs of the people with respect to sanitation, the relationship between access to water resources and economic activities, people's perceptions of the use of latrines, the daily pattern of work and activities in which women are engaged and women's participation in communal and development activities at village level.

In the second report submitted herewith, it is intended to provide a detailed analysis, in relation to the pilot project, of how to effectively obtain the participation of women in a rural society.

1,2 Methodology

We conducted this study in a manner different from that of an ordinary evaluation study. It was not our task to study the benefits or problems of the project. Our study which ran parallel to the implementation programme of the project, based itself on the strategy and tactics adopted at various stages in the implementation of the project. It directed its attention mostly,to study what strategy and tactics would more effectively be employed to organise and carry out a programme of participation by women in a rural society,to discover the responses of women, their husbands and parents and of rural society in general to various methodologies and,to analyse the socio-economic factors contributing to such responses.

It was our belief that information necessary for a study of this nature could more profitably be obtained,by collecting qualitative data rather than quantitative data. The methodology guiding our second field study was based mostly on collecting such qualitative data.

The selection of villages for the case study was done with the concurrence of WHO, UNICEF and the Women's Bureau. The main criterion in selecting villages was that they were representative of the main characteristics broadly found in the district. It was accepted that, the variables taken into consideration in selecting villages for other socio-economic studies in agricultural societies, were equally relevant and valid in a study concerning a Health and Sanitation project in such societies. Accordingly, the villages were selected to represent four characteristics widely found in the Anuradhapura district, namely -

1. An ancient tank village now nourished by the new Mahaweli development scheme;
2. A traditional dry zone village remote from the main road in which the age old socio-economic background has not undergone any serious change;
3. A village having close proximity to and sustained by small trading towns;
4. A village occupied by an ethnic minority in a district where the majority are Sinhala Buddhists.

Firstly, we allowed sufficient time for the investigators to live in these villages and get integrated into the folk life of these rural people. During the time they lived among the villagers, these investigators had contacts and informal discussions with leaders of voluntary organisations, volunteer workers (both male and female), village level officials (like Grama Sevaka, Special Services Officer, Cultivation Officer etc.), individuals who had built for themselves a significant image at the village level and persons like teachers who had come to the village from outside for employment purposes. In these discussions the topics included historical and geographical information about the village, the attitude of villagers regarding water supply, sanitation and other common social problems, participation of volunteer organisations, the problems and needs of the village, its economy and the socio-economic matters etc. These discussions were cordial, simple and relaxed and uncompleted. They were simple and

relaxed in the sense that no notes were taken down and no indication was given that here was an investigator come from outside to extract information on certain matters. In short it was a pleasant conversational dialogue devoid of remoteness. By the end of the month the number of houses acquainted by the investigators was as follows:-

| Village | Houses Aquainted | Total number of houses in the village | Percentage |
|---|---|---|---|
| Kadalawalagama | 22 | 46 | 47.8 |
| Horagoda | 19 | 49 | 38.7 |
| Habarakada | 20 | 59 | 33.8 |
| Upper Mellankulama | 22 | 90 | 24.4 |

This methodology was used productively in all the villages except in Upper Mellankulama, a Muslim village. It was also possible to lay the foundation necessary for the gathering of data for the subsequent study. We thought of adopting a methodology of this type to begin with, because for this study it was essential to build up a rapport more with women. It was not quite successful at Upper Mellankulama due to social and cultural impediments that exist there. In this Muslim community, adhering to their own religious and cultural customs, only the male in the family - the husband - comes forward to meet or talk to a visitor from outside the village. Thus it was a big obstacle to building a close rapport with the housewife, children and other members of the family unit.

In addition to these contacts, we established relations during this period with village level officials who were engaged in official duties in each village.

Secondly, we conducted a series of indepth interviews with the help of the Interview Guide. The sample for these interviews was formally selected. The selection was based on the nature of the houses classified during the baseline study. In this classification, the houses in each village under study, were divided into three categories, namely, permanent, semi-permanent and temporary. Taking into consideration the total number of houses in

each village and the number of houses in each category in a village, we studied a sample of 34% houses in Kadawalagama, 36.7% in Horagoda, 33.8% in Habarakada and 38.8% in Upper Mellankulama. For additional interviews we selected from each village all the volunteer workers (male and female), the Family Health Worker and the Chairman of the Gramodaya Council. The indepth interviews were long and protracted. In some cases, interviews were continued on another convenient date.

Thirdly, we investigated the participation and activities of the village level volunteer organisations, specially the contents of their suggestions and their activities regarding health, sanitation and water supply. For this purpose we examined the minutes and attendance records of meetings of the Gramodaya Councils, specially for 1986, the year during which the project was implemented.

Fourthly, we made observations with due regard to the supply and utilisation of water and to sanitation problems. For instance on a selected day, observations were made morning, noon and evening regarding the details of families obtaining a supply of water from tube wells and about the purposes for which the water is carried. Also observations were made regarding the cleanliness and care of latrines.

Fifthly, during the final stages of the project, two workshops were organised at the village level. At these gatherings, attended by various parties involved in the project, ideas and experiences were exchanged. Among the participants of these workshops were village level officials, volunteer workers and prominent persons of the village totalling 27, as well as two consultants from IRED, Mr. Nanayakkara, the Project Director and Mr. Chandrasena, the Planning Officer assisting him. In the course of these two-day workshops, information necessary to analyse certain data obtained through interviews was obtained. These workshops were also a novel experience for most of the participants. The IRED consultants introduced various questions and the participants were given the opportunity to freely express their views. They also guided the discussion by occasionally giving indications relevant to the questions. These discussions were taped and notes on them were taken. (See Annexe 6 for a list of participants).

Sixthly, an attempt was made through a brief questionnaire to find out and understand the impact the project has had. Specifically, the aim was to discover whether there has been any benefit in the form of material changes and whether there has been any change in attitudes and in participation. (See Annexe 7 for questionnaire).

Seventhly, necessary data was collected from government offices and officials in the area covered by the project.

Eighthly, some of the data collected for the purpose of the baseline study was utilised for this study too.

In addition to the researchers living in the villages, Consultants from IRED too came to these villages from time to time, and examined the information provided by field researchers, and guidance needed in the field was given. Two consultants from IRED have spent a total of 24 man days on three occasions for field work.

Finally, on completion of the field work we had several rounds of discussions at the IRED office on the data collected. Some of these discussions were taped. All the discussions were held under the direction and guidance of the Director of IRED with the participation of field researchers and consultants of the project study. While the discussions were long and detailed, attention was directed to the need for gathering information that had been overlooked or omitted.

It is our understanding that processes of people's participation cannot be properly investigated or measured through stereotyped social science methodologies like questionnaires. Therefore in order to successfully carry out a study that has to rely on qualitative data, it is essential to establish mutual confidence and mutual respect between the community subjected to the study and the researchers conducting the study. In the course of formulating our research methodology exchange of ideas on this matter took place frequently among the researchers. Very often we tried to understand the views of people in a manner different from that of the ordinary researcher. For instance, take the case of a person giving us false information. We tried to understand it from his view point, that he had to do so for a reason important to him. It may be an economic, social or some other consideration. We made him realise that we were aware that the information was not true and we tried to get more friendly with him. In the end we succeeded in getting true information from him.

By providing an opportunity to the respondent to come out with his ideas rather than being subjected to questioning and by appreciating the value of his ideas, it was possible to unfold reality and true facts of a situation. We were able to develop better participation to obtain information by creating in the respondents the feeling that their time is not wasted for something useless but is being spent for something productive and beneficial.

## CHAPTER 2

## SELECTED VILLAGES AND THEIR SOCIO-ECONOMIC BACKGROUND

A detailed account of the socio-economic background of the selected villages was included in the report of the Baseline Study submitted earlier. However, we will restate some of that here emphasising the important aspects, which we consider are useful for a study of this report as a single entity and which are necessary to lay a clearer foundation for the problems to be analysed in this report.

### The physical situation and other socio-economic data of the selected villages

All the villages selected are within the AGA division of Kekirawa in the district of Anuradhapura.

#### (1) Kadawalagama

This village spreads out on either side of the Kekirawa - Ganewelpola highway between the 1st and 2nd mileposts. It is nourished by four tanks. Mahaweli waters flow into these tanks along a canal from Dambulla. Total population is 247 (138 men and 109 women). The number of housing units is 46 and the average occupancy per house is 5.4. Entire population (100%) is Sinhalese. Land ownership is as follows :- 26.1% of families own less than 1 acre each. 37% own from 1 - 3 acres, 19.6% own 3 - 5 acres and 13% own more than 5 acres each. The number of landless families is about 4.3%.

Of the houses, 17.4% are permanent, 51.7% are semi-permanent and 30.9% are temporary. (Permanent - walls, roof and floor constructed out of permanent building materials, semi-permanent - of the three components walls, roof and floor, at least one built out of permanent materials temporary - none of the three main components built out of permanent materials).

At Kadawalagama out of the employed labour force among males, 45% are engaged in agriculture and 20% in government jobs. Out of the rest 25% consist of pensioners, drivers, self-employed persons and those in the trading or defence sectors. Another 11% are unemployed or expecting employment.

Out of the female labour force in Kadawalagama, 29% are engaged in agriculture and 38% devote their full time to domestic work only. About 12% are in government service and another 18% are either unemployed or waiting for jobs. A very small percentage are self-employed or in foreign employment.

In educational standards, this village is somewhat more advanced than the other selected villages. The reason for that is the relatively better economic position of this village which enabled its inhabitants to send their children to other parts of the country for education. It could be observed that children from this village, specially boys, are sent out to other places for further education. According to our survey done in July 1986, about 12% of the male householders and about 6.5% of the wives of householders had received such higher education.

In this village where caste pride and tendency towards traditional values are dominant, the activities of volunteer organisations appear to be weak. The only organisation that is active to some extent is the Funeral Aid Society. Though there is a Rural Development Society, it does not appear to be active. Sarvodaya and the Women's Bureau too are operating in this village. However, there does not appear to be any awakening brought about by volunteer organisations. The Gramodaya Council exists under the charimanship of an elite/elder of 60 years but it does not seem to be of much service to the people.

This village has electricity and a primary school close to it. As the town of Kekirawa is only a mile away, residents of this village have access to the Central School, hospital, market and other major facilities within a very short distance. Around the village are four tanks fed by Mahaweli waters. In addition, there are two big public wells at the two ends of the village as well as several private wells within the village for obtaining drinking water. There are also two tube wells, one within the village and the other in the school ground on the border of the village.

(2) Horagoda

This village spreads around the 11th milepost on the Kekirawa - Galenbindunuwewa main road. Its economy is dependent mainly on agriculture (paddy and subsidiary crops) and paddy cultivation is dependent on rain water. Total population is 243 of which 125 are males and 118 are females. The number of families is 49. In land ownership 36.8% of families possess less than 1 acre each. 51% own between 1 and 3 acres while only 12.2% own more than 3 acres of land each.

In the matter of housing, only 6.1% are permanent houses. While 68.8% are semi-permanent houses as many as 25.1% have been constructed with temporary building materials.

In the field of employment 56% of the male labour force are engaged in agriculture, while 11% are in government service. Self-employed persons number 13% and the number unemployed or expecting employment is about 17%.

Among women 51% help in agricultural activities, 4% are in government service and another 4% in various other employment. About 6% are expecting to be employed and over 35% are occupied with domestic work only.

Education standards are more or less the same among both men and women (householder and wife). A large number have reached up to primary education level. The number of illiterates too is almost the same among males and females. So is the number of those who have gone beyond the 11th grade.

The population of Horagoda is 100% Sinhala Buddhists. Most of the traders are those who have come from outside and settled down there. Because of the economic uncertainty that exists in this village it comes within the category of a harsh village. Most of the villagers eke out a living at subsistence level. Though the majority mention agriculture as their occupation, in actual fact, most of the residents of Horagoda depend for their livelihood on casual labour,

hunting in the jungle or fishing in the tanks. Some families do chena (dry land) cultivation, and during that period they reside on the chena. Even children attending school live in the hut in the chena and go to school from there. After harvesting their crops only that the people return to their homes in the village.

Since recently, there is a trend towards tobacco cultivation in this village. For this the Ceylon Tobacco Company provides seeds, fertiliser, agro-chemicals etc. to the villagers and their value is deducted when buying the crop. Among the villages that were subjected to our study, this is one of the two villages where there is high participation in agriculture by women.

Among the institutional facilities in the village are a primary school, sub-post office and a cooperative retail store. There is a private dispensary for medical services. An Ayurvedic physician too is available in the village.

Access to water both for drinking and for cultivation purposes is quite difficult here. Majority of families obtain their water from two private wells belonging to wealthy persons in the village. Though there is a tube well too, villagers say that water from this well cannot be used for drinking as it has a rusty taste.

Special mention must be made of the fact that in this village a health and sanitation project had been in operation earlier. There are a number of female volunteer workers trained for that project and one of them is involved in the project connected with this study. In the implementation of this project 10 latrines had been constructed in the village but a problem has arisen as the money due on this construction has not been paid. There is also in this village a health project called 'Vedagedara' (Physician's house).

'Vedagedara' is the idea of a Public Health Inspector who had served in this area some time earlier. Now it is in operation in a large number of villages in the Anuradhapura district. The essence of this scheme is the selection of a house in the village as the 'physician's house' and the stocking there of medicines for the treatment of minor injuries and illnesses. Villagers are brought into participation and involvement in the scheme. Services obtained from 'Vedagedara' are free of charge, but if one likes assistance can be offered to get supplies of medicines.

There are a number of active volunteer organisations in this village. Among them are Sarvodaya,Funeral Aid Society, Rural Development Society, Gramodaya Council and political associations.

(3) Habarakada

This village is situated on the Kekirawa - Anuradhapura highway, close to the town of Habarana. It is adjacent to the highway. Out of total population of 359 in this village 204 are men and 155 women. The number of families is 59. Ethnically 93.2% of villagers are Sinhalese and 6.8% Tamil.

Out of the villages that came under our study, this is the only one where the majority of residents own a considerable extent of land. Only 22% of the families own less than 1 acre each and only 5.1% are landless. 64.4% families own from 1 to 3 acres each. Thus here the distribution of land is relatively more equitable.

As for housing 16.9% are permanent houses, while 58.8% are semi-permanent and 24.3% are temporary dwellings.

In education as many as 85% of the chief occupants have completed their primary education only. 12.1% are illiterate and only 3.4% have received a secondary education. Education standards of the housewives are the same as those of the chief occupant.

The percentage of males engaged in agriculture in this village as owner cultivators is almost the same as those of the other two Sinhala villages (namely 54%). The number employed in government service is 4%. Another 7% can be classified as agricultural labourers. Employment in the trade sector is about 6%.

Among women 59% are engaged in helping in agricultural activities while another 5% work as agricultural labourers.

Though several volunteer organisations had started work in this village, participation in them does not appear to be much. One reason for this is that both the householder and housewife are engaged in their agricultural activities most of the day. Rural Development Society, School Development Society, Buddhist Association, Sarvodaya,

Funeral Aid Society and organisations connected with the Women's Bureau are to be found in this village. There are several women who are engaged in agricultural work with assistance from projects run by the Women's Bureau.

Drinking water for the village is supplied by two wells built a long time ago by the government and a tube well constructed recently. For bathing and for agricultural work water is obtained from a stream called Yang-Oya and from the tank.

As this village is only a walking distance away from the town of Habarana, there is easy access to institutional services and facilities.

(4) Upper Mellankulama

This village is situated off the Kekirawa - Jaffna highway about 2½ miles from the town of Maradankadawala. It is a Muslim village. Of the 2½ miles a distance af about 2 miles is along an un-tarred rubble road where no buses ply. But bicycles and cars can be used on this road.

The population of the village is 537 of which 280 are men and 257 are women. They are all Muslims.

As regards land ownership 40% of families own less than 1 acre each. 55.6% have 1 - 3 acres. The balance 4.4% own more than 3 acres each.

The situation arising out of the limitations in land ownership, is reflected in the nature of employment too. Only 28% of the male labour force are engaged in agriculture as their main occupation. Nearly 23% work as agricultural labourers. Government Service is limited to 1% while unemployment is as high as 37%.

Over 73% of the women are engaged in domestic activities only. The growth in the demand for Muslim women for employment in West Asian countries during the recent years is reflected to some extent in this village too. About 6% of the female labour force of this village have gone abroad for such employment. About 4% work in the village as agricultural labourers.

The total number of houses is 90. Of these 38.9% are permanent, 36.7% semi-permanent and 16.7% temporary. Here the housing situation appears to be better than in the other 3 Sinhala villages. This may be due to the building of houses with West Asian earnings as well as the competitive compulsion on others to do the same.

As regards education, as many as 90% of the chief occupant had completed only their primary education. About 7.8% are illiterate.

Among the womenfolk, illiteracy is as high as 21.7%. About 65.1% had dropped out of school in the early grades. Only 12% had completed their primary education.

In this village conditions are harsh with regard to institutional facilities. Residents have to walk 2½ miles to the nearest township. There is only a primary school in the village. Children here do not go beyond primary education. It is difficult to send children - specially girls - walking 2½ miles to reach a school in town. Thus even the more well-to-do families, are not motivated to give their children a better education.

Volunteer organisations are very weak here. There are no women's organisations at all. The only medium of communication that exists in the village is the governing council of the Mosque. Though there had been a Sarvodaya organisation and Rural Development Society earlier, due to lack of response and participation, they have become inactive. At present the village has access to outside networks and resources only through two individuals. One is the Headmaster of the School and other a somewhat affluent businessman.

The common and special features of the four villages

In a comparative study of the 4 villages it can be seen that the basic economy is dependent on agriculture. Three of the villages can engage in paddy cultivation only during one season (namely Maha season from September to February) a year. However, as Kadawalagama tanks are fed with Mahaweli water, most fields there can be cultivated during both seasons. Other three villages have to resort to chena (dry land) cultivation mostly during the Yala season.

Employment of an adequate number of both men and women in government service can be found only in Kadawalagama and Horagoda. In the other two villages no women and very few men are employed in government jobs.

A wide participation by women in agriculture can be seen only in Horagoda and Habarakada. At Kadawalagama such participation is only slight while at Upper Mellankulama it is almost non-existent. The reasons why Kadawalagama women are not attracted to agriculture may be their caste pride, the fact that their educational standards are relatively high and also the employment of a considerable number of women in government service.

At Upper Mellankulama, such a situation exists entirely due to the cultural characteristics and customs of Islam.

In regard to the problem of water supply, the village of Horagoda faces a serious situation in the dry season due to lack of drinking water. In the other three villages no serious situation arises concerning drinking water even during the dry season. At Kadawalagama the public well in the vicinity of the tank get filled with impure tank water during the rainy season. This causes difficulties to about 15 families. However, on such occasions they get their supplies of drinking water from the other public well about 300 metres away.

As mentioned earlier, in regard to water for agricultural activities, three villages are affected badly during one season, namely, Yala.

Regarding the activities of volunteer organisations and the participation of women the four villages are different from one another. At Kadawalagama, there are several volunteer organisations and their activities depend on the enthusiasm of a few educated young women. Many of the educated young men and women are engaged in jobs or further studies in towns. Among older men and women, conditioned by traditional attitudes to a great extent, there is very little participation in or encouragement for volunteer activities. (A more detailed account of the activities of volunteer organisations, specially Gramodaya Councils will be given in a later Chapter.)

Horagoda can be considered the village relatively most advanced in volunteer activities. This has been so for a long time, a strong reason for that being the backwardness and the harsh conditions of the village. The lack of access to institutional facilities and services and the poor level of economic opportunities could have created a situation actively receptive to activities of volunteer organisations. The post of Chairman of Gramodaya Council at Horagoda for the year 1986 was occupied by a woman.

The people of Habarakada though living in close proximity to a main town are leading a somewhat isolated life due to other social reasons. They belong to a caste socially considered to be low. In this village too there are people (men and women) who see the great need to bring outside resources into the village. There is no doubt that these people are desirous of breaking through their isolation and go forward in society. However, the operation of other external forces is obstructing the course of such a rapid advance. For example, the leadership of the Gramodaya Council to which Habarakada belongs, has been for the last several years in the hands of a person who has considerable influence in the area and has powerful connections with the local M.P. Though he is a person interested in and has the ability for social service activities, possibilities and opportunities for the emergence of active leadership at community level, not only in Habarakada but also in other villages coming within the Gramodaya Council area, have been hindered, precisely because of his ability, influence and connections.

The situation at Upper Mellankulama is totally different from this. Out of the villages subjected to our study, this village, from whatever angle you look, is faced with much hardship. Yet they have made little use of volunteer organisations to find relief or solve their problems. As we argued earlier, why is it that, unlike in Horagoda or Habarakada, volunteer organisations are not operating in this village in spite of the severe hardships there?

There are a number of reasons why volunteer organisations are not operating at village level in Upper Mellankulama.

1. Village level officials pay less attention to this village because of difficulties in travelling;
2. Due to cultural reasons it is difficult to get women interested in activities of volunteer organisations;
3. Due to lack of resources in the village men are migrating to other villages in the Mahaweli zone as agricultural workers.

As a result the functions of volunteer organisations are often performed by individuals.

## CHAPTER 3

## WATER AND SANITATION SITUATION BEFORE COMMENCEMENT OF THE PROJECT

### 3.1. Access to Water

Annexes 1.2 to 1.5 show the water resources available in the four study villages. These include the available water resources for domestic use as well as for agricultural use. The common wells are open surface wells which, though located on private land and legally owned by private persons, are in practise used by a number of families. Public wells are open surface wells which have been constructed either by the State or by a local government authority, usually on the initiative of a rural development society. Private wells are open surface wells (sometimes protected and sometimes unprotected) which are owned by individual families and used only by those families on whose land such wells are located. Water for paddy cultivation purposes is obtained from artificial irrigation tanks (wewa) in all four villages. Whenever families need water for irrigating their highland crops, they obtain water either from the tank if such highland crops are near the tanks or else from surface wells. Bathing and washing of clothes is almost always done at the village tank for reasons which have been discussed in the earlier section. It was seen that even at the height of the drought in August and early September, the irrigation tanks have little water left in them - sufficient for bathing and the washing of clothes. Every few years there occurs a severe drought when the tanks go completely dry. During such times, the people go to a tank of a neighbouring village which still retains some water for bathing and washing of clothes.

The interview data reveals that contrary to views generally held by outside agencies, there is no shortage of water for domestic purposes even during the height of the drought in any of the four villages. In Kadawalagama, there are two common wells in this village which do not dry up even during a very severe drought. At Horagoda too there are two common wells which do not dry up even during a severe drought. At Habarakada the temple well at one end of the village, the public well in the middle of the village and a common well at the other end of the

village near the paddy fields do not dry up even at the height of the drought. In addition, there is a tube well constructed under the UNICEF project which people use for drinking - this being the only tube well in the four villages - the water of which is considered by the people as being fit for drinking. In Upper Mellankulama too there is one common well in the middle of the village which does not dry up during the drought. It is also seen from the interview data that because the water level in all these wells goes down during the drought, though the wells mentioned do not run dry, lesser quantities of water are used by the people during the dry months of August and September. Water for household needs other than for drinking is generally obtained from the same wells from which drinking water is obtained. The interview data shows that those who live close to tube wells obtain tube water for household needs other than for drinking but walk somewhat further to a common well to obtain their supplies of drinking water. The sources of water for drinking purposes, for household needs, for bathing and for agriculture purposes during the rainy season and the dry season respectively are shown in Annexes 2.7 and 2.8. The distance to these sources of water even during the dry season for village families is in over 60% of the cases less than 400 metres, while in almost all the other cases the distance that people have to walk to obtain water for domestic needs is between 400 meters and 800 meters. This is also confirmed in Annexes 2.9 and 2.10. The distance between the homesteads and the sources of water in the four study villages are also shown in the four maps appended as Annexes 1.2 to 1.5. It is therefore clear that the need for new sources of domestic water is not a strongly felt need in any of the four villages. It is also seen in Annexe 2.11 while it is the mothers and daughters who fetch water for household purposes, fathers and sons fetch water for agricultural needs. Generally speaking, it can be said that the settlement pattern of the district under study which shows a spread of small village settlements near small village tanks with forests around the settlements does not lend itself to a situation of an acute shortage of drinking water in the dry season. For one thing with the impounding of water in tanks and with the population being small, it is not common for surface wells dug in the lower slopes of a village to dry up in the dry sason. Because the population in any single village is small,

there is no great pressure of population on water resources. In the future, however, both the environmental impact of the felling of the forests for agricultural development on surface water resources as well as the demographic impact of population increase on water resources may result in domestic water supply problem of greater intensity but for the moment, the problem is not an acute one - it is hardly perceived by the villagers to be a problem at all. However, when outside agencies take decisions about rural water supply projects without a proper understanding of the situation as perceived by the people themselves and when such agencies come to an area with 'handouts' of tube wells, people make a claim for such handouts - irrespective of whether they need them or not - by presenting to the outside agency a picture of great hardship and suffering.

The UNICEF project has provided three of the four villages already with a few tube wells. Kadawalagama has been provided with one tube well from which no one obtains water for drinking, bathing or agriculture, while 4.3% of houses obtain water from the tube well for household needs other than drinking. One tube well has been installed at Moragoda. No one uses this tube well for obtaining drinking water or for bathing. 8% of houses use this tube well both in the dry season and the rainy season to obtain water for household needs other than drinking, while 2% of households take water from the tube well for watering their home gardens. At Habarakada two tube wells have been constructed but a pump has been installed in only one of them. This is the only tube well in which the water is perceived by the people to be suitable for drinking. Both in the dry season as well as in the rainy season, 13.5% of households use tube well water at Habarakada for drinking, while 11% of houses use this water for other household needs as well. At Upper Mellankulama tube wells have not yet been sunk. The UNICEF project aims at having one tube well for every 20 families or in the alternative one tube well for 120 persons. Another criterion adopted by the project is that there should be a tube well within half a kilometer of every home.

Apart from the Habarakada tube well, the complaint is that the water that is pumped from the other tube wells has a saline (kivul) taste. There is also a belief that tube well water has a rusty taste (malakada rasa). As the water comes up from a depth of over 100 feet, some of the people

interviewed expressed the view that the taste is caused by toxic substances that have come up with the water. Some of those interviewed complained that the water has a layer of oil floating on it. Still others who were interviewed expressed the view that when more and more water is pumped out of these tube wells, the quality of water may improve.

The siting of tube wells is the responsibility of the technical men attached to the National Water Supply and Drainage Board. These technical personnel select the sites in collaboration with the chairmen of the respective Gramodaya Mandalayas. As a single Gramodaya Mandalaya covers an area of 8 to 10 villages, in selecting the sites, the respective chairmen in turn consult the office-bearers of the active voluntary organisations in each respective village. The consultation is informal. A Gramodaya Council chairman will go to a village with a technical personnel of the National Water Supply and Drainage Board and invite the office-bearers of the more active voluntary organisations to join them in going round the village and selecting the sites for tube wells. In this way, sites have been selected and marked in all four villages. The interview data shows that there is no sharp criticism either of the way in which the sites were selected or of the selected sites themselves. There are no significant allegations of bias or prejudice in site selection. The interview data clearly shows that while the National Water Supply and Drainage Board had decided on the tube well technology as being the most appropriate and viable technology for providing water for domestic needs at village level in the district, the people living in the four villages had their own views about what they consider to be 'more appropriate' technologies for domestic water supply. At Kadawalagama a large percentage of those interviewed expressed the view that it would have been more useful and less expensive if the well that was dug in the Second World War to provide water for a military camp - a well which never runs dry even today - was utilised for a pipeborne water supply to the village. There is an overhead tank near the well, also constructed by the military, which could be renovated (see Annexe 1.2). They point out that water

from this well can be pumped into the overhead tank and then distributed to smaller tanks through out the village from which the households could obtain their water. It was also pointed out that main line electricity is available very near the well and this could be the source of energy for the water pump. At Habarakada, Horagoda and Upper Mellankulama most of those interviewed expressed the view that it would be both less expensive for the government and more acceptable for the people if more public surface wells were dug in place of tube wells. They expressed the view that with the money that is being spent for constructing tube wells for every 20 families, it would be possible to construct many common wells, pump the water from these common wells into overhead tanks and distribute the water from such overhead tanks either to smaller tanks or else directly to the houses. Another suggestion that comes from a minority of those interviewed proposes yet another technology. They point out that with the flow of the Mahaweli water into many of the larger tanks in the district as a part of the Mahaweli Development Scheme, these tanks are able to provide a reliable supply of water to the area throughout the year. They suggest that it might be both less expensive for the government and more beneficial to the people if water from such tanks could be pumped and stored in large overhead water tanks and distributed from there to smaller tanks distributed throughout the different villages at regular distances.

Regarding water supply technology as well as the social and cultural viability of rural water supply projects, there emerges a sharp divergence between the technology decided by the project and the technologies which are desired by the people. The policy relevant question that emerges from this experience is whether our development strategy at village level should be one in which the community is invited to participate in a development process of the government or whether the government should offer itself to participate in the development process of the people. The policy relevant question is

whether the people should take the decisions pertaining to a technology, its social and cultural viability, economic viability, etc. with the help of technical services offered to the people by the government, or whether the government should take the critical decisions pertaining to technology etc. and then try to get the community to participate in implementing the decisions of the government and in maintaining the hardware provided by the government. If the first option is accepted, and the community participation strategy would be one in which the government participate in the development processes of the people by providing services as desired by the people, the role of the bureaucracy will also have to radically change. In such a strategy the government officials will cease to be the decision makers of the people. Their role will be reversed to be persons who service the people in implementing the decisions of the community.

3.2. Sanitation and Sanitation Awareness

Annexe 2.24 shows that apart from Horagoda, over half the houses in the other three villages do not have latrines. In Upper Mellankulama, the Muslim village, only 7.8% of houses have latrines. It is seen that almost all the houses which do not have latrines, go to the jungle for defecation. The interview data reveals that almost all the houses in the four villages have jungle land at very short distances. The jungle adjoins most of the home gardens, while a significant number of those interviewed stated that their home gardens themselves have sufficient scrub jungle to which they can go for defecation. Those living within a close distance of an irrigation tank or canal, go to the scrub jungle adjoining the tank or canal because after defecation they can conveniently reach the water for their ablutions. Those who do not use the jungle that adjoins a tank or canal, carry water with them to the jungle or else in a very few cases they were found to return home for the ablutions which takes place in a small enclosure in the home garden known as an 'ath kotuwa'. As pointed out earlier, small children defecate in the home compound itself : in a minority of cases this is subsequently buried in a pit but in a majority of cases it is simply thrown away to a distance.

The majority of those interviewed explained that it was their view that defecation in the jungle was cleaner than defecation in a small enclosed toilet. They pointed out that in the case of houses that have latrines, the level of water in the 12'-0" pit rises significantly in the rainy season, leaving the latrines smelly and unpleasant. They also point out that defecation in a latrine requires more water than defecation in the jungle would require; defecation in a jungle which adjoins a tank or canal does not require the use of any water that would have been carried to the house for domestic purposes. In the light of this evidence, it is clear that the provision of pipeborne water to houses will be a factor that could contribute significantly in removing one of the constraints that impede the construction and use of latrines.

Even in the village of Horagoda where 75% of houses have latrines, about 20% of the latrines are in fact not in use. In the case of one latrine, the walls have been pulled down, the latrine slab removed and used as a well. Another latrine is used to house pigs.

The interview data also shows that another major constraint in implementing a latrine construction project derives from the governmental procedures for providing assistance for latrine construction. The Department of Health has a programme in which people are given assistance in cash and/or kind to construct latrines. People requiring latrines and wanting to construct them are identified through a village level voluntary organisation - generally the Gramodaya Council which in turn gets the assistance of the village level rural development society. Concrete latrine slabs are distributed to the applicants sometimes before and sometimes after the latrine pits are excavated. The required size of pit is 2'-9" square and 12'-0" deep. At this stage the pit is inspected by the Public Health Inspector attached to the Department of Health and assistance is given either in the form of two bags of cement or else its equivalent in cash for putting up a 2'-0" wide foundation round the pit and for erecting the walls which should be a permanent structure. Wattle and daub walls are not acceptable to the Department of Health and therefore brick and lime has to be used. After the completion of the latrine, the Public Health Inspector has to be informed and he inspects the completed latrine and if it conforms with the stipulated

criteria of the Health Department, a further sum of money is given. The quantum of assistance given by the Department of Health for latrine construction has varied from time to time. As a general rule, it can be stated that, without accounting for free family labour the Health Department provides just over 1/4th the cost of latrine construction. In the case of the UNICEF project in the district, external assistance for latrine construction will account for just over half the total cost.

Interview data shows that very great delays are encountered for the Public Health Inspector (PHI) to inspect first the pit and then the completed latrine. Delays in making payments are very great : the reasons for these delays are understandable. The Public Health Inspector is expected to serve an area of about 2,000 houses and in fact he often serves about 9,000 houses. Transport difficulties and difficulty of access to the dispersed villages of this district add to his problems. As each PHI serves a big geographical area in this sparsely populated district, his work load is too heavy for him to execute efficiently and to the satisfaction of the people. Needing to economise on resources of time and money expended for travel, a PHI would generally not come to a village to inspect just two or three latrines. He would wait till a substantial number of latrines are ready for inspection, before inspecting them. All this leads to delay and discouragement. The incentive for latrine construction provided by the Department of Health is in practise nullified by the very procedures and staffing problems of that very Department.

It is clear that at district level, the Health Department is not equipped to implement efficiently a latrine construction project whose scale is large. A project of this scale cannot be implemented through normal government procedures. It is recommended that arrangements should be made to radically decentralise decision making including inspection as well as the power to authorise payments. Such responsibilities and decision making power should be decentralised to village level voluntary organisations or even to the Gramodaya Council. Furthermore, it is recommended that the scheme itself should be modified to the extent that individual families should be allowed to decide on the type of structure for each latrine and on the materials that could be used for latrine construction. The levels of government assistance could vary for different building technologies selected by individual families.

For instance, the scheme should be modified to enable poorer families to construct latrines with cheaper material for which the Department of Health could offer a smaller quantum of assistance. Local level voluntary organisations such as Gramodaya Council could be devolved with the necessary power to approve or disapprove different building technologies. Basically this means that instead of the government imposing its own criteria of latrine construction on the people, the people through their voluntary organisations should be given the encouragement - through offering a diversity of assistance packages - to construct latrines in the way that they want and using the technology that they feel is suitable for them. Basically, this means that the planners must trust the people and pass on more and more decision making power to the people through village level voluntary organisations. Such a strategy would not only result in the construction of more latrines but it would release the creativity of the poor and will channel this creativity into the development process of the country. Once again this means that in place of a strategy where an external agency such as the government decides on the plan for improving rural water supply and sanitation and then askes the community to participate in implementing the plan, we reverse the process. We allow the people through their voluntary organisations to decide what their water supply and sanitation plan should be; we permit the creativity of the people to express itself and to crystalise into a plan where the water supply and sanitation development processes that are operative, though undeveloped in the village itself would be supported. The external agency such as the government steps in to provide the necessary services in the form of funds, technical know-how, training etc. for the people's own processes of water supply and sanitation development to develop and grapple with the water and sanitation situations at village level. The factors relating to the use and non-use of latrines have been discussed in an earlier section. Here it can be added that even where there are latrines, they are used by women and by old people. Men do not generally use the latrines even when there are latrines in their own house.

Annexes 2.12, 2.13, 2.14 and 2.15 indicate the level of attention paid by the villagers to maintaining cleanliness in and around the home. Looking at all four tables together, it can be surmised that in Kadawalagama and Egbarakada the level of cleanliness in the environment

of the home is good while at Horagoda and Upper Mellankulama not much attention is paid to maintaining a clean environment around the home. Even in the case of Kadawalagama and Habarakada, it is seen that the level of cleanliness around the home is higher at Kadawalagama and lower at Habarakada. The interview data reveals that since both these villages are located near urban centres, urban influences are greatest in these two villages. At the same time, since the involvement of women in economic activities is low at Kadawalagama, the women have more time to devote to the home and its environment. In Upper Mellankulama too women are not involved in economic activities and here the relatively low level of cleanliness in and around the house is reflective of the fact that attention to such aspects of sanitation as keeping the home environment clean and tidy are not given much attention in villages other than those villages which are close to towns and are subject to the influence of an urban, middle class life-style.

Although little attention is paid to maintaining a clean environment round the home in the village of Horagoda, it is interesting to see that it is only in this village that a very significant number of houses have constructed latrines. Horagoda is a relatively isolated village and as it was shown earlier it takes a long time to travel from this village to the town where health service facilities are located. Beeause of its relative isolation and difficulties of travel, access to health services was a strongly felt need in this village. UNICEF responded in the recent past with primary health care projects in this village. Three different projects dealing with primary health care and health education known by the name of Vedagedara, Suvasarana and Sethsarana respectively were implemented in this village with great success. All these projects were focused on the primary health care needs of a village where health care was a strong felt need on account of geographical factors and difficulties of travel. The UNICEF's programme entered this village through a strongly felt need ; and around this need UNICEF succeeded in mobilising this village to support its programme. Interview data shows that the UNICEF's programme became a genuine 'people's programme' because its central activity was a response to a strongly felt need of the people. This was the reason why the other

components of the UNICEF package such as latrine construction received such significant response from the people of Moragoda. Once the people are mobilised round a felt need, all components of the programme including those components which are only peripherily related to the people's felt needs, such as the construction of latrines also get accepted by the people. The interview data shows that this was the process that resulted in the construction of such a large number of latrines in Moragoda.

The lesson to be learnt from the Moragoda experience is that when one is trying to get a community to accept a type of service or behaviour which falls low in the hierarchy of felt needs of a village, the strategy that works is one in which a multi-faceted package of activities is structured into a programme which is introduced to the village through a central activity which is a meaningful response to a strongly felt need of the people. The other facet of the programme which may include water supply, latrine construction, etc. should revolve round this central pivot. On the other hand, if we try to mobilise the people around a water supply activity or a latrine construction activity in an environment in which people give low value to these activities, the programme is not likely to succeed in mobilising the people into meaningful action.

Another relatively unsuccessful strategy that is very often adopted by external development agencies rests on the premise that by raising the level of knowledge and information pertaining to the inter-relationship between water, sanitation and health at village level, people can be expected to place a high value on latrine construction, environmental sanitation and access to 'pure' drinking water whereas before the communication of such knowledge and information, the value placed on these matters by the same people would have been low. The interview data clearly shows that this premise is wrong and therefore a project strategy that bases itself on this premise will also be unsuccessful. Both the interview data as well as the information given in Annexe 2.16 clearly show that over 90% of the people of Moragoda, over 60% of the people of Kadawalagama and over 40% of the people of

Habarakada and Upper Mellankulama are aware of the relationship between water, sanitation and health. Annexe 2.17 indicates that people, through experience, are of the view that when they are enjoying good health they have the necessary strength to resist the various types of infection that are waterborne while Annexe 2.18 shows that during times of illness, when the resistance of the body to infection is perceived as being low, people start using water which is boiled or heated. Annexe 2.19 shows that as a general practice, people do not drink boiled water in any of the study villages. People's behaviour in matters of water and sanitation seems very rational and in their own view the premises on which their behaviour is structured are justified in terms of their own practical experience. In the context of such clear thinking based on experimental knowledge, the premise that people have to be 'educated' about water, sanitation and health through health programmes is rather faulty. A project strategy based on such a faulty premise will result in relative failure.

As pointed out earlier, water and latrine construction receive low value in the four study villages. A project which tries to introduce new sources of drinking water and new interest in latrine construction activities without having these two elements as perepheral facets of a multi-faceted programme which revolves round a strongly felt need cannot be expected to stimulate anything but a formal response from most families.

The women's participation component of the UNICEF project seeks to mobilise women to plan and implement the project activities and maintain the project over time through a health sub-committee of the respective Gramodaya Councils. Such sub-committees are expected to be set up in the near future in the Gramodaya Councils to which the four study villages belong. At present, the respective chairpersons of the four relevant Gramodaya Councils have selected volunteers to work in the four study villages on the women's participation component of the UNICEF project. The six volunteers for Kodawalagama were in practise named by the family health worker of the village (she is a government official of the Health Department and was formerly known

as the PHN or Public Health Nurse). The six names were then approved by the Gramodaya Council chairman. At Horagoda the four volunteers - two boys and two girls one of whom was a GCE Advanced Level qualified female were selected by the Gramodaya chairperson herself. At Habarakada it is stated that three volunteers were selected from among the office-bearers of voluntary organisations in the village. At Upper Mellankulama six volunteers were selected by the chairman of the Gramodaya Council in consultation with the office-bearers of what he considered to be the most active voluntary organisation in the village. The volunteers go through a training course for four days - a course which is largely focused on water, sanitation and health. The volunteers of Kadawalagama and Habarakada have completed their training, while the training of volunteers of Horagoda has been arranged. The training of the volunteers of Upper Mellankulama has not yet been arranged because, being a Muslim village, the people want the training programme to be conducted in the village itself. Moreover, the programme has to be conducted in Tamil which is the language spoken in the village, and persons who can lecture in Tamil are not easily found in the district. The interview data shows that since water and latrine construction are matters to which the people in the four study villages give only a low value, the volunteers are being perceived by the people simply as persons who function as a one way communication link between the external developmental agency and the village. They are perceived by the people as a kind of village level voluntary, unpaid extension officer. Since the volunteers have only very recently been recruited, it is too early to comment more extensively on the role they play at an empirical level. For the moment it is sufficient to say that according to the interview data, the people in their own minds are developing two separate conceptual categories - the conceptual category of a 'leader' and the conceptual category of a 'volunteer'. A leader is one who mobilises the village by organising activities which meet the felt need of the people. The leader does so by successfully combining the resources of the village and resources obtained from an outside agency. A leader gives leadership to a process of the people. A volunteer on the other hand is being conceptualised by the people as a person who is performing an unpaid service for a developmental agency and acting as a village level extension agent or a village link

for a communication process which originates outside the village. A clever volunteer, if he/she is working in a project which meets a felt need of the people and is therefore integrally tied up with an economic or social process of the people, can emerge as a village leader. The interview data indicates that separate conceptual categories of this sort are developing in the minds of those interviewed.

The actual motivation of the volunteers has already been discussed in an earlier section. As seen earlier, they look upon their work as providing a qualification for career improvement and as providing an opportunity for developing a useful network of contacts with the district bureaucracy. It might be added that as long as the functions of the women who are expected to assume roles of responsibility in the water and sanitation project do not entail frequent travel out of the village to meet and negotiate with persons manning the delivery mechanism of the project in the sub-district capital or the capital, such women will not find themselves faced with any disadvantage. But it must be remembered that the difficulties of transfer between villages as well as between villages and towns being what they are, women unlike men will find it very difficult and inconvenient to frequently travel to urban centres, from their villages in order to liaise with the delivery mechanism of the project. However, such necessity has not yet arisen because the women's participation component of the UNICEF water and sanitation project is still in its early period of implementation. Hence it is difficult to observe this hypothesis empirically and comment more extensively on it.

## CHAPTER 4

## THE PEOPLE'S PERCEPTION OF WATER AND SANITATION

The contents of this section draw heavily on ideas expressed by Sunimal Fernando in an earlier publication prepared by him for WHO entitled 'Planning and Implementing Rural Water Supply and Sanitation Schemes with Community Participation : Potentials and Restraints (A Study of Four Village Level Projects in Sri Lanka)'. The study was directed by Sunimal Fernando and conducted by the Marga Institute for WHO in 1983 - 1984.

Rural water supply and sanitation projects in general are solutions to water and sanitation problems as perceived by planners. For instance, planners say that in Sri Lanka nearly sixty percent of those who seek outdoor hospital treatment suffer from diseases which result from poor environmental conditions including polluted sources of drinking water. Planners seek to reduce the occurance of these diseases by improving the environment through safe drinking water projects and latrine construction projects. Morbidity conditions such as Diarrhoea (particularly in infants and pre-school children), Helminth infestations (such as Roundworm and Hookworm), Infective Hepatitis, Enteric Fevers and Amoebiasis are spread by the faeco-oral route especially through contaminated hands, food, flies and water. Planners point out that while in Sri Lanka the crude death rate per 1,000 population dropped in the last four decades from 21.9 in 1945 to 7 in 1980 and the infant mortality rate dropped from 140 per 1,000 population in 1945 to 44 in 1980 and the expectant of life at birth increased from 45 in 1945 to 66 in 1980, the morbidity pattern of diseases, particularly those related to environmental conditions showed no appreciable change in the same period. According to the Ministry of Health, the diarrhoeal diseases morbidity rate remained practically constant from 1952 to 1976. The diarrohoeal diseases and helminthiasis formed the third highest category of hospital morbidity in Sri Lanka in 1980. Planners also perceive that these water and sanitation related diseases also have debilitating effects on those affected, taking away a part of their productive time, undermining their capacity for initiative and disrupting the schooling of children. Having identified

the water and sanitation problem in the way they do, planners perceive the solution as laying in the provision of safe drinking water and hygienic latrines coupled with the mounting of health education programmes aimed at changing the water and sanitation related behaviour of the beneficiaries. The solution incorporates the planner's perception of what quality of water people should use, how the water should be stored, how it should be used, e.g. boiled before drinking etc. and the planner's perception of personal hygiene, e.g. washing of hands with soap after defecation and hygienic disposal of human excreta, e.g. through the use of toilets which are hygienically constructed and maintained.

Beneficiaries, on the other hand, do not necessarily perceive their water and sanitation situation in quite the same way as the planners of water and sanitation projects. The people of the 4 villages that were studied, perceived their water and sanitation situation quite differently from the planners of the water and sanitation projects designed for them. In many instances, situations that were seen by the planners as constituting water and sanitation problems were not seen by the villagers as problematic situations at all.

The planner's perception of what constitutes a water and/or sanitation problem is derived from a fund of knowledge based on science. The knowledge results from highly systematic data gathering and reporting on the relationship of morbidity, water quality, water usage, faecal disposal, personal hygiene etc. followed by sustained, systematic and professional classification. This in turn is followed by conceptualisation, generalisation, development and testing of theories (defined as logical interlocked generalisation) and the application of theoretical findings to practical situations. Planners conceive their development projects on the basis of knowledge which has been built on a systematic, professional, scientific analysis of reality. Scientific information is thus used by planners for problem identification and problem solving where water, sanitation and health are concerned.

While health planners generally tend to draw their strength from problem identification and problem solving based on professional knowledge or 'scientific knowledge' the people of the 4 villages that were studied were found to draw strength for problem identification and problem solving in matters relating to water and sanitation on the basis of a different stock of knowledge. This is the stock of 'ordinary knowledge' or knowledge that does not owe its origin, testing, degree of verification, truth status or currency to 'professional' or 'scientific' techniques but rather to common sense','casual empiricism and thoughtful speculation and analysis. This knowledge can be highly fallible, but it is knowledge; common knowledge too - whether it is later proved to be true or false - is knowledge all the same to anyone who accepts it as a basis for action. It was found that in the 4 villages studied, for identifying water and sanitation problems as well as for solving them, the people depended heavily on 'ordinary knowledge' while the planners depended largely on 'professional' or 'scientific' knowledge.

In the 4 villages studied, the important components of 'common knowledge' relating to water and sanitation were found to be the following:-

(1) Water should not ideally be boiled before drinking as boiling changes the quality of the water. Thirst cannot be successfully quenched by drinking boiled water.

(2) When there is an epidemic in the area - e.g. of diarrhoea or of malaria - water should be boiled and drunk as disease can be transmitted through drinking water.

(3) On cold days, old people should drink warm water at night, especially if they are not in good health.

(4) If a person is sick and taking medicine his resistence to infection through waterborne germs is believed to be low. Therefore the patient should use heated water for drinking as long as he is taking medicine. When he is well, he should revert to drinking non-heated water. What is used is heated water (Thambapu Vatura) and not boiled water.

(5) The qualities of 'good drinking water' are - the water should be clear, transparent 'like the eye of the crow'; there should be no sediment; it should be colourless; it should not be brackish; it should be tasteless - it should not have a brackish-taste (kivul raha), salt-taste (lunu raha), rusty-taste (malakada raha), pipe-taste (paippa raha) or mud-taste (mada raha) etc.; it should have no gas smell (gas-gandha), dirt-smell (kunu gandha), rust-smell (malakada gandha) or fermented smell (pal-gandha) etc.; it should be cool (sisil;seetha) and should not have been sun-burnt (such as in the case of the top layer of water in an open tank) or burnt through the trapping of heat from the earth (polowă) such as in the case of a closed well (kekeruna vathura); also no 'film' should form on top of the water.

(6) Bathing should ideally take place when there is plenty of water - e.g. in an irrigation reservoir (wewa) or a river/stream (oya/ela). Immersing oneself in the water while bathing is more beneficial to health than bathing by pouring water on oneself with a bucket- as in the case of a well bath.

(7) Bathing is intended not merely to cleanse the body but more to 'cool' the body; - hence the importance of immersing oneself in an irrigation reservior or river/stream in preference to bathing at a well. As bathing is intended to cool the body, one should not go in the hot sun immediately after a bath. For the same reason, customary bathing places on rivers/streams and irrigation reservoirs are commonly located near big trees which provide shade from the sun for bathers.

(8) The colour of bathing water is not considered to be of great relevance. There is no need for bathing water to be absolutely clear like drinking water. However, bathing water should not be muddy. Customary bathing places on rivers/streams and irrigation reservoirs have sandy floors and not muddy floors and it is largely for this reason that people go to the customary bathing places (nana mankada) rather than to any place along a river/stream or irrigation reservoir for bathing.

(9) Bathing water should have no smell.

(10) Bathing water should not be brackish or salty as a lot of soap needs to be used when washing the body in brackish or saline water. If a person bathes in the sea, he would wash himself with 3 - 4 buckets of fresh water on his return.

(11) It is preferred if there are fish in bathing places because such fish would remove dirt and other pollutants from the water.

(12) Soap is used only for cleaning the body when bathing and for washing clothes. Soap is not generally used for washing hands - even after defecation. If one bathes while returning home after working e.g. in a farm, soap is generally not used. If one goes for a bath from home, soap is invariably used. However, if soap is not used, the body is scrubbed with either some coconut fibre , a polished stone, a cloth etc. or else the body is scrubbed against a tree or a wall.

(13) People tend to bathe a little more often in the dry (hot) season than in the wet (cool) season because the need to cool the body is felt more strongly in dry hot weather. People take a near daily bath in the villages studied.

(14) Washing of clothes usually takes place immediately after bathing. Flowing water is preferred. Brackish and saline water is not favoured as much soap is wasted when washing clothes in such water.

(15) The qualities that are favoured in the case of water used for cooking purposes are identical with the ideal qualities of good drinking water.

(16) In the case of water that is to be used for washing utensils - taste and colour are not serious constraints. However, such water should not have any smell. Brackish water is considered all right for washing utensils. Muddy water will not be favoured if there is an option available.

(17) People prefer to defecate in the bush rather than in a toilet. Greater mental satisfaction is obtained by defecating in the open rather than within the narrow confines of a small toilet.

(18) When going to the bush, people carry water with them. Or else after defecation in the bush, a person would either go to a stream or waterhole (if there is one close by) for ablution or in a very few cases return home for ablution. In a very few gardens there is a small temporary enclosure (about 3' x 3') near the house which is used for urinating and for ablution after defecation. This enclosure is known as a 'athu-kotuwa'.

(19) People do not generally wash their hands with soap after ablution. They use the right hand for eating food and the left hand for ablution after defecation.

(20) Women are not afraid to go alone to the bush, as jungle land is found close to most houses in the four study villages. Women do not have to go far in search of a thicket.

(21) Children under 10 years of age generally defecate in the home garden, a little away from the house. Children under 5 defecate very near the house and their ablutions too are attended to near the house itself. Faeces of small children lying near the house (in the 'midula') or in the home garden (gewatta) would be thrown away to a distance by an adult of the household.

(22) Water is carried usually in round clay pots (kalagediya). After reaching the water source, a little water is put into the clay pot/ bucket, the bottom of the pot is lightly scrubbed with the hand and the water is then thrown out. This is done to clean the pots of any sediment (mandi) that may lie at the bottom. The pots or buckets are then filled with water and taken home. The clay pot filled with water is taken into the house or more generally into the kitchen where it is kept in a dark place away from the sun. The mouth of the pot is covered with aluminium cup, a clay cup, a basketry cover or a coconut shell. The water in this pot is used only for drinking. The other pots are also kept usually in the kitchen and then taken near the improvised stand where the cooking utensils are kept (valan messa); - the water in these pots is used for domestic purposes other than drinking. It was noticed that the drinking water pot is generally washed more conscientiously than the other pots, indicating the importance attached to removing any sediment that may otherwise 'spoil' the drinking water.

(23) The rope and bucket used for drawing water from a well are generally not allowed to touch the ground. The bucket, when not in use, is kept face downwards on a wooden stake so that it does not get contaminated with sand.

24. The germ theory of disease causation is widely known in all 4 study villages. Around 50% of respondents were fully conversant with this knowledge. This is not surprising in an environment where literacy rates and educational levels are high by the standards prevailing in developing countries and access to the mass media is also relatively high. The other health messages, e.g. the communication of diseases through water, the impact of sanitation on health, the importance of boiling water before drinking, the importance of immunisation of children against certain diseases etc. have been equally effectively communicated to all sections of the 4 study villages through schools, western doctors, Public Health Inspectors, Family Health Workers, government hospitals, the radio, T.V. and the newspapers. The new knowledge coming through these channels is wide-spread in the 4 villages. The knowledge is not rejected but most aspects of the 'new' knowledge - though adequately communicated to the people - are 'overlooked' rather than rejected. The new knowledge is translated into active behaviour whenever an advantage is seen in doing so - e.g. when an epidemic is spreading people boil their drinking water but revert to the old practice of drinking unboiled water once the immediate danger has receded.

25. While not entirely rejecting, therefore, the possibility that bowel diseases could be transmitted through unclean drinking water, people combine this possibility with other possible causes of bowel diseases that are part of their common knowledge. They maintain that bowel diseases could also be caused by eating old food (e.g. in public eating houses); such diseases could also be brought on by a drought, by excessive heat. People maintain that small children could develop diarrhoea because the food was not correctly prepared - e.g. the consistency of the milk was incorrect. They maintain that skin diseases could be caused by the 'heat' especially during the hot dry season when people may not have access to sufficient quantities of water for bathing and cooling the body. The impact of health education programmes and the communication of the health message pertaining to the relationship between water, sanitation and health has been to modify the knowledge base of the people who now tend to maintain that bowl diseases, skin diseases,

helminth infestations, enteric fever, infective hepatitis etc. have many different alternate causes among which are unclean drinking water and poor sanitation. Unclean water and poor sanitation are not considered to be the dominant causes of these diseases but simply two of many possible causes.

26. People in the 4 villages maintain that sediment in drinking water can cause stomack diseases.

27. Defecation is not socially permitted near a drinking water source. A latrine too is never constructed near a well. The reason given by the respondents is that drinking water should not be allowed to get 'spoilt' by contamination with human excreta as it would make the water smell bad (gandha). The reason adduced however is not that the faecal contamination of drinking water is detrimental to health.

28. It was seen that people perceive immunisation programmes for children as being useful. However, Ayurvedic home remedies (Ath-Beheth) are very commonly used for de-worming of children.

It was seen that the people in the 4 study villages have certain perceptions of water usage, excreta disposal, disease communication, sanitation and hygiene. Those perceptions are seen to derive from the people's stock of common knowledge pertaining to water, sanitation and health. People's water and sanitation related behaviour - in this field- flows out of these perceptions.

Witin a soeietal context defined in relation to two different stocks of knowledge relating to water, sanitation and health, how could rural water supply and sanitation projects be planned and implemented in such a way that they are accepted and utilised by a greater number of beneficiaries than at present? This problem should be always addressed by those implementing rural water and sanitation projects.

'Ordinary knowledge' on which the water/sanitation/health perceptions of the study villages is based is itself not a homogenous entity . Some scientific knowledge gets incorporated into ordinary knowledge. Some ordinary knowledge takes the form of water/ sanitation/health related norms rather than facts. Though for purposes of model building in an earlier section, 'ordinary

knowledge' and 'scientific/professional knowledge' were posited as two distinct types of knowledge, in the real world situation, those two categories of knowledge are not mutually exclusive types. Both kinds of knowledge have much in common in that they are both firmly anchored on empirical experience. They are not totally different from each other as may seem at first sight. Both kinds of knowledge originate from the same techniques of speculation hypothesis formulation, investigation, verification, conceptualisation and theorising. Whereas common knowledge is derived from casual investigation and casual verification as practised in a non-formalised way throughout society by all kinds of people, scientific/professional knowledge is derived from the use of specialised techniques of investigation by professionally trained scientists or professionally trained investigators working with special instruments under controlled conditions of observation.

It has been seen that new knowledge relating to water/sanitation/health when communicated to the 4 study villages by water/sanitation/health planners, has not been rejected but some components of the stock of new knowledge have been 'overlooked' by not being transformed into new water - usage, sanitation and health practices. The new water/sanitation/health knowledge, when newly communicated is received by the people as 'speculative suggestions' which they then casually investigate by making casual observations. Having verified this knowledge, people will incorporate it into their stock of common knowledge. However, the important point is that the new knowledge will be transformed into new forms of action (e.g. new water usage practices, new sanitation practices etc.) only when societal conditions converge to render the benefits of adopting new practices greater than the costs of giving up older ones.

The costs and benefits of adopting a new water usage, sanitation or health practice are determined within the socio-politico-economic-cultural framework in which the decision to do so is made.

This concept is best clarified with the use of few examples drawn from the empirical experiences of the 4 study villages. Three

examples are discussed below:-

(1) The decision to be taken by an individual family whether to use the new source of clean drinking water provided by the project or continue to use the traditional source of unclean drinking water : The added benefit of using the new source would perhaps be the saving of time and effort in fetching water as the new source is closer to the house than the old traditional source of drinking water. This same family would also perceive another benefit in that the chances of contacting diseases transmitted through polluted water would be a function of how individual families perceive the chances of falling ill through drinking from the traditional water source and of the perception of illness itself by individual families. For instance, if a family through experience perceives that in actual practice the chances of contacting illness through the use of the traditional water source is very small, then, in the case of such a family the perceived benefit defined in terms of 'reduction of chances of contacting any of the water transmitted diseases' would in turn be very small. Respondents in all 4 study villages in fact perceived the chances of contacting a water transmitted disease by using the traditional sources as being very small indeed and hence they perceived the benefit in health terms of switching over to the new source of clean water provided by the project also to be very small. Even where illness itself is concerned, respondents in all 4 study villages, from all strata of society, perceived illness in a manner quite different to the perception of illness by persons in developed countries. Illness was perceived as an ordinary occurrence. In the rural context, when a person falls sick, treatment is sought either through a home remedy or with medicine from the local Ayurvedic doctor or from the nearest free government hospital/dispensary and the sick person refrains from going to work until he is better. If there is some urgent work to be done on the farm or work-place some

other member of the family would attend to it until the person recovers. In the rural environment, illness does not seriously disrupt the normal pattern of work. Illness (water transmitted or otherwise) is not perceived as something that is worth spending any great time or effort to prevent. If for instance one has to spend substantially more time and effort to obtain 'clean water' from a new source in comparison with the lesser time and effort spent when using the old traditional source in order to reduce the chances of contacting illness, when weighing the costs and benefits of taking such a decision, a person living in any of the 4 study villages will place a low value on 'illness prevention' because illness is not perceived as a condition that merits the deployment of much resources of time or effort to prevent. The low value given in the rural context to illness prevention is further stabilised by the very good infrastructure of health services available in Sri Lanka. As for the perceived cost of adopting a new source in preference to a traditional one, if the water from the new source is - in terms of the people's perception of 'good water' - not so good in taste as the water from the old source - e.g. it may have an undesirable 'pipe taste' (paippa raha) or rust taste (malakada raha) or 'brackish taste' (kivul raha/dediya), - the lowering of the quality of water by adopting the new source will be seen by the beneficiaries as a 'cost'. In deciding whether to adopt a new source of drinking water provided by a rural water supply project or whether to continue using the traditional source of drinking water, each individual family will weigh the benefits and costs involved in such a decision by placing different values on the benefits and costs as perceived by them. If the benefits exceed the costs, a family will adopt the new source, whereas if the costs exceed the benefits, the family will continue using the traditional source of drinking water even after the rural water supply project is completed. Sometimes the cost benefit balance sheet would be different for the wet season and dry season respectively. Quite often a family has one source of drinking water in the wet season (closer to the house) and another source in the

in the dry season (further away, since the wet season water source may run dry in the dry season). In such situations, the benefits of adopting the new source for an individual family may exceed the costs of doing so in the dry season only. The family would then use the new source in the dry season and revert to the old source in the wet season. However, this situation does not occur in any of the 4 study villages.

(2) The decision to be taken by an individual family whether to construct a hygienic toilet in the home garden near the house or use the bush (scrub jungle) for defecation : An analysis of observation and interview data from the 4 study villages shows that the propensity to construct toilets increases with the increase in the time taken to reach the scrub jungle for defecation. The clearing of scrub jungle in response to population pressures and the resulting pressure on land and the extension of areas under cultivation result in an increase in the time needed to reach the scrub jungle for defecation. This applies specially to women since men - unlike women - generally move longer distances out of the home in connection with their daily work routine and can therefore more conveniently reach a scrub jungle for defecation while attending to their daily work programme. As the scrub recedes, rural women begin to prefer using toilets rather than walking long distances to the nearest available scrub. The benefit of using a toilet varies proportionately with the distance to the nearest scrub.

The empirical data from the 4 villages also showed that another perceived benefit of constructing, using and hygienically maintaining a toilet relates to the 'level of modernisation' of a family. Sri Lankan villages are highly incorporated societies - incorporated into national, ecnomic, social, political and cultural systems through the forging of a diversity of networks which link the rural to the urban systems. Some families in villages are more incorporated into urban systems than other families. These families generally tend to emulate urban life-styles which are seen as relatively 'modernised'. Sociologically, the more 'incorporated' rural families place a positive

value on 'modernisation' (i.e. emulating the external features of an urban life-style). The construction, use of hygienic maintenance of of a toilet is valued by such families as a facet of modernisation. Broadly speaking, the higher the level of education and higher the level of family income, the higher would be the degree of incorporation and level of modernisation. This is a very general sociological observation and does not mean that all modernised rural families have reached relatively higher levels of education or that all rural families enjoying higher levels of income are relatively more modernised. All that it means is that there is a broadly observable correlation between modernisation and education, and modernisation and income, in rural society. On the cost side a family will consider the cost in terms of money and labour needed for constructing a toilet and the loss of a certain amount of psychological satisfaction in defecating within the confines of a small toilet instead of doing so as before in the open scrub. A family will take a decision on toilet construction only after the family members have evaluated in their own minds the economic, social and cultural costs and benefits involved.

(3) The decision to be taken by an individual family whether to boil water before drinking :

Once again, it was seen through an analysis of observation and interview data from the 4 study villages that individual families take their decisions about boiling or not boiling drinking water after evaluating the economic and psychological costs and the economic and social benefits of doing so. The cost factors relate to the perceived fall in water quality by boiling and the expense of time, effort and fuel. The benefit factors relate to disease prevention (on which a relatively low value is generally placed on account of factors already discussed) and 'achievement of an aspect of modernisation' - because boiling of water before drinking is considered to be also a facet of an urban life-style and hence an aspect of modernisation. In those social situations in which socio-economic-cultural benefits of boiling drinking water exceed the economic and psycho-cultural costs of doing so, people will boil their drinking water or at least officially

subscribe to the norm that water should be boiled before drinking because observation data suggests that the number of families actually boiling their drinking water is substantially lower than the number of families officially claiming to do so.

The interview data from the 4 village studies leads itself to the conclusion that failure on the part of recipient communities to utilise the facilities provided by rural water supply and latrine construction schemes to the maximum, has nothing specifically to do with rural ignorance of the relationship between water, sanitation and health. It has been argued that knowledge coming from outside - e.g. water, sanitation and health related 'scientific' knowledge - is never rejected by rural societies but received not as 'knowledge per se' but as 'hypotheses' or 'speculations' which a recipient rural community then investigates and verifies through a methodology characterised by 'casual empiricism' and 'casual observation' as discussed earlier. After verification through casual empirical methods, that part of the knowledge coming from outside which stands the test of verification gets incorporated into the stock of common knowledge of rural society. For knowledge to get transformed into action such knowledge must be made 'useable'; and knowledge is useable only when the benefits accruing from the use of such knowledge outweigh the costs involved in doing so.

In the 4 rural water supply and sanitation situations under study, scientific knowledge pertaining to water and sanitation was found to have been successfully communicated to the recipient rural communities which were seen to have incorporated most of this knowledge into their respective stocks of common knowledge. The knowledge thus communicated and incorporated by rural communities can be more successfully transformed into 'usable knowledge' if such projects are designed and implemented in such a way that the economic, social, cultural and psychological benefits of adopting new water and sanitation practices are designed to outweigh the economic, social and psychological costs of doing so for a greater number of village households.

# CHAPTER 5

# PROJECT ORGANISATION AND IMPLEMENTATION

## 5.1. Project Organisation

A water supply and sanitation project is being implemented since 1983 in the Anuradhapura district by the UNICEF. The financial grants necessary for this main project are being provided by the UNDP. The implementation is by the National Water Supply and Drainage Board and the Department of Health. The coordination is done by the Government Agent.

A sub pilot project on water supply and sanitation was started in 1985 . Funds for this project too are supplied by the UNDP but through the Women's Bureau. The Women's Bureau is also responsible for the implementation of the sub pilot project with which this study is concerned.

There is a consultant on behalf of the Women's Bureau residing within the project area to look after the implementation activities. To assist him a plan implementation officer too has been seconded for service. Till recently this consultant had his office in the same premises as that of the AGA but now he has his own office.

The funds allocated for the project are deposited in an account in charge of the AGA and the AGA releases funds on the request or recommendation of the Consultant.

Village level assistance for the implementation of the project within the AGA division is obtained by the Consultant mostly through the Gramodaya Council or volunteer workers (male and female). In addition to this the assistance of officials of the Health Department is obtained. In this the officers who are mostly involved with the approval of the District Director of Health Services are the Public Health Inspectors and the Family Health Workers.

For training volunteer health workers both male and female, the services of doctors working in the hospitals of the area and the Public Health Inspectors are utilised.

In order to facilitate the implementation of the project another step taken is to set up a Health Committee attached to the Gramodaya Council. A Family Health Worker functions as its Secretary. This

Committee is expected to implement health programmes at village level and engage in activities concerning latrines and access to water. Among health programmes are included mainly maternity clinics, immunisation and nutrition (herbal broth) for children etc.

The intention is to get women interested in these programmes and thereby direct their participation towards the objectives of the project.

Another aspect of the programme is to train teachers in a large number of selected schools to get them involved in the programme so that the message of the project can be communicated to homes via the school children.

UNICEF, WHO, UNDP and the Women's Bureau meet once a month to review the progress of the project. IRED which is responsible for this study is represented at these meetings by its Director.

5.2. Selection of Volunteer Workers

The main strategy of the project was to get the volunteer workers to perform the tasks of carrying the message of the project to villages and obtaining more and more participation of women at village level. For this it was expected to select persons who were willing to work on a voluntary basis and who were able to devote a part of their time for the project.

The most appropriate procedure for this was, to select male and female volunteers through the Gramodaya Council which consists of village level volunteer organisations. The intention was to discuss this matter in the Gramodaya Council, obtain the views of the representatives of volunteer organisaations and then select suitable persons . We directed our investigation to ascertain to what extent this intention became a reality in its implementation. (The composition and the working of Gramodaya Councils and the degree of success of the attempts to implement some aspects of the project through them will be discussed in a later Chapter).

The Chairman of the Kadawalagama Gramodaya Council thought that it was not necessary to discuss this at a meeting of the Council and that there was no harm in nominating persons who in his opinion were capable of undertaking such responsibilities. Accordingly, he appointed persons using his discretion. All his nominees were women.

The Chairperson of the Horagoda Gramodaya Council acted in a similar manner, but here nominees included one male. However, there was a female volunteer worker who had received training under a project implemented earlier by the Health Department and who on hearing about this project had come forward on her own offering her services. She too was recruited.

The Chairman of the Gramodaya Council to which Upper Mellankulama belongs followed a different procedure. He consulted the leaders of the volunteer organisations of constituent villages on this matter. Thus at Upper Mellankulama, the chairman of the School Development Society and the Chairman of the Sarvodaya Association who were consulted made the recommendations. Among those recommended by them were the wife of the Chairman of the School Development Society and the daughter of the Sarvodaya Chairman.

At Habarakada too the Chairman of the Gramodaya Council appointed the volunteer workers according to his discretion. He had intervened to set up certain organisations and appoint women volunteer workers as chairpersons of those organisations. They were then given membership in Gramodaya Councils. A women volunteer worker serving the village of Habarakada is one such person representing the Gramodaya Council on behalf of a housing society.

The number of volunteer workers chosen in this manner was 13 (12 females and 1 male). Two of these have left the village for employment elsewhere and it was not possible to interview two female volunteers at Upper Mellankulama. Questions were answered on their behalf by the father and husband respectively. Thus we were able to obtain the views of only 9 out of the 13 volunteer workers in the four villages coming under the study. Their comments regarding the procedure for selection can be summarised as follows:-

Menike (38 years) has studied up to GCE (OL) and is unmarried. She said 'Chairman of the Gramodaya Council is a relation of ours. He asked me whether I would like to work as a volunteer worker. I agreed. Mostly I work for volunteer organisations and sometimes I work for the Women's Bureau too'.

Kotakadeniya (21 years) has studied up to GCE (A.L.) and is unmarried. 'I work as a volunteer teacher in the neighbouring village. Therefore I have little time to participate in the work of the health project. Yet I like that kind of work very much. It was the Chairman of the Gramodaya Council who got me involved in this'.

Vinitha (19 years) has studied up to GCE (O.L.) and is unmarried. She got involved in volunteer work as the request of the Gramodaya Council Chairman'.

Nimali (22 years) has passed the GCE (A.L.). 'Earlier I worked as a volunteer worker in a programme carried out by the Health Department. At present I am the only person actively working in this project. I got involved in this project purely by accident. One day I heard that a meeting was being held in connection with the health project at the Poragoda School. I too went there, to find some persons selected by the Gramodaya Council and some gentlemen from outside having a discussion about this project. I told them I too would like to join. That is how I got involved. The other two persons selected by the Gramodaya Council are no longer working in the project. I am the only person active. My brother too is working for Sarvodaya'.

Nimal (21 years) is educated up to GCE (OL) and got a training for about a year at a Art Institute in Colombo. 'It was the Gramodaya Council Chairman who asked me to join this project. I participated in the training as well as the first survey. But I was not in the village during the past several months. Now I hope to work again in the project'.

Chandrani (29 years) is married and has one child. Her husband is a hospital worker. 'I particiated in public activities and work of various societies even before marriage. Now I have less time because of domestic duties. It was the Gramodaya Council Chairman who assigned this responsibility to me'.

Jasmine's husband (speaking on her behalf) 'The Chairman of the Gramodaya Council asked me to select a few women vounteer workers. Parents do not like to send their daughters for work like this. They are not educated. They have no social awareness. However, in order to obtain some service useful to the village I suggested the name of my wife. But I act on her behalf'.

Nazamine's father(speaking on her behalf) 'I am the president of the local Sarvodaya Society. It is difficult to carry on union activities here. It is difficult to get these people interested in anything. But in order to solve this problem of finding a volunteer I gave my daughter's name. But I have to attend to everything connected with the work of the project. I won't allow any lapse in the work because my daughter does not go'.

In all the other villages except Upper Mellankulama, we came across during our study,a number of male and female volunteer workers who had been trained for activites in other projects, but activities indirectly connected with this project. They had been trained by the Department of Local Government. Their task was to look after tube wells that had been constructed. They had received a three day in-house training. This training included -

1. Objectives of the water supply project;
2. Water and Health;
3. Community participation;
4. Technical matters concerning tube well pumps;
5. Pratical training in minor repairs and dismantling and installing pumps;
6. Discussion on other questions regarding tube wells;
7. Relevant film shows etc.

The trainees had been selected out of women residing in houses close to the tube wells. They were over 18 years of age and able to read and write. The four trained workers we met were between 18 and 22 years and had studied up to G.C.E. (.O.L.). However not one of these had been recruited to work in the project under the present study. All of them said that they were not aware about the selection of volunteer workers for this project and three of them informed us that if they knew, they would very willingly have offered their services. The other said that in an earler self-employment project implemented by the Women's Bureau, she had been treated with indifference and therefore her mother would not allow her to participate in any volunteer service in the future.

The essence of all the foregoing comments is that, in our opinion, selection of volunteer workers could have been done carefully and efficiently. Such a conclusion can be justified even more, when one takes into consideration the fact that health programmes are being implemented in our remotest villages

and that in most of these villages one could find several people who have had experience in participating in such programmes. However, only three such persons appointed, one in Horagoda (Nimali) because she came forward on her own and two others in Kadawalagama and Habarakada respectively because the Gramodaya Chairmen wanted them. Our view that it would have been better if persons with previous experience were selected, is further confirmed by the fact that the two or three volunteer workers whose performance is the best are those who had gained experience in previous projects.

5.3. Training of volunteer workers

A programme, formal as well as systematic, had been formulated for the training of volunteer workers. While the training period was four days, lodging, meals and travelling expenses were provided.

Assistance of doctors and Public Health Inspectors was obtained for training, and the methods used were varied, as follows:-

1. Lecture
2. Slides
3. Film shows
4. Drama and other group performances
5. Discussions and exchange of ideas
6. Training in practical work.

The training programme had been based on the belief that more effective results could be obtained through pratical training rather than through listening to lectures and taking down notes. It would be correct to say that it had been structured in a novel and stimulating manner.

For example, on the final day of the training programme, there was an exercise involving mothers, children and trainees. 10 mothers accompanied by children under 1 year in age had been brought to the programme. The trainees were divided into ten groups and each group was made to interact with a mother and child, obtaining from them a comprehensive account of their health. Later this information was

presented by group leaders and discussed. (See Annexe 3 regarding an observer's account of the training programme.)

Thus sufficient scope was provided by the training programme for the trainees to obtain an adequate knowledge about the project so that they would be well equipped to carry out the tasks expected from them.

5.4. Coordination

As mentioned earlier too a water supply and sanitation project is being implemented in the Anuradhapura District by the UNICEF with the cooperation of a number of State institutions (Government Agent, Health Department, Ministry of Local Government etc.) This main project funded by the UNDP has been in operation for four years now . The present sub pilot project was started in April 1986, with the financial assistance of UNDP, by the Women's Bureau.

The coordinating officer for the main project that is being implemented throughout the district is the Government Agent. The assistance necessary for the implementation of the project at village level is being provided by the relevant Ministries, divisional Assistant Government Agents and Gramodaya Councils.

The pilot project subject to our study is being implemented in only one AGA division, namely Kekirawa. The tasks of guiding it and coordinating it are being performed by the Women's Bureau.

The main concern of this sub project is directed towards mobilising women's participation in water supply and sanitation activities and by means of that creating an interest among rural families to more productively make use of the material amenities (like wells, latrine etc.) provided by the main project.

5.5. Problems of Coordination

As under the main project, necessary resources like tube wells and latrines under this project too are distributed by the relevant departments. For instance, latrine slabs/latrine pans needed under the

sub project too can be obtained only by placing an order through the Director of Health Services.

The procedure followed by the Ministry of Local Government with regard to constructing tube wells, deciding the sites for them etc. in the AGA division where the pilot project is being implemented, is the same as that in other areas of the district coming under the main project. They had not made any alterations in their arrangements to accord with the requirements of the AGA division where the pilot project is being carried out.

For example, though there were volunteer workers operating in almost every village within the AGA division where the pilot project is being implemented advice and assistance in deciding the sites for tube wells had been obtained only from the Chairman of the Gramodaya Council.

Though in three out of the four villages coming under the study there were trained volunteer workers appointed by the Assistant Commissioner of Local Government for the purpose of looking after the tube wells already constructed, there was no coordination between them and the volunteer workers of the pilot project.

In the villages studied, there were tube wells, with sinking completed but pumps not fixed. But neither the volunteer workers nor the Chairmen of the Gramodaya Council had any inkling about or connection with the future arrangements of their completion.

There was no coordination among the relevant and responsible institutions to supply without delay and at the required time the necessary materials (like latrine slabs etc.) so that the enthusiasm generated by the pilot project could be sustained.

The volunteer workers who were responsible for the implementation of the project at village level had their linkages, mostly only with the Consultant from the Women'sBureau and the person assisting him. They had organised health education programmes,kolakenda (herbal broth) programmes, maternity clinics, immunisation programmes, etc. But they had not taken the necessary steps to mobilise the women who come forward

through these programmes, to participate in water supply and sanitation activities.

5.6. Contribution of volunteer workers in programme implementation

The tasks that volunteer workers are expected to perform in implementing programmes within the sub project area are as follows :-

1. Implementing various programmes under the guidance of the Gramodaya Council Health Committee;
2. Enhancing the participation of rural women in health activities, specially in Child and Maternity Health Care and improving their knowledge;
3. Getting women interested and educated about tube wells being provided to villages, how to select a suitqble site for their construction, how to make proper use of them and how to look after them and maintain them etc. and promoting of voluntary participation in such activities;
4. Creating women's initiative and guidance in encouraging the members of the family to construct and make use of latrines and improving the knowledge and participation of women as the members of the family unit who have to bear the greater responsibility in sanitation activities.

In implementing the programme, it was expected to obtain the assistance, especially of family Health Workers and Public Health Inspectors and of community organisations and prominent persons at village level. However this task that had to be done through setting up Health Committees under the Gramodaya Councils was not achieved in any of the Gramodaya Council areas to which the four villages under the present study belonged. More details regarding this will be discussed in the Chapter on the activities of volunteer organisations and the participation of women.

## CHAPTER 6

## ACTIVITIES OF VOLUNTEER ORGANISATIONS AND WOMEN'S PARTICIPATION

### 6.1. Volunteer organisations to discuss

It is necessary at length the activities of volunteer organisations and the participation of people and women in them, in the villages under study. This is important because the success of the project under study depends on the extent to which women participate in it.

At the same time it is also important to find out in what type of rural volunteer organisation women can be mostly organised.

We will base this discussion of volunteer organisations not merely on the four villages but generally on the Gramodaya Councils to which these four villages belong.

A Gramodaya Council is an aggregate of volunteer organisations based on the Grama Sevaka division, the lowest unit in the civil administration structure of Sri Lanka. The government too intervenes in setting it up. The post of Secretary of this Council is held, ex officio, by a State official called Special Services Officer. His duties cover two Grama Sevaka divisions.

The area of authority of a Gramodaya Council generally covers 5 - 10 villages. We give below the number of villages and the number of volunteer organisations that come within the areas of Gramodaya Councils to which the villages under our study belonged.

| Gramodaya Council | No of Villages | No. of Volunteer Organisations |
|---|---|---|
| Kadawalagama | 10 | 19 |
| Horagoda | 08 | 17 |
| Habarakada | 08 | 21 |
| Upper Mullenkulama | 06 | 15 |

All these volunteer organisations function independently. The Gramodaya Council is made up of the presidents of these organisations. In these villages there are also some other organisations that are not represented in the Council. Among this category of organisations, the

more prominent are the political associations. Out of the organisations included in the above Table we give below the number of organisations in the villages under our study that are represented in the Gramodaya Council as well as the number of such organisations led by women. As mentioned earlier too in a village there can be other organisations not included in the Gramodaya Council.

| Village | No. of organisations represented in the Gramodaya Council | No. of such organisations led by women |
|---|---|---|
| Kadawalagama | 03 | 02 |
| Horagoda | 01 | 01 |
| Habarakada | 04 | 02 |
| Upper Mellankulama | 02 | - |

Taking the Gramodaya Council areas as a whole and taking the villages under study as a whole, it can be concluded that there is quite a significant women'sleadership in volunteer organisations.

| Village | Percentate of organisations with women's leadership at Gramodaya Council level | Percentage of organisation with women's leadership at village level |
|---|---|---|
| Kadawalagama | 21 | 66 |
| Horagoda | 06 | 100 |
| Habarakada | 33 | 50 |
| Upper Mullenkulama | 33 | - |

Though women's participation at Gramodaya Council level apparently is low at Horagoda, the only woman representative there is the Chairman of the Council.

On the basis of their activities and participation this mass of of volunteer organisations can be classfied as follows:-

1. Organisations whose activities as defined by practice require only a minimum linkage with the external system for obtaining services and resources. These are by and large inward looking organisations that function at village level. The Women's Rural Development Society, the School Development Society, the Buddhist Society, the Buddhist Women's Society,

the Muslim Society, the Funeral Welfare Society, the Christian Society and Hindu Kovil Society by and large fall into this category. The practise the type of work by these organisations has not called for any serious linkages with the socio-political and economic system external to the village.

2. Organisations whose activities as defined by practise require strong linkages with the external socio-political system. The rationale for these organisations lies in their ability to channel resources from the external socio-political system for development in the village. In a socio-economic environment in which development at village level has not been propelled by a dynamic growth of capital and technology from within the village itself, the obtaining of resources and technology from outside the village system is critically important for village level development in Sri Lanka. Village level organisations which in practise act as brokers linking the village with the external socio-political system centered round the government and the political party in power, therefore play a critically important role in the social and economic life of the village. The Rural Development Society(to some extent) and the political societies fall into this category. The interview data shows that different sections of the village elite linked to the party in power compete with each other for power and position within these organisations. The office bearers of these organisations if they are to perform their functions efficiently, need to develop and maintain a good network of contacts with the district political hierarchy connected with the governing party and to a lesser extent also with the district bureaucracy.

3. Organisations which have no real evolution from within the village but have been set up by external developmental agencies who want an organisation through which to implement a fairly small scale development project at village level. These are not brokerage type organisations which have negotiated developmental projects with an external agency and in doing so have brought an external developmental agency into the village. Generally speaking the process has been the other way round. An external agency has found its way into a village

where it wants to implement a project relative to its aims and objectives, and needing a relevant organisation for its activities at village level, has organised a group of persons interested in its project into a new organisation through which the project is implemented. The Sarvodaya Society, the Mahila Samithi, the Women's Bureau Society, the Family Health Society and the UNICEF Society fall into this category. In practise these societies implement very specific programmes brought into the village largely at the initiative of an external development agency with resources largely provided by such agency itself. Village level volunteers are generally found to participate in programmes implemented by organisations of this type. Ideologically, the participation of village level volunteers is supposed to indicate that the programme - which in fact was brought from outside - does also respond to a felt need and a developmental objective of the village itself.

In the Sinhala villages that came under our study, it is apparent that the traditional attitudes regarding the participation of women in public activities have disintegrated. The two Sinhala villages where this feature is specially marked are Horagoda and Habarakada. In our baseline study we indicated that in these two villages, the women are very much advanced with regard to membership in volunteer organisations. We also pointed out that the main reason for that was the closer association of women in these villages with the economic process. This conclusion we put forward in our baseline study without much substantial reasons can now be confirmed as the result of deeper studies done later.

However in our continued study we discovered a serious discrepency between being members of a volunteer organisation and participating in its activities. During the baseline study we asked the question 'Do your wife and/or daughter hold membership in any volunteer organisations?.' The replies to this question showed that the extent of membership in volunteer organisations was as follows:-

| | | |
|---|---|---|
| Kadawalagama | ... | 42.6% |
| Horagoda | ... | 83.7% |
| Habarakada | ... | 67.8% |
| Upper Mellankulama | | 4.4% |

However, in our subsequent study we pried deeper into the question to find out the extent of actual participation by them in the activites of these organisations. The replies showed that the extent of active participation by women in the work of volunteer organisations was as follows:-

| | | |
|---|---|---|
| Kadawalagama | ... | 23.8% |
| Horagoda | ... | 39.5% |
| Habarakada | ... | 32.5% |
| Upper Mellankulama | | .0% |

In this exercise our attention was drawn to another interesting feature of women's participation from which we concluded that there are two aspects to women's participation. One is the 'willingness to participate' and the other is the 'opportunity or ability to participate'. What we had identified in our baseline study was the first aspect, while the second aspect was revealed to us in the present study. In reality, a large number of women in these villages are 'willing to participate' in volunteer activities. But the serious problem is that the opportunity - the time and the leisure - for such activities is very little. At Horagoda and Habarakada, out of the adult women, 51% and 59% respectively have, in addition to their domestic chores, to help the men in their agricultural work. In these two villages another 8% and 9% respectively are employed in other jobs. Thus the time and the leisure they have to volunteer for social and public activities are very limited.

However, at Kadawalagam where women's participation in volunteer organisations is low, their participation in economic activities too is not much. And at Upper Mellankulama where there is minimum participation by women in economic activities their active participation in volunteer work is almost nil. (See Annexe 2.19 A)

6.2 Volunteer Organisations that could attract women more easily for participation

According to information gathered during our study women appear to be more attracted to participate in activities of the first and third categories of organisations as classfied above. On further inquiry it was found, that women's participation centre around organisations that are expected to and do provide individual benefits, rather than around organisations that aim at common rural development. Prominent among organisations in which women's participation was bigger were -

1. Funeral Aid Societies;

2. School Development Societies; and

3. Religious organisations.

In addition to these, there was a fair amount of participation in rural development societies meant for women only and in societies formed by the Women's Bureau specially for women.

For example at Kadawalagama women's participation in 3 meetings of the Funeral Aid Society was 67%. At Horagoda their participation in one meeting of the School Development Society was 62.5%.

Similarly, at Habarakada and Kadawalagama the participation of the groups of women mobilised by the Women's Bureau for the self-employment projects was very high. However, these groups were small and most of the participants were young women.

These facts confirm the view that mobilisation of women to participate in volunteer activities can more easily be done through organisations that implement programmes providing individual benefits. The School Development Society deals with the educational problems of the members' children. The Funeral Aid Society provides much assistance on the occasion of a death in the family. In the case of organisations such as self-employment societies one can personally expect some financial or other material gain.

Another reason why this type organisation is more attractive to women is their relatively peaceful nature. In organisations like the Funeral Aid Society, School Development Society or a religious society there are no serious controversies or heated debates. For instance, a School Development Society headed by the Principal of the School or a religious society in which the patronage of the clergy is inevitable can be expected to provide a pleasant and safe atmosphere.

In addition, there are within these four Gramodaya Council areas volunteer organisations exclusively for women. The women's societies are a little more than 8% of the total number of organisations in the Gramodaya Council areas.

K.T.D. Menike (42 years) lives with seven family members including the mother. Her father is dead. The mother draws a widow's pension. On the day she visits the nearby town to draw her pension, she participates in a Pensioners' Funeral Aid Society. Menike is also an active member of the Kadawalagama Funeral Aid Society. At the same time she plays a prominent role in the activities launched by the Women's Bureau and works as a volunteer worker in the Water Supply and Sanitation project. She has a younger brother and sister in government service. They encourage her in her volunteer activities.

L.H. Kotakadeniya (61 years) lives with the wife and 3 children. His main occupation is agriculture. He participates in the work of the Rural Development School Development Society and the Funeral Aid Society. His wife attends the meetings of the Women's Bureau Society. The daughter is a volunteer worker (Kadawalagama).

L. Wilson Kurera (68 years) has studied up to the 3rd standard. There are two families living in his house. His family of seven and the daughter's family of three. His main occupation is agriculture. His participation in volunteer work is not much. The wife participates in the Funeral Aid Society while the married daughter participates in the work of the Women's Bureau Society (Kadawalagama).

J. Jayasuriya (56 years) has studied up to the 2nd grade. There are six in the family. The main occupation is agriculture. Whil the wife is active in a Kulangana (Women's) Society, the daughter Jasintha having received training in self employment under the Women's Bureau is engaged in such activities (Habarakada).

Jayaratna Perera (38 years) is a bus conductor and has studied up to the 10th grade. He is married and lives with the wife and two children, (a daughter and son aged 08 and 3½ respectively). It is mostly the wife who participates in volunteer activities. Her main concerns are the Kulangane Society and the Funeral Aid Society. On special occasions like funerals, the husband too gets leave and joins her (Habarakada).

Vitharanage Simon (49 years) has studied up to the 4th grade, is married and has 4 children. He has no opportunity to participate in volunteer activities because he is fully occupied in agricultural work. But the wife participates in the activities of the Kulangana Society only (Horagoda).

D.P. Dhanapala (29 years)has studied up to the 2nd standard. He has two children and is occupied in agriculture. In the sphere of volunteer work, both he and his wife participate in the work of the Rural Development Society and the Funeral Aid Society, as time permits. But in the sphere of politics only Dhanapala participates (Horagoda)

## 6.3.Inclination towards various volunteer societies

The total number of volunteer organisations existing in the areas of authority of the Gramodaya Councils to which the four villages under study belonged was 72. They can be classified as follows:-

| Type of Society | Number | Percentage of the Total |
|---|---|---|
| Rural Development Society | 23 | 31.94 |
| Funeral Aid Society | 10 | 13.9 |
| Young Farmers' Club | 03 | 4.16 |
| Women's Society | 06 | 8.33 |
| Religious Society | 09 | 12.5 |
| Sarvodaya Society | 02 | 2.77 |
| School Development Society | 09 | 12.5 |
| Others (Volunteer labour, sports, community centres) | 10 | 13.9 |
| | 72 | 100 |

The most popular type of organisation at the village level is the Rural Development Society. There are many reasons for this. It is the organisation that is made use of by many State institutions as a medium of resource distribution to the villages. It is also a medium through which access can be found to minor development works at village level. Further it is the volunteer organisation that the Government recognises as most important. For example,if requests for small village culverts or minor school buildings are made through a Rural Development Society, the response of State institutions will be quite favourable. Further, the fact that these societies are established through the intervention of Government officials and that there is a separate Department and a Ministry looking after them are reasons why they get high priority and consideration.

The other volunteer organisation that is given high priority by the rural folk is the Funeral Aid Society. This organisation is one of their own creations. As mentioned earlier too 47% of the total number of societies have closer participation by women.

## 6.4. Gramodaya Council

Mention was made earlier in this Chapter about the area of authority and the composition of a Gramodaya Council. As the Gramodaya Council is the village level institution from which assistance is sought in the implementation of the rural water supply and sanitation project relevant for our study, it is useful to have a fuller discussion about it.

The assistance of the Gramodaya Councils for the implementation of this project was sought at two major stages.

1. At the outset, to select volunteer workers for the project.
2. During implementation to carry out the project activities in the villages.

The first of these, has already been discussed to some extent pointing out the procedure adopted by the Gramodaya Councils in selecting volunteer workers.

What we intend to discuss here is the appropriateness of choosing the Gramodaya Council as a rural institution competent enough to handle such an assignment.

Here we need to analytically examine further the structure and composition of the Gramodaya Council. Theoretically, a Gramodaya Council is an institution composed of presidents of volunteer organisations elected by the people of a Grama Sevaka division (lowest administrative unit). Its chairman is elected by its members - namely the presidents of the constituent organisations. Its secretary is a state official. He has no voting rights. His function is to maintain properly the minutes, records and other documents of the Council and to attend to duties such as convening meetings etc.

But practically, the position is somewhat different. The Special Services Officer, the State official who is the Secretary of the Council, has to recommend to the AGA each year the organisations that can become members of the Council for their registration. In this act he can use his discretion and refuse to recommend some organisations. This happens often.

The Special Services Officer is directly appointed by the M.P. of the area according to his choice. Inevitably he is politically prejudiced and there are serious allegations of partiality and

favouritsm made against him. He has the power to ensure that the Gramodaya Council consists of only those organisations that he likes.

Not only can he refuse to recommend already existing organisations, he can also register new organisations friendly and loyal to him.

The Habarakada Gramodaya Council, one of the Councils we studied, is a fine example of this. In 1986 the number of volunteer organisations included in it was 36. Of these about 16 were nominal organisations set up by the Chairman. This Chairman has been holding this office continuously for the last five years. He has very powerful political linkages. He can get the Special Services Officer to register organisations in the way he wants. (Fortunately he is a clever person and the Council has been able to get a considerable amount of useful work done by utilising his talent and political connections)

## 6.5. Participation of Gramodaya Councils

Below is a table showing the participation at meetings in the year 1986, of the representatives of volunteer organisations, as well as of those officials appointed by virtue of their office in the Gramodaya Councils that came under our study. This table does not include the attendance at the meeting which elected the office bearers. As a large number of members were present on the day of elections, it is possible to get a wrong picture of general (average) participation if that attendance is included in the table. As there had been two meetings in the year 1986 for electing office bearers - in January 1986 for the year 1986 and in December 1986 for the year 1987, the picture can be further misleading if attendance at these two meetings is included. Therefore we have taken into consideration only the meetings held in the other 10 months in working out the average participation.

| Gramodaya Council | No. of Meetings held in 1986 | Percentage attendance of volunteer organisation representatives | Percentage attendance of State officials |
|---|---|---|---|
| Kadawalagama | 05 | 57.8 | 18.3 |
| Horagoda | 05 | 66.8 | 24.8 |
| Habarakada | 09 | 51.6 | 19.4 |
| Upper Mellankulama | 08 | 40 | 25 |

Though meetings should have been held every mont , at Kadawalagama and Horagoda, half the number of stipulate' meetings had not been held. However, the attendance of representatives of volunteer organisations at the meetings held seems to be adequate. On the other hand, though the Councils at Habarakada and Upper Mellankulama have held 9 and 8 meetings respectively, the attendance of representatives of volunteer organisations at these meetings is less satisfactory. In the case of government officials, their attendance at meetings in all the Gramodaya Councils does not exceed 25%. Moreover in three out of the four Councils, the only official participants were the School Principals, who represented the School Development Societies. Only in one Gramodaya Council, namely Kadawalagama, the Family Health Worker had attended meetings. Her percentage attendance was 60, that is 3 out of 5 meetings.

## 6.6. Activities of Gramodaya Councils

We probed into the activities of Gramodaya Councils in the year 1986 to find out what resolutions were passed by them and to what extent they had been acted upon. Such a probe becomes important, as we mentioned earlier too, in view of the fact that the water supply and sanitation project under study is expected to be coordinated through the Gramodaya Councils.

According to our classification of the resolutions adopted in the year 1986, they are as follows:-

| Gramodaya Council | Resolutions on economic development | Resolutions on common services and voluntary labour (Shramadana) | Resolutions on Health activities | Total |
|---|---|---|---|---|
| Kadawalagama | 04 | 08 | 03 | 15 |
| Horagoda | 03 | 06 | 01 | 10 |
| Habarakada | 02 | 05 | 06 | 13 |
| Upper Mellankulama | 01 | 02 | 04 | 08 |
| Total | 10 | 22 | 14 | 46 |

A large number of these resolutions (47.8%) were pertaining to development schemes for the common benefit of the village and could be implemented by utilising the labour and other resources available in the village itself or obtainable locally. Among these proposals, for instance, were reparing of roads through voluntary labour, construction of a community hall, cleaning the school buildings through voluntary labour, reparing tanks through voluntary labour etc.

Further, there were resolutions about getting access to electricity, constructing public latrines and many proposals concerning health activities. Specially in Habrakada and Mellankulama Councils over 50% of the resolutions were in connection with health activities. In examining these resolutions, we noticed that in those two Gramodaya Council areas the influence of the pilot project on Water Supply and Sanitation was wide spread. Most of the resolutions adopted were in connection with activities involved in the project. As examples, we can mention the resolutions on obtaining latrine slabs without delay, inquiring about tube wells, speedy action regarding tube wells, setting up health committees, launching programmes through health committees, informing the people to dig latrine pits and have them ready etc.

Three out the four Gramodaya Councils (the exception being Kadawalagama) had built up adequate relations with the villages regarding common services in their respective areas and had been actively engaged in programmes. Often this positive feature was due not so much to the democratic nature of the Councils' composition as to the qualities and linkages of the individuals who held the post of Chairmen in these Councils.

Specially the Chairman of the Habarakada Gramodaya Council, as we mentioned earlier too, is a person powerful both economically and politically, with the enthusiasm and the ability to organise activities. The Chairman of Upper Mellankulama too is the same. As an example of his work we can mention the case where he had obtained ten latrine slabs for the village of Upper Mellankulama and when he found that six of these slabs were lying unused for a considerable time he handed them over to another village . His personal dedication to the work of the Gramodaya Council and the project is of a high level.

## 6.7 Gramodaya Health Committees

A great deal of work was expected to be done through the Gramodaya Health Committees in the project area. As mentioned earlier, though there had be n an interest in and enthusiasm for some aspects of the project due to the personal initiative and abilility of the Gramodaya leaders, there was no evidence to show that the Health Committees had been properly activated and induced to perform their tasks for the project.

By the end of 1986, Health Committees had been set up in the Gramodaya Councils of Upper Mellankulama and Habarakada. But these Committees had not coordinated any activities. In the other two Gramodaya Councils there had been preliminary discussions regarding the setting up of Health Committees but the arrangements had not been done in a formal manner.

(See Annexe 4 for the Constitution, responsibilities and functions of Gramodaya Health Committees.)

There is no indication that Chairmen of Gramodaya Councils are willing to share their responsibilities. As the functions of a Gramodaya Council are limited they seem to be more inclined to carry out their responsibilities alone by themselves. They seemed to be reluctant to allow the committee to handle activities like constructing tube wells and distributing latrine slabs, for fear of losing the opportunity to get popular in the village.

The reason given by the Gramodaya Chairmen to explain away this attitude of theirs was that it was difficult to get together members for Health Committee activities. However, there seems to be some basis for this argument put forward by the Chairmen. According to the constitution issued for the purpose of setting up Health Committees under the pilot project a Health Committee shall consist of the members of the Gramodaya Council as well as representatives of various other sectors. (See Annexe 4)

Among those expected to be brought into the Health Committees under this latter category of broad representation are Public Health Inspectors, Doctors working within the area of the Gramodaya Council, women leaders selected under the project and volunteer workers (male and female).

While the Chairmanship of the Committee is held by the Chairman of the Gramoday Council ex officio, the Secretary shall be the Family Health Worker.

Thus the Committee appears to have an attractive popular representation but it is not easy to activate it.

Firstly, it is difficult to get the members together because its membership is even larger than that of the Gramodaya Council. Secondly, by getting a public officer like the Family Health worker to do the work of coordinating, many problems arise. She has to find the extra time necessary to attend to work connected with the convening of meetings. She is not given any incentive for this extra work. Government employees like Family Health Workers cannot be expected to devote their time and energy on a voluntary basis to attend to work outside their official duties. As we mentioned earlier too, Family Health Workers of three Gramodaya Councils had not attend a single meeting of the Council.

Further as a result of expecting the Chairman of Gramodaya Councils to function as Chairmen of these Comittees too, the possibility of creating a new type of arrangement has been blocked.

If the available volunteer workers trained under the project were made the core component of this Committee, and if the cooperation of women leaders who were in the Gramodaya Councils as well as of the other women selected by the project was made available to these workers, much better results could have been obtained. The assistance of the Gramodaya Council Chairmen and Family Health Workers could have been utilised as guidance for the Committee.

The Gramodaya Health Committee was an attempt made to get together a number of groups representing varied aspirations and different strata to work for an aim that had to be achieved on a voluntary basis. These groups included busy State officers of the health sector, leaders of voluntary organisations, other women leaders at village level and voluntary workers. Through our study we realised that this is a kind of Committee that was difficult to be activated for practical purposes.

If in some way or another, this was a Committee that could have been activated, or at least one that could have been gathered together, then there is no doubt, that it would have turned out to be an organisation where there were plenty of people to give advice and guidance, but very few people to do the actual work.

> Jayasiri (36 years) is Chairman of the Habarakada Gramodaya Council. He is a government official, has contracts with the government and other business ventures. He says 'The project consultant gave us instructions to set up a Health Committee under the auspices of the Gramodaya Council and through that to engage in water supply and sanitation activities. This is a very good idea. We tried to implement this idea a number of times. But it is very difficult to get people together. I prepared an alternative arrangement for this purpose. By encouraging and helping many volunteer workers within my Gramodaya Council area to get the leadership of volunteer organisations I have got them into the Gramodaya Council. Chandrani from the village of Habarakada is one such volunteer worker who came to the Gramodaya Council through a volunteer organisation. By this method I believe that we can do what the Health Committee has failed to do.'

> Merril Senagama (age 52) Chairman of the Upper Mellankulama Gramodaya Council is a small business man. He says 'Consultants of the water supply and sanitation project come to meet us often. Personally I work hard to implement this project within my Gramodaya Council area. We have got instructions to activate the Gramodaya Health Committee. We discussed about this in the Council in mid-1986. But it is difficult to get the Committee together. Even the attendance at Council meetings is not sufficient'.

This Gramodaya Council had adopted a resolution calling for the setting up of a Health Committee and for the holding of a series of meetings in the village within the Council area to explain the aims and activities of the project.

# CHAPTER 7

# PROJECT ACTIVITIES AND THEIR IMPACT

## 7.1. Structure of the project

As we mentioned earlier too, the basic and most important aim of this pilot project relating to water supply and sanitation was to accomplish the activities of the project through mobilisation of broad and effectual women's participation. This necessity to acquire the experiences of a pilot project aimed at mobilising a greater participation of women arose due to certain unsatisfactory results of the main project that had been in operation in the whole Anuradhapura district for a number of years. The two institutions UNDP and UNICEF were mobilised to subscribe to this main project with the aim of implementing a programme of water supply and sanitation (latrines ) in a dry zone area in Sri Lanka like the district of Anuradhapura because the incidence of diseases caused by the use of polluted water and non-use of sanitary latrines in such areas had become a grave problem.

However, under the main project it was not possible to obtain a response from the inhabitants of the villages as satisfactory as was expected by constructing tube wells and providing material and financial assistance to build latrines through the existing State institutions. In planning this pilot project, one of the main factors taken into consideration was that such a situation was created as a result of implementing the project in isolation without the participation of the target people who would be the beneficiaries.

In the rural society of Sri Lanka it is the housewife and the older girls of the family who have to shoulder the major burden and responsibility not only in obtaining a water supply for domestic use but also in attending to situations when members of the family fall ill. As such it was further assumed by the planners of the pilot project that it would be the housewife and the older girls of the family who would be directly affected by the convenience or hardships in water supply as well as the difficulties caused by succumbing to illness. Accordingly, the project had clearly to be designed to attract the attention and ensure the participation of the housewife and the other female members of the family.

The idea of those who planned the project was to give prominence to women in activities connected with water supply (e.g. selection of suitable sites for tube wells, construction of tube wells, ensuring that they are properly used, protected and maintained etc.) as well as in activities connected with sanitation (e.g. convincing and encouraging people to use latrines, constructing latrines and instructing people in the proper use and maintenance of latrines etc.) and thereby build up women's leadership in the village. Through that they hoped to direct the attention of women towards the actvities of the project. After that women could gradually be drawn into other sanitation and health activities. This would make it possible to enhance the knowledge of women about health and sanitation by means of other health education programmes. For instance, women could be mobilised to engage in activities like educating expectant mothers about the usefulness of pre-natal care and encouraging them to attend maternity clinics, pursuading parents to get their children immunised building up greater concern about child health and nutrition by means of nutritional programmes like Kōlàkenda, educating parents about improving and ensuring the health and sanitation of their children by utilising what they can obtain from the environment at little or no expense etc.

With these aims in view, the project was structured as follows:-

1. Selection of female volunteer workers to include at least one worker from each village.
2. Formal training of the selected volunteers.
3. Setting up of a Health Committee attached to the Gramodaya Council so that the trained volunteers too are included in the Committee.

The responsibility for implementing all the activities of the project at the village level is devolved on this Committee. The Chairman of the Gramodaya Council is also the Chairman of this Committee, ex officio, while the Family Health Worker is its Secretary. Under this organisational basis, it is the function of the Gramodaya Health Committee to provide

guidance and encouragement, to continuously supervise project activities and to provide all necessary assistance to volunteer workers.

In the field of grassroots level activities of the project, the main link bringing the project into contact with the families living in a village is the volunteer worker. Thus a big responsibility rests on her and she has to do much of the project work. Among a volunteer worker's duties were:-

1. Conducting a survey about the conditions of the village;
2. Identifying the families without latrines and pursuading them to construct latrines;
3. Implementing nutrition programmes (Kolakenda) for children with the participation of the women in the village;
4. Conducting maternity clinics and immunisation programmes with the help of the Public Health Inspector and the Family Health Worker;
5. Raising the standards of health knowledge of rural people through education programmes;
6. Organising women's groups for purposes of selecting the sites for tube wells, helping in the construction of tube wells, protecting and maintaining these wells etc.

7.2. How the Project was implemented

A. Tube Wells

It was stipulated under the project that a tube well should be provided for every 20 families in the relevant villages. Further houses without latrines or using temporary latrines should be provided with latrines.

Prior to the commencement of the pilot project the number of tube wells constructed by the main water supply and sanitation project operating in the Anuradhapura district was as follows:-

| | |
|---|---|
| Kadawalagama | ... 1 |
| Horagoda | ... 1 |
| Habarakada | ... 2 |
| Upper Mellan-kulama | ... 0 |

(In one out of these wells, tubes had been sunk but it had not been equipped with other accessories necessary for drawing water)

By the time we completed our study in April 1987 not a single new tube well has been constructed in any of the villages. However, the National Water Supply Board had marked two sites in the village of Upper Mellankulama for the construction of tube wells.

B. Latrines

The number of latrine slabs distributed under the project to the study villages is as follows:-

| | | |
|---|---|---|
| Kadawalagama | - | 0+ |
| Horagoda | - | 8 |
| Habarakada | - | 15 |
| Upper Mellankulama | | 10++ |

+ Kadawalagama was expected to be provided with latrine slabs by the first week of April 1987.

++ 10 latrine slabs had been provided to the village of Upper Mellankulama, initially. Subsequently, 5 slabs were taken away from those who had failed to take any steps to construct latrines and given over to another village on the instructions of the Chairman, Gramodaya Council.

C. Health Education Programmes

During the year ending April 1987 the project had implemented the following Health, Health Education and Nutrition programmes:-

| Village | Nutrition (Kolakenda) | Maternity Clinics | Immunisation | Health Education |
|---|---|---|---|---|
| Kadawalagama | 3 | 2 | 4 | 5 |
| Horagoda | 5 | 2 | 4 | 1 |
| Habarakada | 2 | ? | 3 | 1 |
| Upper Mellankulama | 3 | 3 | 4 | 2 |

7.3. Impact of the Project

Water Supply - The pilots of the project, namely, volunteer workers, as well as Gramodaya Council which was used as a base for project implementation had placed great expectations on the supply of water by means

of tube wells. One of the basic facts that emerged out of our baseline study as well as the subsequent studies was that even during a drought none of the villages under study was subjected to any serious hardships due to lack of water, specially drinking water. In Kadawalagama and Habarakada 60.9% and 64.4% of families respectively did not have to go more than 400 metres for their drinking water. Same was the case with 73.5% and 70% of families in Horagoda and Upper Mellankulama respectively.

If we lay aside for a moment the question of the priority and safety of the water used for drinking, it can be said that none of the four study villages encountered any urgent or serious problems regarding water. Except in one village - namely, Horagoda - all the other villages had one or more small tanks adjoining them. Meanwhile, except in Upper Mellankulama in each of the other three villages there had been at least one tube well that was usable, even before the project started. However, there does not seem to be much contentment or acceptance regarding these tube wells among the user families in these villages. Water supplied by tube wells was used for drinking in only one village, namely Habarakada. Even there only 20% of the families used the water for drinking, while 7% of the families use water from tube-wells for bathing and washing the face 21% use this water for domestic purposes, such as washing plates, pots and pans and ablutions after defaecation etc.

At Kadawalagama 39% of families use water from tube wells for bathing, washing the face and house garden purposes while 35% use this water for domestic purposes such as washing plates, cooking utensils etc. Even at Horagoda where access to sources of water was rather limited very little use was made of tube well water. Here the number of families using this water for bathing, washing the face and home garden purposes was only 12% and the number using it for domestic purposes such as washing utensils and ablution was only 15%. (See Annexe)

In order to get a further and better understanding regarding the use of tube wells by people in the villages, we organised a two-hour observation at tube well sites three times a day (morning, noon and evening) to gather information regarding the drawing of tube well water. Accordingly to this observation data (See Annexe) the picture is as fcllows:. At Kadawalagama 15 persons between 6 a.m. and 8 a.m., 4 persons between 12 noon and 2 p.m. and 12 persons between 4 p.m. and 6 p.m. making a total of 31 persons drew water from the tube well. This water was carried to their homes for the following purposes:- 11 persons (35%) for bathing and washing the face, 13 persons (42%) for home garden purposes and 7 persons (23%) for domestic purposes (cooking, ablutions etc.)

At Horagoda one of the main facts that emerged from our observation was that the number who came to obtain water from the tube well was very small. There were 6 persons between 6 a.m. to 8 a.m., 2 persons between 12 noon and 2 p.m. and 3 persons between 4 p.m. and 6 p.m. making a total of only 11 persons came to get water from the tube well. The purposes for which this water was carried home were; 7 persons (64%) for domestic use in the kitchen, 2 persons (18%) for washing the face etc. and 2 boys (18%) for some sports activity.

In Habarakada the picture was as follows;- 14 persons between 6 a.m. and 8 a.m., 12 persons between 12 noon and 2 p.m. and 8 persons between 4 p.m. and 6 p.m., making a total of 34 persons carried water from the tube well. The purposes were, 18 persons (53%) for domestic use in the kitchen etc., 11 persons (32%) for bathing and washing the face. Only 5 persons (15%) carried the tube well water for drinking.

Taken as a whole in the villages where tube wells have already been constructed, the water from them is being used, as mentioned above, for limited purposes only. Even that use is made only by residents who live very close to the wells. Judging from the present position, there is certainly no indication that any improvement could be brought about in the situation regarding drinking water by increasing the number of tube wells. Tube wells have been constructed in three of the four study villages. In two of these three wells the water has an unpleasant salty taste. (We discovered it ourselves in our observations). In the tube well at Habarakade which is

used by a few families to obtain water for drinking, the water when compared to the water in ordinary surface wells cannot be said to be satisfactory in taste. It is said that even tea brewed with this water and food cooked using this water give an unpleasant taste in comparison to tea and food prepared by using water from surface wells. In view of this fact, even if a tube well is provided for every 20 families, it will not be a solution to the problem of supplying pure water for drinking. However when problems and activities regarding sanitation are taken into consideration, tube wells can be of immense service to the people living in these villages.

Hemalatha (23 years) is married and helps in agricultural work. She says 'The distance from our house to the tube well is about 20 meters. We bring water from this well for cooking and for washing plates and cups, pots and pans, as well as for washing faces and bathing children. But water for drinking is obtained from the common surface well. Water from the tube well has a slight insipid taste. But there is not much difference in the taste of food cooked with this water. I have to spend a good part of the day in helping my husband in agricultural work. Before the construction of the tube well all the water needed for domestic use had to be brought from the common well. The distance to the common well was much longer than to the tube well. So I had to spend a considerable amount of time for this purpose. Now, of course we have very much less difficulties regarding our water requirements.' (Habarakada)

M.Dingirihamy (37 years) is married and works as a casual agricultural labourer. She says ' The distance from our house to the tube well is about 10 - 15 metres. During the dry season I get employment in vegetable gardens. Before the tube well was constructed we had to get water from the common well. I had to walk about 50 metres to get there. On days I have work as a casual labourer, I have to prepare lunch early in the morning. Bringing the water needed in the house, too, had to be finished in the morning before I went to work. Now I go to the common well only to get a pot or two of water for drinking. All the water needed for other purposes I obtain from the tube well. This is a great convenience. As water from the tube well is unsuitable for drinking critics say that it is useless to construct tube wells. However, even though tube water is not suitable for drinking, it is very useful for other domestic purposes (Horagoda).

Kusumawathie (27 years) is married and has 3 children. Husband is an agricultural labourer. She says 'Before marriage I too went to work. But now as I have 3 small children, I do not go to work. The distance to this tube well from our house is about 15 metres. We obtain water for all our requirements from this tube

well. Earlier we obtained water from the well in the temple premises, to which we had to walk more than 50 metres. During the first few days when we started drinking tube well water we felt a slightly peculiar taste. But now we have got accustomed to it. (Habarakada)

Niranjale Rajakarna (11 years) is a student. She says 'the distance to the tube well from our home is about 50 metres. Water for domestic use is obtained from the common well. But to wash the face before going to school, I go to the tube well. On my return I carry a bucket of water. That is to water the flower plants. (Kadawalagama)

Indrani Basnayake (15 years) is a student in the 11th grade attending the local Maha Vidyalaya (Secondary School). She says 'The tube well is about 25 metres away from our house I carry water from this well to water my flower plants. I like flower cultivation. It is my hobby. Earlier I used to walk 60 metres to bring water for my plants. Now without any difficulty I can water my plants . Thanks to this tube well. Water from the tube well is also used for washing the face and the body (Kadawalagama)

Ismail Abdul Hameed (45 years) is married and has 4 children. The two elder sons are 22 and 18 years of age. He says 'I have one acre of high land and 3 acres of paddy fields. I cultivate paddy during the Maha season and during Yala season. I raise chillies and various grains. Often high land crops are destroyed due to scarcity of water. For chillies a good amount of water is needed when the plants are young. If water can be provided by means of tube wells, I believe that our dry land cultivation can be successful. But so far not a single tube well has been constructed (Upper Mellankulamaa)

We mentioned at the beginning of this chapter about the great expectations that the volunteer workers as well as Gramodaya Council had placed on tube wells the more important of the two basic material resources provided by the project.

Anyone who becomes curious about the above analysis regarding the tube wells can very well raise the question why the volunteer workers and Gramodaya Councils have placed such special hopes on tube wells if the rural people subjected to this have not responded favourably towards tube wells. As described comprehensively in our baseline study too, among rural people of Sri Lanka there exist deep rooted and traditional attitudes regarding 'pure or safe water'. It is not possible to educate such people to think on scientific lines about pure water in a short period of time. Nevertheless

it is equally wrong to conclude that successful results cannot be obtained or that no productive purpose will be served by providing the people of these areas with a scheme of water supply by means of tube wells merely because their immediate response to tube wells is not as favourable as expected.

Moreover the objective of the project in providing tube wells is not only to ensure a supply of 'pure water' for drinking. The project has another important objective too, namely, ensuring these rural people access to water as a remedy for the many problems of sanitation arising out of water scarcity in dry zone areas specially during periods of drought. For example, however many latrines are built in these areas, the expected results cannot be obtained as long as there exists a scarcity of water.

Though at a first glance these villages do not appear to have such a serious water problem, the level of water consumption of the people of these people of these villages does not seem to be adequately high, may be due to their mode of life fashioned by age long traditions. A table showing their daily water consumption taking into consideration the use of water for drinking, cooking, washing faces and ablutions (Annexe 2,22) and another table showing the daily per capita consumption of water compiled on the same basis (Annexe 2.23) are attached. According to this table the daily consumption of water per family is 20.5 litres at Kadawalagama, 16 litres at Horagoda, 17 litres at Habarakada and 20.1 litres at Upper Mellankulama. The level of water consumption in Horagoda and Habarakada is relatively lower than in the other two villages. This may be due to the fact that many families at Horagoda and Habarakada spend the greater part of the day away from their homes engaged in agricultural work. On the whole the water consumption in all the four villages is at a very low level. For instance, it was discovered that no one in any of the villages drinks more than 1 litre of water a day. Similarly, water is used very sparingly in washing faces and for ablutions.

In studying these tables one conclusion that can be drawn is that the amount of water consumed by the people of these villages for any of the purposes is far below the required level. Therefore, even though the idea has gained ground that these people are not favourably disposed towards tube wells due to various prejudices about the suitability of tube well water as well as to the prevalent idea that surface well water is pure

and good for drinking, the truth that has to be grasped is that there is an urgent and absolute necessity for a water supply scheme to provide these rural people in the dry zone with an easier access to water.

Out of the four villages where we conducted our study regarding the efficacy of constructing tube wells to provide easier access to water, tube wells had been already constructed in three villages. In these villages many of the residents we interviewed were critical of tube wells. These criticism was based mainly on the opinion that tube well water cannot be used for drinking purposes. However, the technical officers involved in the tube well scheme claim that with the continued use of tube wells over a period of time, the insipid taste of the water may disappear to a great extent. We feel that if, as the project formulators originally intended, the programme for the construction of tube wells was implemented in coordination with the other programmes of the pilot project, the results would have been quite different. If as was expected, a tube well was provided for every 20 houses, if the women' organised by the project were given the responsibility for taking part in selecting the sites for tube wells, constructing them, protecting and maintaining them, and if the rural people were educated through these women's groups regarding the co-relation between sanitation and the use of an adequate quantity of water for cleaning and other hygienic purposes, there could have been a change in the people's attitudes towards tube well water. Further, if the work of constructing tube wells was integrated with the implementation of the pilot project, then the enthusiam of the volunteer workers and their dedication to the project would have become more intense.

7.4. Latrines and Sanitation

The other major objective of the project was to construct a thousand latrines within a year in the project area namely the AGA division of Kekirawa. The programme formulated for this was as follows:-

- First to conduct a baseline survey with the help of the women volunteer workers and take a census of latrine requirements in each village.
- Next to call for applications through the Gramodaya Councils (Health Committees) and select those who wish to get latrines constructed.

- Then to supply the necessary material assistance to those families selected by the project for constructing latrines. The total value of the assistance (in materials and cash) is Rs. 700/-. The latrine slab and the squatting pan will be supplied by the Health Department. Its cost will be deducted from the Rs. 350/- given by the Health Department as assistance to latrine builders. This cost may vary from time to time but the recent figure was Rs. 150/-. As material assistance the project supplies 2 bags of cement and at prevailing prices their cost (Rs. 240/-) is deducted from the cash given. The balance cash of Rs. 110/- from the project and Rs. 200/- from the Health Department will be paid after the construction of the latrine is completed. During the period of construction except the supply of materials no other assistance (e.g. cash) is given.

During the year in which the project was in operation the Department of Health too, in pursuance of their own programmes, had distributed latrine slabs and pans to construct another 500 latrines within the same area as that of the project. Further there was an agreement reached that these 500 families too would receive material and cash assistance given by the project up to a maximum value of Rs. 350/-.

In order to obtain the stipulated assistance in the prescribed manner the following requirements had to be fulfilled:-

- the latrine pit should have a minimum depth of 12 feet.
- around the latrine pit a foundation trench one foot deep should be dug and on it a foundation wall 3 feet high should be built.
- the latrine slab should be placed on this foundation.

Cement is supplied specifically for the purpose of building a strong foundation as it is considered to be an essential requirement in view of the condition of the soil in the area. The people are encouraged to build the walls and the roof too with permanent building materials. However, even though these components are built with temporary materials e.g. walls with mud and roofs with woven coconut

coconut leaves, as it will not affect the payment of the final instalment of cash assistance, strict attention is paid to the fulfillment of the condition that the foundation should be solid and strong.

The Public Health Inspector has the complete authority to recommend whether the latrines have been properly built or not. The final instalment of assistance in cash is released only if he recommends that latrines have been built in conformity with the relevant standards.

A table showing the extension of latrines in the village under study during the period between July 1986 when the project was launched and April 1987 when the project was expected to be completed is given as Annexe 2.24. The table also shows the number of various types of latrines existing during this period. According to this table, the number of families having latrines during this period shows an increase of 21.7% in Kadawalagama, 2% in Horagoda, 28.8% in Habarakada and 5.5% in Upper Mellankulama.

On a further examination of the table it can be seen that there are considerable differences in the rate of construction of latrines a number of important facts come to light.

- As was mentioned earlier in this chapter, Kadawalagama had not received from the project slabs or any other assistance for latrines until the first week of April 1987. However, in this village a considerable progress in latrine construction has been achieved as a result of residents themselves building latrines at their own expense.
- In Horagoda even before the project started, use of latrines was wide spread (75.5%. However, 94.8% of those latrines were where temporary pit latrines. Though in Table 2.24 the growth in the number of latrines in this village is shown to be only 2%, many residents who had temporary latrines had converted them into permanent latrines with the assistance given by the project.
- In comparison to the other villages Habarakada has advanced considerably in the rate of construction of latrines. Here there is an increase of 28.8% in the total number of latrines and of 38.2% in the number of water sealed latrines.

We wish to focus special attention on a number of matters in analysing the procedure adopted in providing latrines. This procedure consist of

1. Providing necessary materials (latrine slabs and cement) to construct latrines.
2. Encouraging and supervising the construction.
3. After construction is completed recommending the payment of the cash assistance and finally paying this money.

It was the responsibility of the volunteer workers to conduct a survey in the villages regarding latrine requirements and to pursuade families without latrines to build new latrines. For this they had to convince them about the importance of having latrines, explain the aims and objects of the project and tell them what assistance could be obtained through the project. Accordingly, it was the volunteer workers who 'promised' that assistance could be obtained from the project for the villagers to build new latrines. But according to the manner in which the project was organised the programme for providing latrines was directly linked to the normal procedure adopted by the Health Department in providing latrines. Further the basic conditions laid down for assistance were the same as those of the Health Department, (e.g. the conventional requirements that the pit should be at least 12 feet deep, that the Public Health Inspector should certify that all work had been duly completed etc.). As the geographical area of authority of the Public Health Inspector was quite large, very often he found it difficult to visit all the places where construction work had been completed in order to issue the final recommendation in time.

In the four villages that came under our study the final instalment of cash assistance had not been paid upto the first week of April 1987 for any of the latrines constructed under the project. As a result, we were informed, that the volunteer workers were faced with an embarassing situation. This failure to pay the final instalment without delay was a serious obstacle to pursuading other families to construct new latrines. Even the Chairman of the Gramodaya Council of Upper

Mellankulama who participated in project activities with much enthusiasm was discouraged and disappointed.

The activities of the project began from about the end of April 1986. In the dry zone the Maha season rains start at the beginning of October and continue till about January the following year. It is difficult to dig latrine pits during this rainly season. Many pits had collapsed halfway through the digging and they had to be abandoned. This was a major obstacle in the way of reaching the anticipated target in latrine construction under the project.

Even though the volunteer workers got together with the villagers and motivated them to construct latrines, they were helpless when it came to obtaining the promised assistance for the latrines that were completed. It was not possible for them to intervene. This assistance had to be obtained through the bureaucratic machinery. Even though the responsibility for delivering latrine slabs rested entirely with the Health Department, there were occasions when the project consultant, in his enthusiasm and eagerness to make the project a success, transported latrine slabs and cement in his own official vehicle.

In our baseline study we did not inquire as to which members of the family did actually make use of the latrine when the family had a latrine. However, while the study was proceeding, an opinion was expressed during discussions between Researchers and Study Consultants as well as in talks with prominent people, whom the Researchers met in the field that often in rural areas though a family had a latrine not all the members of the family used it. In our evaluation study we made it a special point to check whether this opinion was acceptable or not. The information we collected on this topic is contained in Annexe 2.25. According to this table, except in Horagoda, in the other three villages in over 80% of the families that own latrines, all family members make use of the latrine. In Horagoda alone, the use of latrine by all the members of the family is limited to 65.8% of families. In this village in 1/3rd of the number of families that have latrines, only the older members use the latrines. On the whole,

the idea that even where a family has a latrine, all the members of the family do not make use of it has to be rejected.

> Nimali (22 years) has passed the GCE (AL) and is a volunteer worker at Horagoda. She says: ' My problem now is the difficulty in getting my father's permission to come for work under the project. Earlier he gave me permission to do this kind of work quite readily. Even before this project was started I was working in this area as a volunteer health worker. During that time I had pursuaded about 10 families to construct new latrines on the basis that assistance would be obtained. A long time has elapsed since they completed the construction. The former Public Health Inspector had even taken their signatures for the payment of the final instalment. But they have still not been paid. When I went round to pursuade people to conduct latrines under this project, many people asked whether the same thing would happen this time too. I told them that as a number of other organisations are involved in this project money can be obtained expeditiously. However, the same thing has happened this time too. Families that had completed construction of latrines under this project too have not got their cash assistance yet. Because of this a situation has arisen where we cannot go about in the village attending to other activities of the project.'
>
> Merril Senagama (52 years) Chairman of Upper Wellankulama Gramodaya Council is a small businessman. He says 'This is a very good project. In addition to the volunteer workers I too go among the villagers to pursuade them to construct latrines. Sometimes I tell them things which are not true in order to get them to build latrines speedily, e.g. I used to tell them that if they did not complete construction before such and such a date, it would be difficult to obtain the final payment. Because of this, quite a number of families in my area completed construction speedily. Now I cannot face them because the final instalment has not been paid to them yet. Public Health Inspector too is a busy officer. Though he has repeatedly promised to visit the village to inspect the latrines that are completed he has failed to turn up so far.

## 7.5. Health Programmes and Health Education

The active participation of volunteer workers and Family Health workers who were involved with the project was seen mostly in Health Programmes. This work included conducting maternity clinics, organising immunisation and nutritional programmes for children and Health education activities. We mentioned earlier too that the Project Consultant and the coordinating officers were able to conduct a useful and successful training course for volunteer workers. As a result of this training and the renewed

enthusiasm it created, the volunteer workers were motivated to organise a series of educational programmes as well as to implement activities related to water supply, sanitation and other health problems in their village areas. During the period in which the project was in operation, the number of such programmes organised in the 4 study villages was 46. Of these 14 were in Kadawalagama, 12 in Horagoda, 8 in Habarakada and 12 in Upper Mellankulama. A percentage breakdown of these programmes is given in the table in Annexe 2.26. On a perusal of this table it can be seen that the most popular programme at Kadawalagama was the Health Education programme. At Horagoda it was the Kolakenda (herbal broth) programme which was a part of the Child Nutrition Programme and at both Habarakada and Upper Mellankulama, the Immunisation programme was the most popular. On a further study of the table it is seen that three out of the four different types of programmes (that is except the Kolakenda programme) essentially needed the participation of health officers. However, these were not programmes organised within the villages with the relevant health personnel coming into conduct them (e.g. immunisation and maternity care). They were organised by the volunteer workers by encouraging and pursuading people to attend clinics and programmes in nearby hospitals and health centres on days that they are conducted. For example, expectant mothers, children etc. of Kadawalagama were organised to go to the hospital in the nearby town to attend the maternity clinic or to get immunised.

The only activities that the volunteer workers could tackle alone by themselves without the intervention of health officers were the Kolakenda distribution and health education. These programmes had been conducted adequately only on two villages namely, Horagoda and Kadawalagama. Another important feature with regard to health programmes was that even in Upper Mellankulama where the participation of volunteer workers was quite low, a large number of programmes had been conducted successfully. The credit for this should go to the Public Health Inspector, Family Health Worker and two prominent individuals in Upper Mellankulama.

T.B. Dayawathie (26 years) is the Family Health Worker at Upper Mellankulama. She says 'In organsing health activities in a village like Upper Mellankulama one has to face many serious problems. The main reason for that is the cultural taboo on women whereby the young women are prevented by their parents from doing volunteer work. The officers connected with the project say that distribution of Kolakenda must be done at least twice a month. Unlike in other health programmes such as immunisation and maternity care in nutritional programmes such as distribution of Kolakenda the assistance of volunteers from the village is very essential. For its activities in the villages, the project appoints at least two volunteer workers for each village. In Upper Mellankulama three volunteers had been appointed. Nut not one of them gives any assistance for these activities. However, with the help of males in the village, I have managed to organise a few kolakenda programmes.'

Anoma Dissanayake (26 years) is the Family Health Worker at Horagoda. She says 'In this village there is a volunteer worker who had been working in association with us and the Health Department for a long time. Her name is Nimali. She is energetically engaged in activities of this project being implemented by the UNICEF and the Women's Bureau. We come across such enthusiastic young women rarely. Her cooperation is of invaluable assistance to me in performing the tasks connected with the project as well as my official duties. In spite of many difficulties we were able to implement a large number of Kolakenda programmes during the past year mainly because of her enthusiasm.'

K.B. Amilawathie (28 years) is the Family Health Worker at Kadawalagama. She is married. Shey says 'There is a separate Child Health Care programme run by the Health Department. It is known as 'Sathara Saviya' (which means 'four strengths'. Under this programme we focus attention mainly on four tasks. They are -

1. Keeping a proper record regarding a child's growth;

2. Oral treatment for dehydration in diarrhoea patients;

3. Breast feeding and introduction to a supplementary diet at the proper age;

4. Immunisation.

Attention has been focused on these tasks under the pilot project run by the UNICEF and the Women's Bureau too. Therefore these tasks are now being performed with the additional assistance of the volunteers working for the Project. At least once a

> At least once a month children of this village are provided with Kolakenda or some other soup. It is soup mostly. All the chidren of the village, without any difference, participate in this programme'.

In addition to the health programmes carried out by volunteer workers with the assistance of Health Department officers, the Project has mobilised the assistance of school teachers of the area in order to spread knowledge regarding health and connected problems among the rural people. This programme is based on the idea that teachers will educate school children about good health habits so that the children will carry the message into their homes. Under this scheme 33 teachers selected from 29 schools within the project area have been trained. The Project Consultant has given instructions that in addition to their own public health programmes the volunteer workers should set an example to others by demostrating good health habits first in their own homes. For example, a volunteer worker in order to demonstrate the need for cleaning teeth before going to sleep, can brush her own teeth after dinner in the open compound to be seen by the neighbours, or in order show the necessity of boiling water it can be done in the open so that neighbours can see it.

# CHAPTER 8
# PARTICIPATION IN PROJECT WORK

## 8.1. Participation by Volunteer Workers

A table showing the age and educational qualifications of the 13 volunteer workers as well as their contribution to the project is given as Annexe 2.27. According to this table the educational standard of volunteer workers in three of the villages, other than Upper Mellankulama, was at least GCE (OL) or higher. All except three of the volunteers (76.9%) were between the ages of 18 and 21. The main factors taken into consideration in analysing Annexe 2.27 were -

- the enthusiasm shown for project work;
- the time spent for project work;
- the degree of comprehension of the project and its importance and
- initiative and dynamism.

On a perusal of the table it can be seen that of the total number of volunteers 30.7% engaged themselves in the activities of the project with extreme efficiency and productively, while 15.3% were those who performed an adequate and effective function on behalf of the project even though not involving themselves in all aspects of project work. Another 23% were those who did not give much priority or consideration to project work and who nevertheless participated occassionally in some activities of the project while the balance 31% did not take part at all in any of the project activities. Among the volunteer workers who did not take part at all in any project activity were one (out of the three) from Horagoda, one (out of the two) from Habarakada and two (out of the three) from Upper Mellankulama.

In the villages under study, the motive force for project activities was provided by the volunteers belonging to the first two categories mentioned above. They were the guiding spirit of project implementation. Except in Upper Mellankulama, in all the other three villages there could be found at least one volunteer worker who participated quite efficiently.

The task of a volunteer worker was to engage herself, in the village she represents, in activities connected with the project, in close collaboration with the Health Committee of the Gramodaya Council. Here by project activities are meant, creating an enhanced interest in and mobilising the participation of the women in the village in water supply and sanitation activities and thereby extending and developing health education among rural women. While the volunteer workers were expected to perform these tasks, the functions assigned to the Health Committee were, to meet once a month and draw up the programme of work for the ensuing month, to provide the volunteers with the necessary assistance and encouragement to carry through this programme within the alotted time, to meet again at the end of the month and review the work done during the preceeding month, identifying the achievements as well as the short-comings and engage in a self critical analysis of the causes for success or failure. And then the Committee will get on to the task of drawing up the programme for the next month.

Though the Gramodaya Health Committee programme attractive at a glance, appeared at the beginning to be capable of mobilising people's participation, it proved to be a failure. The experience of implementing this programme is quite discouraging and the results are quite different from what was expected. Evidence to show that the Health Committees functioned in the way expected could not be found in any of the four Gramodaya Councils subjected to our study. In this situation the volunteers became helpless. However, it must be mentioned that the Family Health Workers, the Project Consultant and the officer assisting him, taking over the functions of the Health Committees on themselves have tried their best to encourage and inspire the volunteers. But having to function within the area of an AGA division it was no easy task for the Consultant and his Assistant to guide and participate in all the activities organised by the volunteer workers.

> Manike (42 years) is unmarried and has passed the GCE (OL) - Kadawalagama. She says : 'Gramodaya Health Committee does not perform any function in connection with project activities. We on our own try to do our best to make the project a success. When we organise nutritional programmes like 'Kolakenda' we inform the relevant officials. But we are sorry to say that we do not get their cooperation. As a result we get

demoralised. If the officials come forward to participate in these programmes at least once in two or three months, we will be encouraged and better results can be obtained.

Chandrani (29 years) is married and has one child. Has passed the GCE (OL); Habarakada). She says 'It is true that a Health Committee has been set up in our Gramodaya Council. But it is not a Committee that meets often or does any work. However, in carrying out the work of this project, I get the maximum cooperation from the Gramodaya Council Chairman and specially from the Project Consultant. I am the only one left as a volunteer worker at Habarakada. As I am a member of the Gramodaya Council and act accordingly, I am not much affected by the inactivity of the Health Committee. We discuss many matters pertaining to the project at meetings of the Gramodaya Concil. All other necessary instructions and cooperation I get ungrudgingly from the Project Consultant.

It is our observation that in spite of all the difficulties that had to be faced the volunteer workers have been able to discharge a considerable amount of the responsibilites assigned to them. One of their main tasks was to gather information pertaining to the project. Then in order to mobilise community participation in various health programmes from time to time, they had to visit families, sometimes many times for one programme. Annexe 2.28 and Annexe 2.29 indicate how the volunteer workers and Health officials have been meeting the residents in order to implement project activities in each village. In particular Annexe 2.29 shows the number of times volunteer workers have visited homes. It can be seen from the table that except in Upper Mellankulama in all the other three villages, volunteers had visited each house at least once in connection with project activities. In Kadawalagama and Horagoda, there have been two, sometimes even more visits to over 50% of the total number of houses. In Habarakada alone the number of houses which had been visited more than twice is about 35%. The main reason for these numerous visits by volunteer workers and officials to houses of villagers was to pursuade the latter to construct new latrines. In Kadawalagama there was another important reason for such visits, namely the organisation of health education activities. (See Annexe 2.30).

T.G. Podimenike (30 years) is married and has two daughters aged 7 and 1 (Horagoda). She says 'We have only 1/2 an acre of land. As the income from it is not sufficient for our living my husband and I both go to work as labourers. During The Maha season we grow chillies and vegetables in our garden.

Volunteer workers and sometimes the Family Health Worker visit our home to inform us about the immunisation programmes and the dates fixed. They say that, as we have to go out to work, such prior information will help us to attend the clinics on the dates fixed. We have no latrine. The volunteer worker has informed us that in order to obtain a latrine slab for us we must first complete the digging of the pit. But as we had been busy we did not get an opportunity to dig the pit.'

Kadirage Rosalin Nona (26 years). Has passed the 8th grade. There are two children, a son (3 years) and a daughter (1 year). Husband works as a labourer in a tourist hotel in the nearby town. He comes home only during weekends. She says 'Earlier we had no latrine. A volunteer worker visited us and explained the importance of using a latrine. She told us that assistance can be obtained for building a latrine. We have completed the digging of the pit. but due to the rains it is now filled with water and we are unable to complete the construction.'

8.2. The expectations of volunteer workers

On a consideration of the expectations of volunteer workers and of the manner in which they participated in the project they can be divided into a number of categories:

- those whohave received an education of a standard sufficient to get employment in government service or in some other institution and who have discontinued their school education recently hoping to get such a job;
- Those who are desirous of obtaining satisfaction merely by engaging themselves in social service work and who want to overcome the boredom of staying inside the home the whole time by doing some sort of work;
- those whose sole aim is to obtain from the project some benefit or other for the village or for themselves.

In the 4 villages that were subjected to our study, the number of volunteer workers who could be included in the first category mentioned above is about 62%. The second category would be about 15% and the third about 23%. Of these the first and third categories consisted of persons who were mostly concerned about obtaining some benefit for themselves by working in the project. They hoped that such a benefit would come naturally or that they could make use of their association with the project

to get some benefit. For instance, they think that the training and the experience they get as well as the contacts and linkages they build up by working in the project will be helpful to them in securing employment.

> L.H. Kotakadeniya (21 years). Has passed the GCE (AL). Is expecting to get a job (Kadawalagama). She says : 'At present I am involved in some activities of Women's Bureau Society while teaching in a Government School about 2 miles away as a volunteer teacher. In addition to these,whenever I have the time I participate in the work of this health project too. However much I work for volunteer organisations, they do not seem to be concerned about helping me to get some employment. What I fear now is whether our entire lives have to be devoted to volunteer work alone. When I first joined volunteer activities I had the hope that such work would help me to get a job.
>
> Suwineetha Fonseka (20 years). Has passed the GCE (Habarakada). She says 'Earlier I worked, along with Chandrani, as a volunteer worker in this project. But now I participate in a sewing training course (Juki machines) conducted by the National Youth Service Council. Though I like volunteer work very much, I expect to obtain some employment when I finish my training in Juki machines.
>
> Nimali (22 years). Has passed the GCE (AL) (Horagoda). She says : 'In our family I have only a brother. He is also a volunteer worker for Sarvodaya. During the last two years, I have made numerous applications for jobs. But it is rarely that I receive even an acknowledgement. Even though my father is a farmer no cultivation is done during the Yala season due to lack of water. So economically we are badly off. I want a job because I want to help my family economically'.
>
> Chandrani (29 years). Is married (Habarakada). She says 'Even before marriage I was involved in volunteer activities. Now because of my children it is difficult to continue with such work. But I have no intention of giving it up. My husband works in a hospital. He does not very much like my doing work for volunteer organisations. However, it is not easy to give up at once the work that I have been accustomed to. I get a lot of satisfaction from the type of activity.

This fact, namely the hope of volunteer workers to get some benefit through their involvement with volunteer work, has emerged over and over again in various ways both in rural level workshops we conducted as well as in our personal interviews with volunteer workers. There had also been a wide spread rumour that a selected number of volunteers from among those who participated in the last stages of the project would be given certain benefits. By a study of this project the knowledge we have gained regarding 'voluntary service' is that 'purely voluntary service' is a fruitless excercise that is doomed from the very outset. Institutions providing funds

for pilot projects such as these where pursuasion and encouragement are essential components of the project lay greater emphasis on the voluntary aspect of project activities. However, in practise it is not unreasonable to come to the conclusion that time has now come to abandon the hope of relying on the voluntary responses of the people involved at the village level (specially of the educated unemployed young men and women) for the implementation of projects. This pilot project reveals the fact that all the volunteers who were its main activists were burdened with economic hardships and were seeking solutions to the problems the family was faced with

8.3. Participation of Officials

For the implementation of the project the participation of a number of categories of officials was necessary, namely,

- officials of the Sri Lanka Women's Bureau which directed the project activities;
- Executive officers such as local Assistant Government Agent and the Superintendent of Health Services for project coordination;
- Field officers of the Health Department (such as Public Health Inspectors, Family Health Workers etc.);
- Special Services Officers in dealing with rural institutions like the Gramodaya Council;
- Officials of the National Water Resources Board; and
- Officialsof non-government voluntary organisations at the rural level such as the Gramodaya Council.

Within the area of the AGA division subjected to our study there were 15 Gramodaya Councils. To attend to the health requirements of these 15 Councils there are 2 Public Health Inspectors and 15 Family Health Workers one for each Council area. On behalf of the Women's Bureau there was a Resident Consultant to direct the activities of the project while there was also a Planning Officer to assist him. At the beginning of the project the coordinating activities were carried out with AGA's office as the centre. Later a separate project office was opened.

The Consultant from the Women's Bureau, in implementing the project had to obtain the necessary assistance through the above mentioned officials. In long interviews we had with the Public Health Inspectors and Family Health Workers it was revealed that there was no clear understanding regarding the difference between their compulsory official duties and the declared objectives of the project. Among their normal official duties, specially in connection with the health education activities of the Department of Health, was the responsibility of organising and implementing programmes based on the above mentioned 'Sathara Saviya' - a specific Child Health Programme. The project under our study was no doubt closely linked with the Health sector. But its main objectives were not limited to health education only.

The main objective of the project under our study was to translate into practice the assumption that schemes like the Water Supply and Sanitation project can be successfully implemented by mobilising the participation of rural women.

> T.G. Dayawathie Family Health Worker (Upper Mellankulama) says 'I have no clear understanding as to who is carrying out these activities - whether it is our Health Department or some other institution'.
>
> Gunasekera, Public Health Worker (Horagods) says 'This project covers a large number of villages in my division. But I came to know about it first not as the PHI of the area. My first contact with it was as a lecturer. Then only that I came to know that such a project is being implemented in my area.'
>
> K.B. Anulawathie, Family Health Worker (Wadawalagama) says 'There is a separate health education programme conducted by us in the Health Department. My only contact with this UNICEF project (that is the name by which the project is mostly identified by Public Health Inspector, Family Health Workers and village people) is as a lecturer. I have given lectures under the auspices of the project on breast feeding, supplementary diet, family planning etc. Once at a meeting of Family Health Workers held at the M.O.H. office the AGA gave us instructions to investigate into the merits and demerits of tube wells, their use etc. Some UNICEF representatives too were present on this occasion'.

However, the authority and the responsibility to inspect the latrines and to recommend the payment of the final instalment on completion of building operations rested only with the two above mentioned Public Health Inspectors. The number of Gramodaya Councils that came under their authority was 15. They had not participated in a single meeting held in 1986 of any of the Gramodaya Councils that came under our study. In the case of Family Health Workers, five out of the seven meetings of the Kadawalagama Gramodaya Council held in 1986 were attended by the relevant Family Health Worker. But Family Health Workers had not attended a single meeting of any of the other Gramodaya Councils.

In our search for some record of the Gramodaya Health Committees, we discovered that Health Committees had been set up in all Gramodaya Councils. But we could not discover any facts to show that these committees have met in the manner intended by the project or that they formulated any specific programmes of their own. However, at some meetings of the Gramodaya Councils decisions relevant to and affecting Health Committees seem to have been taken. For example, at the Kadawalagama Gramodaya Council meeting held on 30.1.1987 the constitution of the Health Committee was proposed and adopted. Further, a resolution had been moved to conduct a Kolakenda nutrition programme at the Kadawalagama school on 13.2.87 and to select a house in the village lacking in cleanliness and hygiene, convert it into a clean and sanitary house and exhibit it as a model sanitary house.

Similarly at the meeting of the Horagoda Gramodaya Council held on 30.1.87 a constitution for the Health Committee set up at the meeting held on 14.10.86 under the UNICEF health project was adopted. (The Family Health Worker had not attended either of these meetings).

The Habarakada Gramodaya Council had in October 1986 discussed the setting up of the Health Committee.

The instructions of the Superintendent of Health Services to officers of the Health Department regarding participation in the activities of the pilot project were to the effect that they can 'participate in the activities of the pilot project so long as such participation does not interfere with their daily official duties'. It was the opinion of most of the officials interviewed by us that there should be some kind of benefit in return for participation. However, an official of the

Health Department who had been provided with transport facilities was not satisfied with that. It is useful to give deeper thought to some of the criticisms voiced about project activities at a village level workshop conducted by us.

> '.....This is a project formulated somewhere else and imposed on us. If there was some formal discussion before planning this project with those who do field work, what would have emerged is a different type of project. I first got involved with this project as a lecturer. It was later that I had anything to do with its implementation'.

> '.....Shouldn't there have been a formal exchange of views before assigning the responsibilities for selecting volunteer workers to the Gramodaya Councils? At least the Health Extension Services sector should have been consulted. Because the mobilisation of volunteer work in its activities is not something new to the Health sector.'

> '.....We have to carry out activities of this pilot project while at the same time attending to our normal official duties. We should get some sort of incentive for this kind of work either in the form of a financial benefit or in the form of some relief in our official work'.

What do these facts point out? They point out that it is necessary to carefully work out the manner in which a set of officials following a conventional bureaucratic pattern are brought into involvement with the implementation of a pilot project of this nature. We feel that if the essence and content of this project were clearly explained to the officials who were to be involved, a group of officials willing to work with dedication to serve their areas could have been found. The other lesson to be drawn from these facts is that in enlisting officials to assist in projects of this nature it is essential to select persons with a greater consciousness. Specially in a project of this nature which aims at mobilising the participation of rural women, it is essential to employ a set of officials 'who are not official', who are capable of comprehending the mentality of the rural people, their likes and dislikes, what they want and do not want and who can communicate and deal with these people with a humanitarian attitude. In this project, except in the Consultant and his assistant, one could not see a correct understanding of the project or a dedication to the community in the other relevant officials.

8.4. Participation of rural women beneficiaries

We had pointed out in our report of the baseline study that on the whole, except in the village of Upper Mellankulama, in the other villages that came under our study there were no serious obstacles preventing the participation of women in social activities. Five (62.5%) out of the eight organisations representing the four study villages in the Gramodaya Councils were led by women. Further we indicated the women's active participation in volunteer organisation as -

23.8% in Kadawalagama;
39.5% in Horagoda; and
32.5% in Habarakada.

The four tables in Annexe 5 show the manner in which an average housewife in the villages of Kadawalagama, Horagoda, Habarakada and Upper Mellenkulama spends her day. The contents of this table are based on a detailed study of the daily activities of the housewives of each village. As the sample for this study 26% of the total number of houses from Kadawalagama, 24% from Horagoda, 25% from Habarakada and 23% from Upper Mellankulama were selected. On analysing these tables it can be seen that except in Horagoda, in the other three villages, a housewife gets the opportunity of having at least 4 hours of rest during a period of 16 hours from 5.00 a.m. to 9.00 p.m. In Horagoda alone the period of rest of a housewife is very short. The reason for it is their very substantial contribution to economic (agricultural) activities. Habarakada women too contribute a great deal for such activities but they get more leisure because their fields of activity are very close to their homes.

As the Health Committees did not function in the proper manner intended by the project, and as the programme of constructing tube wells the entry point of the project meant to be utilised in winning the participation of women's groups, was not implemented at all, the main base on which women's participation was intended to be built got shattered. During the year in which this study was done not a single new tube well was constructed and even where the wells had been dug and only the fixing of pumps had to be done, the work was not completed.

Thus one of the major aims of the project was completely neglected. In the Horagoda Gramodaya Council area there were 6 wells which had been dug even before the starting of the project and in which only the pumps had to be fixed. In the Kadawalagama Gramodaya Council area this number was more than 15. The machinery available in the district for digging tube wells had often been removed by powerful politicians of the area to be used for digging tube wells in their electorates. The personnel working in the project were powerless to do anything in matters like these.

The programme for providing latrines too had more or less come to a stand still as latrine slabs could not be obtained at the proper time and as no further work could be done due to rains. In this situation the sustenance of the project depended solely on the implementation of programmes like health education, immunisation, maternity care and Kolakenda distribution etc. Annexe 2.31 indicate the response to such programmes organised by volunteer workers and Family Health Workers. There had been a 100% participation in all the villages for immunisation programmes and maternity clincs while the response to the Kolakenda programme too had been adequate.

However, except in Horagoda, the response to this health education programme had been poor. In Horagoda the participation in health education programmes too seems to be quite high. That may be due to the fact that the volunteer worker in this village is very efficient and the fact that various health programmes had been in operation even before the starting of the project. The health programme known as 'Vedagedara' (physician's house') initiated by Mr. Sudasinghe, a former Public Health Inspector of the area is still functioning successfully. This scheme has now been approved even by the UNICEF. (It has been named the UNICEF aided project for primary health protection and child health care in remote villages of the dry zone/Anuradhapura).

If the programme for the construction of tube wells and the programme for the provision of latrines had been implemented in the expected manner, the opportunity would have been created to a great extent to draw the somen for health education programmes and to improve their participation and knowledge. The failure of the water supply sector to take any productive steps, and the failure to obtain cash assistance without delays even for latrines that had been constructed have contributed to the undermining of the people's confidence in the project.

Annexe 2.32 gives a table showing the extent of knowledge among the people of these of study villages regarding water borne diseases, before and after the starting of the project. This table does not show very large differences. Yet the increases in the knowledge about water borne diseases shown in the table are 10.9% in Kadawalagama, 2.1% in Horagoda, 19.9% in Habarakada and 10% in Upper Mellankulama. In Horagoda the percentage increase is not much. But the knowledge there about water borne diseases was very high before the project. . This low level of knowledge regarding water borne diseases makes it clearer why there is no adequate participation in health education programmes.

# CHAPTER 9

## CONCLUSIONS AND RECOMMENDATIONS

### 9.1. Conclusions

In the light of the foregoing discussions and comments conclusions to be drawn regarding the implementation of the pilot project are as follows:-

1. In the four villages subjected to the study, water and latrines were not requirements of high priority. In all the four villages the priority placed on these needs by the people was rather low. Therefore, if water supply and sanitation projects are to be implemented in villages like these, they have to be introduced not as separate or isolated health programmes but as projects integrated with other programmes catering to high priority rural needs such as income generating processes.

2. The Gramodaya Councils in the four study villages have failed to respond satisfactorily to the confidence and hopes placed in them as the village level organisational instruments that would assist in the implementation of projects at the rural level. Though in places project activities had been carried out to some extent solely due to the personal interest and ability of the Chairman of the Council, as an institution the Council has failed to act.

3. The assistance for the project was obtained through the officials of the Health Department. They were duty bound to carry out in their daily official tasks the same activities as were envisaged by the project. But many of these officials were not prepared to be mere followers carrying out the instructions of an external agency in a field where they were specialists.

4. The material resources (tube wells, latrine slabs, cement etc.) necessary for the project had to be obtained through the Water Resources Board and the Department of Health. The Committee directing the project was not able to ensure the delivery of these resources in proper time to suit the needs of the project. This has caused the collapse of a major sector of the project.

5. Neither the Chairman of Gramodaya Councils nor even some of the Family Health Workers had even a minimum knowledge about the project - its aims, the strategies to be used in achieving those aims, the necessity for a project like this etc.

6. The project appears to be one that is planned and formulated from above and imposed on the villages. As a result of the failure of the Health Committee the project lost even the little opportunity it had to bring out the creative abilities of the volunteer workers and to make them feel that they are implementing a programme for the formulation of which they too have contributed. There were indications that such creative ideas would have emerged, if Health Committees functioned properly and if the volunteer workers and the women leaders in the villages had some means of exchanging ideas. As an example, the idea that came up at the Kadawalagama Gramodaya Council meeting to exhibit a clean and sanitary house as a demostration can be mentioned. What has so far happened is the implementation of some ideas put forward by Project Consultants and officials of the Health Department.

7. In the selection of volunteer workers, except in Upper Mellankulama in all other Gramodaya Councils, the Chairmen had given preference to educated young women. In most cases these are women who are expecting employment and as soon as they get jobs they will abandon voluntary work and the project. For projects of this nature educational qualifications are not so important. It is sufficient to engage persons who do not expect employment away from the village, who have a certain amount of education (primary level) and who are willing to work with dedication to the project. Such persons can be found in villages. (At Upper Mellankulama, the selectees have a low level of education. But their inactivity is not due to that but to other cultural factors)

8. The two villages that have been shown a special interest in participation in the project are Horagoda and Habarakada. One of these (Horagoda) is an isolated village with harsh economic conditions and the other (Habarakada) is a village isolated socially. The conclusion that can be drawn from this fact is that in villages that are subjected to economic or social isolation and consequent hardships there is greater possibility for successful community participation.

9. The training programme organised and conducted for volunteer workers of the project was usefully and appropriately structured to meet the needs of a project like this.

10. The organisation in which women's participation can be better mobilised are the School Development Society, Funeral Aid Society, Kulangana (Women's) Samiti and the Dayake Sabhas attached to the temples. There is participation in Rural Development Societies to some extent and hardly any in political organisations.

11. It is a correct decision to engage the services of one volunteer worker for every 20 houses. 20 houses are an easily manageable unit.

12. The scheme to provide material assistance and finally cash assistance to construct latrines will not produce successful results. In villages like these where economic hardships prevail, there have been many instances where material aid such as cement have been sold to get a little money.

13. In this project the function assigned to volunteer workers was only to pursuade and encourage people. As a result they had sometimes to face embarrassing situations. After having pursuaded villagers to construct latrines and when villagers want to obtain the payment of their final instalments for completed latrines, these volunteers fall into a helpless and hopeless position. It is our opinion that for the success of a project in which voluntary work is an important component, it is absolutely essential for people to have confidence in volunteer workers and for some value or worth to be attached to their services.

14. There were two reasons for the loss of confidence of beneficiaries in the project. One was the complete failure of the water supply sector to take any steps to fulfil the aims and promises of the project. The other was the failure to pay the cash assistance for completed latrines in proper time.

## 9.2. Recommendations

1. It is recommended that in planning projects like these in the future, they should be integrated with small scale self-employment projects or other programmes that will yield economic benefits.

2. A Gramodaya Council in theory is an institution that is based on people's participation at the village level. However, in practise, it is often an institution that operates on the interests and abilities of one single individual. Therefore, for projects like these there should be created separate organisations of their own. However, there is nothing wrong in obtaining the patronage of the Gramodaya Council.

3. The leadership of such newly created organisations should belong not to officials but to community leaders or volunteer workers (whether Government or NGO) who will be dedicated to the relevant task.

4. If officers from other institutions and departments are brought into involvement with projects then (1) they should be carefully selected so that only persons who are prepared to work with dedication are brought in (2) they should be equipped with a wide understanding of the aims and objectives of the project and (3) they should be seconded for service with the project on some system of incentives.

5. In projects where coordination between various departments becomes necessary, the Committee that directs the activities of the project must include officials who have the authority to get things done by such departments or a Political Authority must be available.

6. It is absolutely essential to provide a clear and broad understanding about the project to the target community or at least to their representatives.

7. Even though the project had been planned from above, at least before its implementation at the village level it should be thoroughly discussed with officers, volunteer workers and other village leaders from whom assistance is expected for its implementation.

8. In selecting voluteer workers for projects like these preference should be given to those who have not intention of leaving the village for employment or other purposes.

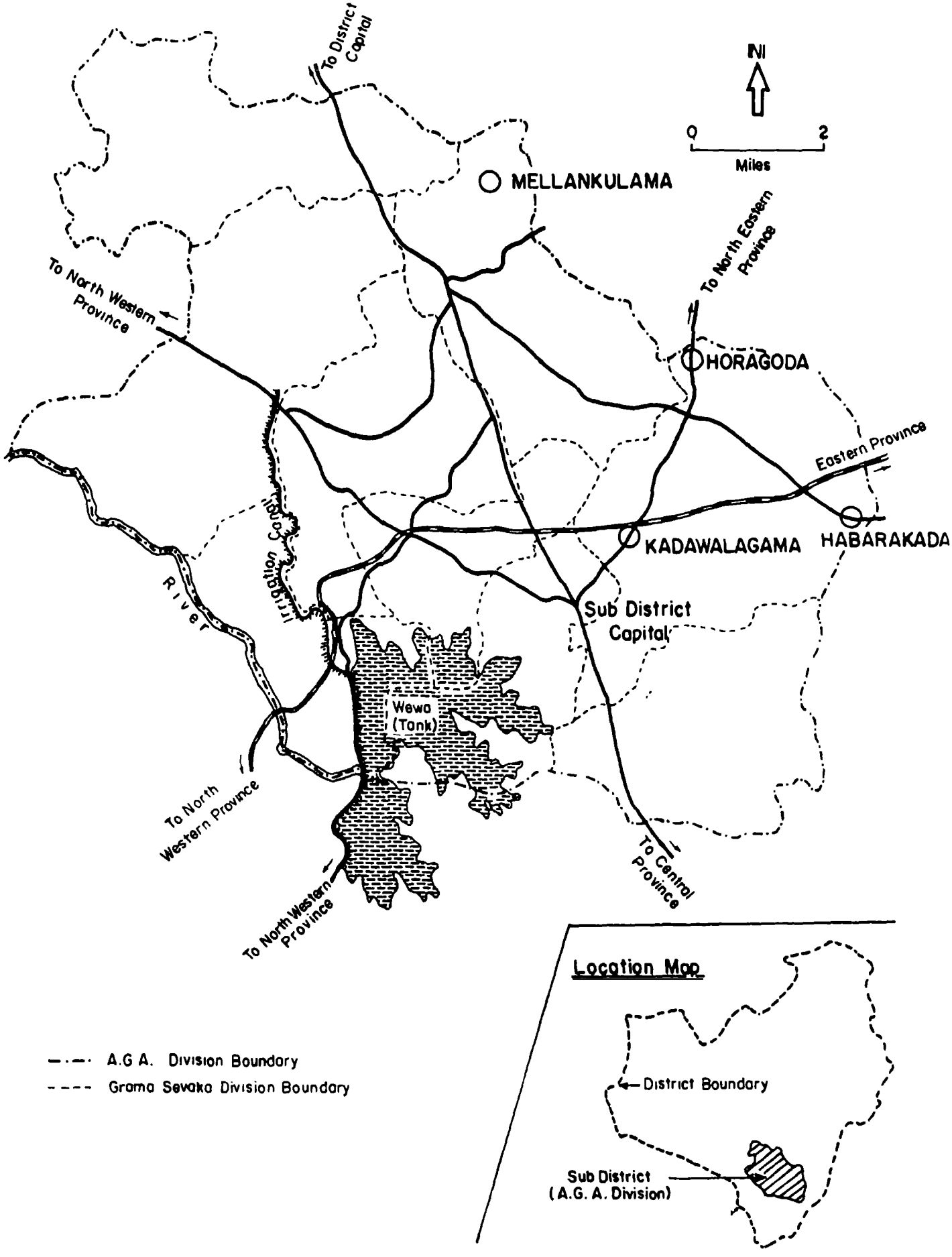
9. If in the future it is expected to implement similar projects needing the participation of women, information about the project should be communicated in advance to the women of the area relevant to the project. The organisations that are most suitable as media for such communication are School Development Societies, Funeral Aid Societies, Kulangana Samiti or Dayaka Sabha of temples.

10. It is recommended that the programme for building latrines should be carried out as a collective programme. The area unit of the volunteer worker, consisting of 20 houses can be taken as the collective unit for this purpose. A group consisting of one from each house and led by the volunteer can be organised for this purpose. After determining the number of families who have no latrines the project can supply the necessary material to the group. Digging of pits and other construction work can be organised by the group on a collective basis. If the unit of 20 houses includes families that already have latrines, they may not cooperate with the group. This is no problem. In that case those who need to build latrines can form into a group.

11. It is recommended that the procedure that has to be followed in obtaining cash assistance for latrines that have been completed should be relaxed. We feel that volunteer workers should have the authority to recommend this payment. If there are any obstacles to this in the form of financial or establishment procedures then the more readily available and accessible Family Health Workers could be enlisted as officers recommending payment. In any case it is recommended that who ever may be the officer inspecting the latrines and recommending payment he or she should do so in association with the relevant volunteer worker.

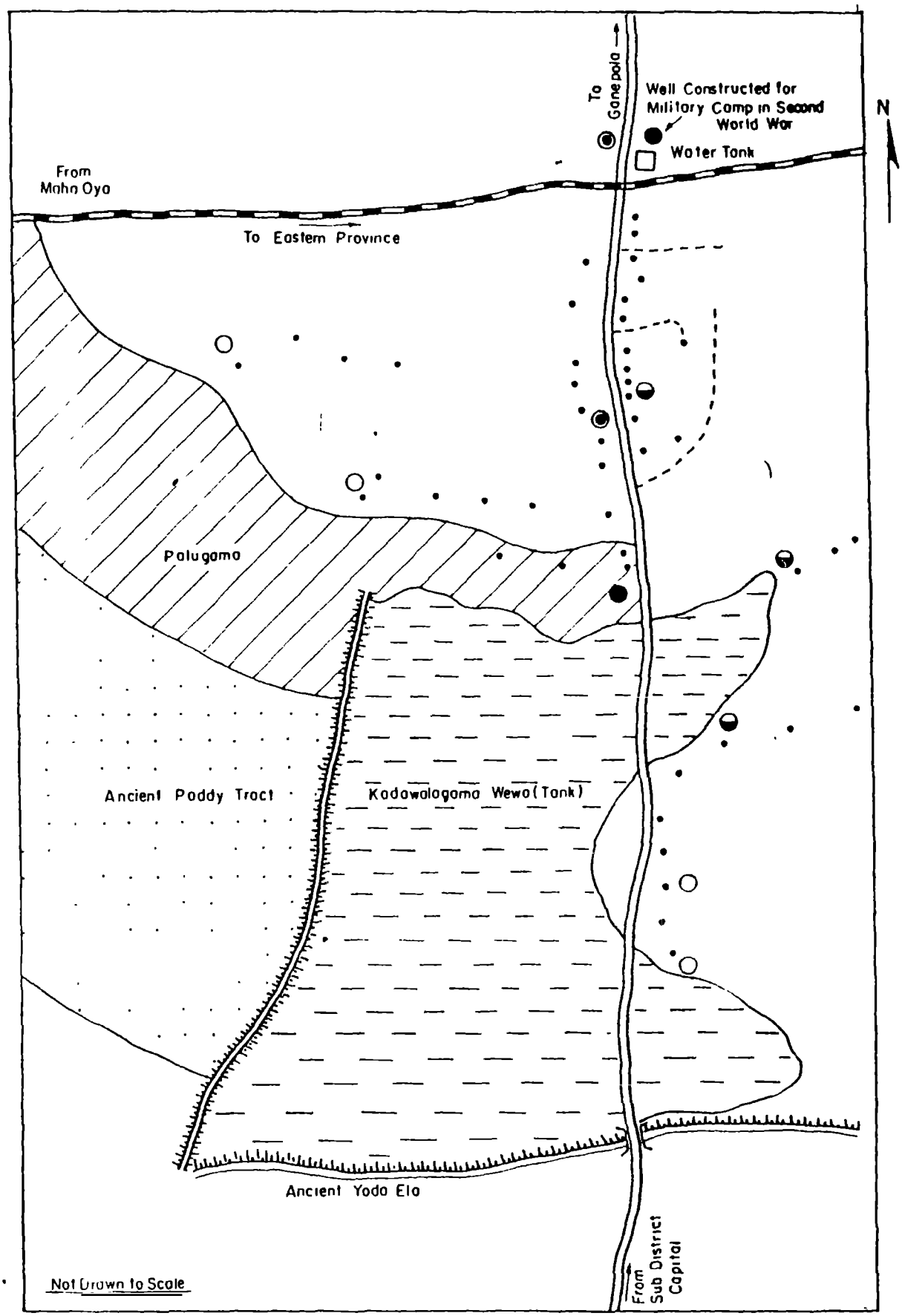
ANNEXE 1.1

# SUB DISTRICT ( A.G.A. Division )



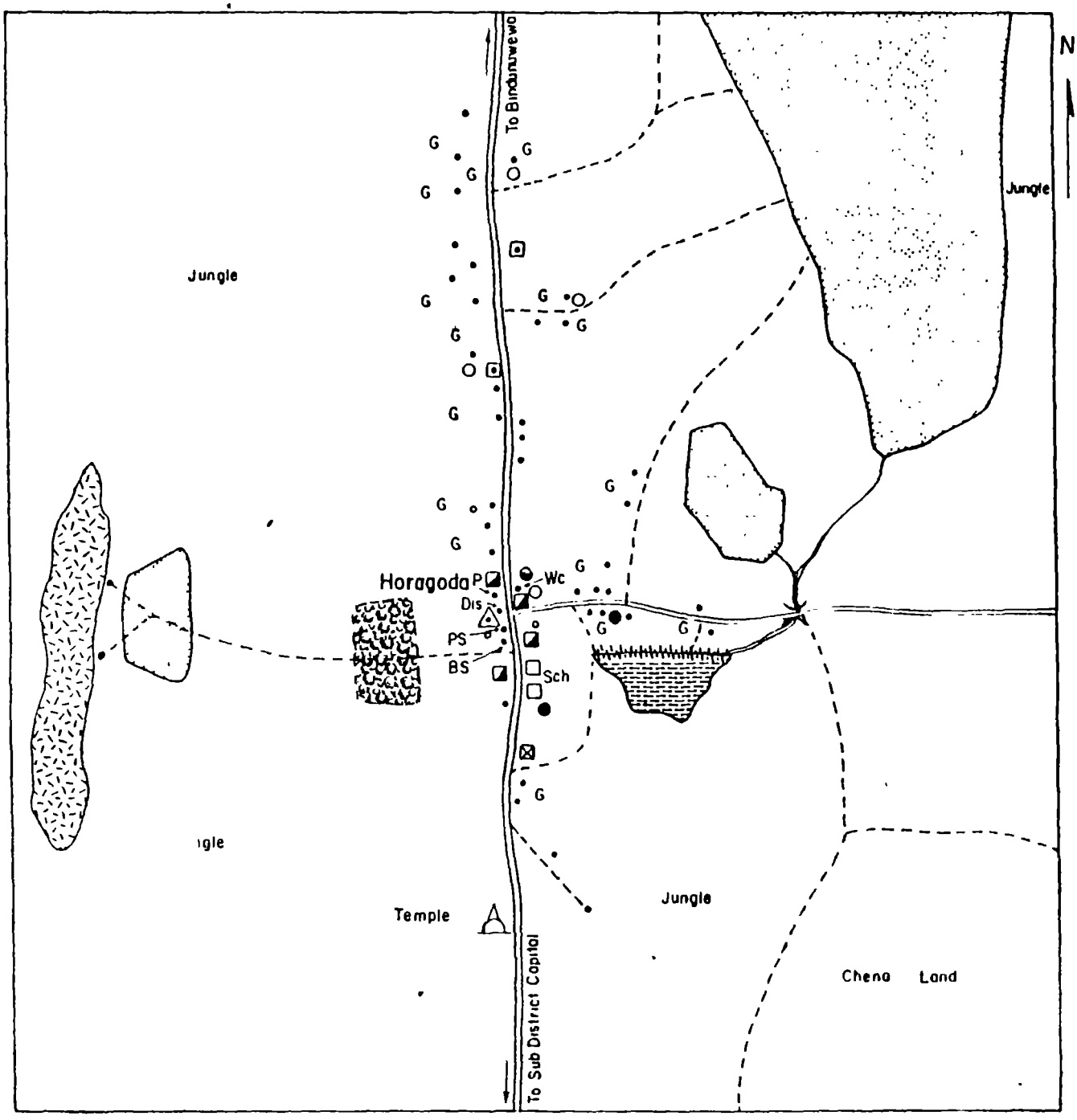
ANNEXE 1.2

# SKETCH MAP OF KADAWALAGAMA



ANNEXE 1.3

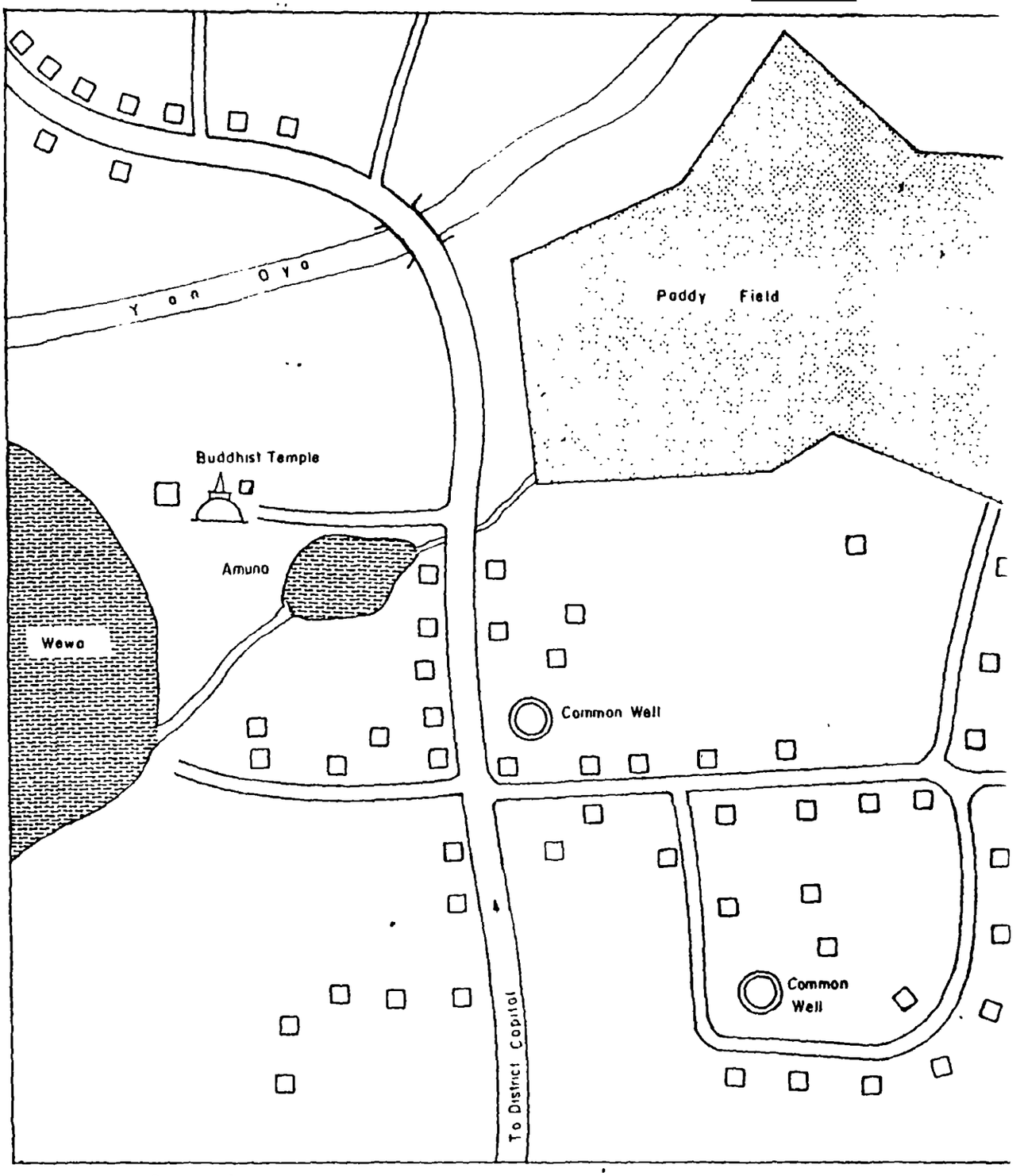
# SKETCH MAP OF HORAGODA




| | |
|---|---|
| Main Road | Sch School |
| Minor Road | P Post Office |
| Foot Path | Dis Dispensary |
| Homesteads | Wc Womens Centre |
| Paddy Fields | PS Pre-School |
| Hills | Rice Mill |
| Private Well | BS Barber Saloon |
| Abandoned Well | Bicycle Repair Shop |
| Cemetery | Irrigation Canal |
| Tank | Culvert |
| Common Well | Carpentry Shed |
| Tube Well | G Home Gardens |
| | Boutiques |

ANNEXE 1.

# SKETCH MAP OF HABARAKADA

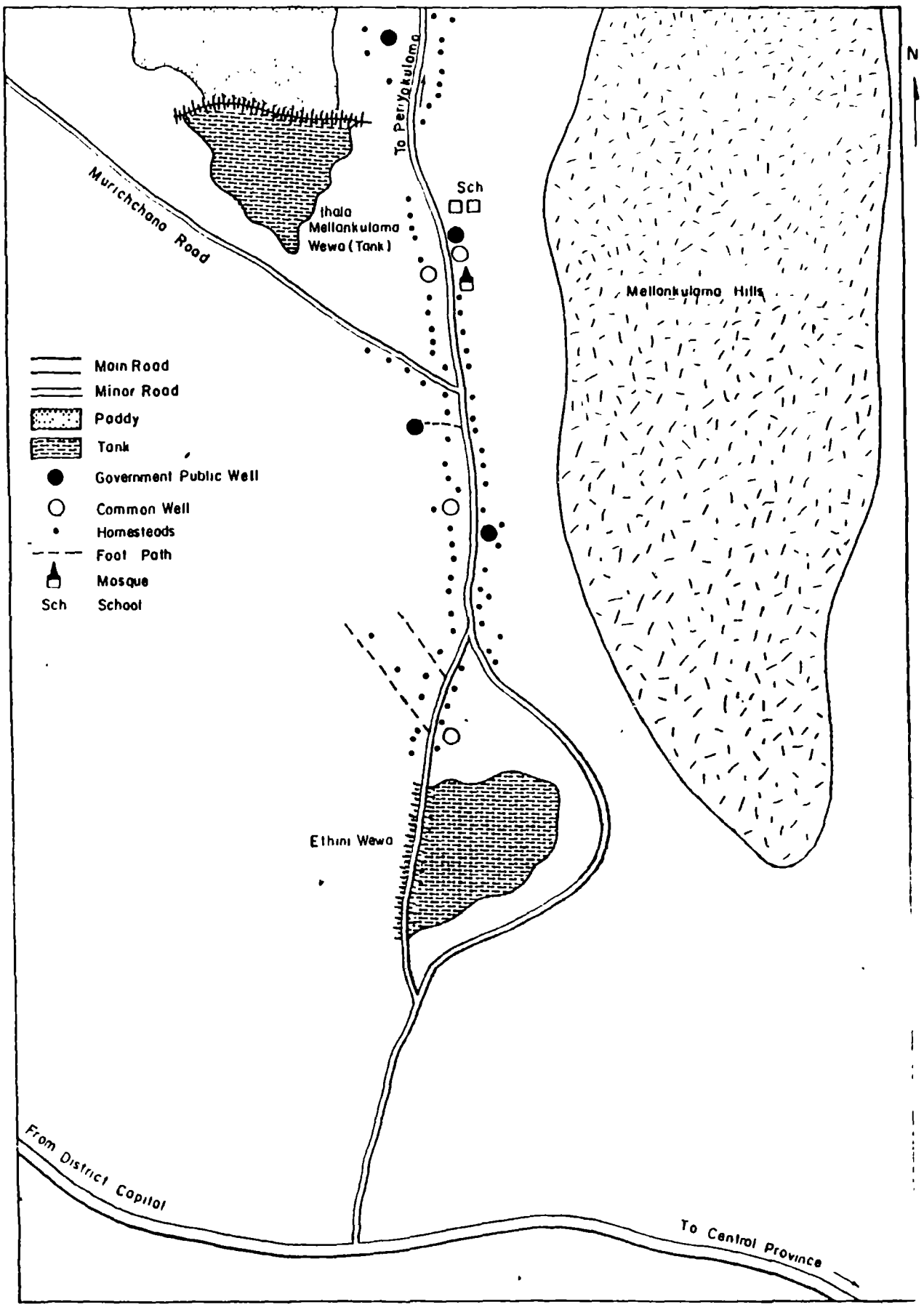



Not Drawn to Scale

☐ Homesteads

ANNEX I.2

# SKETCH MAP OF IHALA MELLANKULAMA




Not Drawn to Scale

ANNEXE 2.1

## POPULATION DATA
## (% Frequency Distribution)

Sample Size - 100%

| Village | Total Population | Female | Male |
|---|---|---|---|
| Kadawalagama | 247 | 109 | 138 |
| Horagoda | 243 | 125 | 118 |
| Habarakada | 359 | 155 | 204 |
| Upper Mellankulama | 537 | 257 | 280 |
| Total | 1,386 | 646 | 740 |

(Source : IRED Survey - July 1986)

ANNEXE 2.2

## NATURE OF THE HOUSE

(% Frequency Distribution)

Sample Size : 100%

| Village | Permanent | Semi-permanent | Temporary | No Information | Total |
|---|---|---|---|---|---|
| Kadawalagama | 17.4 | 51.7 | 30.9 | - | 100 |
| Horagoda | 6.1 | 68.8 | 25.1 | - | 100 |
| Habarakada | 16.9 | 58.8 | 24.3 | - | 100 |
| Upper Mellankulama | 38.9 | 36.7 | 16.7 | 7.7 | 100 |

Permanent - If the roof, floor and the walls are made of permanent building materials.

Semi Permanent - If one of the 3 main parts are of semi permanent building material.

Temporary - If all 3 parts are of temporary building materials.

(Source : IRED Survey - July 1986)

ANNEXE 2.5

## TOTAL AREA OF LAND

(% Frequency Distribution)

Sample Size 100%

| Village | Less than 1 Acre | 1 - 3 Acres | 3 - 5 Acres | More than 5 Acres | No Land | Total |
|---|---|---|---|---|---|---|
| Kadawalagama | 26.1 | 37.0 | 19.6 | 13.0 | 4.3 | 100 |
| Horagoda | 36.8 | 51.0 | 6.1 | 6.1 | - | 100 |
| Habarakada | 22.0 | 64.4 | 1.7 | 6.8 | 5.1 | 100 |
| Upper Mellankulama | 40.0 | 55.6 | 1.1 | 3.3 | - | 100 |

(Source - IRED Survey - July 1986)

ANNEXE 2.6

## EMPLOYMENT PATTERN OF THE STUDY VILLAGES

(% Frequency Distribution)

Sample Size : 100%

| MALES | Agriculture Owner Cultivators | Government Employment | Agriculture Labourers | Pensioners | Self-Employment | Trade | Security Forces | Drivers and other | Un-Employed or Un-employable | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Kadawalagama | 45 | 18 | - | 5 | 14 | 1 | 5 | 1 | 11 | 1 |
| Horagoda | 56 | 11 | - | 1 | 13 | - | 1 | 1 | 17 | 10 |
| Habarakade | 54 | 4 | 7 | 2 | 7 | 6 | 4 | 4 | 12 | 100 |
| Upper Mellan-kulama | 28 | 1 | 23 | - | 7 | 2 | - | 2 | 37 | 100 |

| FEMALES | Agriculture Owner Cultivators | Government Employment | Agriculture Labourers | Agriculture and Household Activities | Household Activities only | Self employed | Abroad | Other | Un-employed or Un-employable | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Kadawalagama | 3 | 12 | - | 26 | 38 | 2 | - | 1 | 18 | 100 |
| Horagoda | - | 4 | - | 51 | 35 | - | 4 | - | 6 | 100 |
| Habarakada | 1 | - | - | 59 | 29 | 1 | 3 | - | 2 | 100 |
| Upper Mellan-kulama | - | - | 4 | 1 | 73 | 1 | - | 6 | 15 | 100 |

(Source - IRED Survey - July 1986)

ANNEXE 2.7

SOURCES OF WATER DURING THE DRY SEASON FOR DRINKING, FOR AGRICULTURE PURPOSES, FOR BATHING AND WASHING AND FOR HOUSEHOLD NEEDS

(% Frequency Distribution)

Sample Size : 100%

| | Kadawalagama | | | | Horagoda | | | | Habarakada | | | | Upper Mellankulama | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
| Own Well | 17.4 | 2.2 | 2.2 | 19.6 | 8.2 | 6.1 | 2.0 | 10.0 | 20.3 | - | 1.7 | 20.3 | - | - | - | - |
| Public well | 52.2 | - | - | 39.1 | 30.6 | 2.0 | - | 30.0 | 39.0 | - | - | 39.0 | 100 | - | - | 95.6 |
| Common Well | 30.4 | - | - | 28.3 | 55.1 | 14.3 | - | 46.0 | 23.7 | - | - | 25.4 | - | - | - | - |
| Stream | - | - | - | - | - | - | - | - | 1.7 | - | 83.0 | 3.5 | - | - | - | - |
| Tank | - | 17.4 | 97.8 | 8.7 | 6.1 | - | 98.0 | 6.0 | 1.7 | 57.6 | 15.3 | - | - | 8.9 | 100 | 4.4 |
| Tube Well | - | - | - | 4.3 | - | 2.0 | - | 8.0 | 13.6 | - | - | 11.8 | - | - | - | - |
| No necessity | - | 80.4 | - | - | - | 75.6 | - | - | - | 42.4 | - | - | - | 91.1 | - | - |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

1 - For Drinking

2 - For Agriculture Purposes

3 - For Bathing and Washing

4 - For Household Needs

(Source - IRED Survey - July 1986)

ANNEXE 2.8

SOURCES OF WATER FOR DRINKING, AGRICULTURAL PURPOSE, BATHING AND WASHING AND HOUSEHOLD NEEDS DURING THE RAINY SEASON

(% Frequency Distribution)

Sample Size : 100%

| | Kadawalagama | | | | Horagoda | | | | Habarakada | | | | Upper Mellankulama | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
| Own Well | 17.4 | 2.2 | 2.2 | 19.6 | 8.2 | 6.2 | 2.0 | 10.0 | 20.3 | - | 3.4 | 20.3 | - | - | - | - |
| Public Well | 47.8 | - | - | 37.0 | 30.6 | 2.0 | 4.0 | 30.0 | 39.0 | - | - | 39.0 | 100 | - | 1.1 | 95.6 |
| Common Well | 34.8 | - | - | 28.3 | 55.1 | 12.2 | 8.0 | 46.0 | 25.4 | - | - | 25.4 | - | - | - | - |
| Stream | - | - | - | - | - | - | - | - | 1.7 | - | 88.1 | 3.4 | - | - | - | - |
| Tank | - | 43.5 | 97.8 | 10.9 | 6.1 | - | 86.0 | 6.0 | - | 57.6 | 8.5 | - | - | 5.6 | 98.9 | 4.4 |
| Tube Well | - | - | - | 4.2 | - | 2.0 | - | 8.0 | 13.6 | - | - | 11.9 | - | - | - | - |
| No Necessity | - | 54.3 | - | - | - | 77.6 | - | - | - | 42.4 | - | - | - | 94.4 | - | - |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

1 - For Drinking

2 - For Agricultural Purposes

3 - For Bathing and Washing

4 - For Household Needs

(Source : IRED Survey - July 1986)

ANNEXE 2.9

## THE DISTANCE TO SOURCES OF WATER FOR DRINKING, AGRICULTURAL PURPOSES, BATHING ANI WASHING AND HOUSEHOLD NEEDS DURING THE DRY SEASON

Sample Size : 100%

(% Frequency Distribution)

| Distance | Kadawalagama | | | | Horagoda | | | | Habarakada | | | | Upper Mellankulama | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
| Less than M. 400 | 60.9 | 13,0 | 84.8 | 76.1 | 7[illegible].5 | 20.4 | 22.4 | 79.6 | 64.4 | 5.1 | 22.0 | 64.4 | 70.0 | 4.4 | 10.0 | 72.2 |
| M. 401 - 800 | 37.0 | 2.2 | 13.0 | 21.7 | 24.5 | 4.1 | 10.2 | 18.4 | 35.6 | 33.9 | 67.8 | 35.6 | 25.6 | 3.3 | 53.3 | 25.6 |
| M. 801 - 1200 | 2.1 | 2.2 | - | 2.2 | 2.0 | - | 55.2 | 2.0 | - | 20.3 | 10.2 | - | 4.4 | - | 35.6 | 2.2 |
| More than M. 1200 | - | - | 2.2 | - | - | - | 12.2 | - | - | - | - | - | - | 1.1 | 1.1 | - |
| No necessity | - | 82.6 | - | - | - | 75.5 | - | - | - | 40.7 | - | - | - | 91.2 | - | - |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

1 - For Drinking

2 - For Agricultural Purposes

3 - For Bathing and Washing

4 - For Household Needs

(Source : IRED Survey - July 1986)

ANNEXE 2.10

## DISTANCE TO SOURCES OF WATER FOR DRINKING, AGRICULTURAL PURPOSES, BATHING AND WASHING AND HOUSEHOLD NEEDS DURING THE RAINY SEASON

(% Frequency Distribution)

Sample Size : 100%

| Distance | Kadawalagama | | | | Horagoda | | | | Habarakada | | | | Upper Mellankulama | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 | 1 | 2 | 3 | 4 |
| Less than M 400 | 60.9 | 32.6 | 84.8 | 73.9 | 73.5 | 18.5 | 14.3 | 79.6 | 64.4 | 3.4 | 25.4 | 64.4 | 70.0 | - | 8.9 | 71.1 |
| M 400 - 800 | 34.8 | 2.2 | 10.9 | 21.7 | 26.5 | 4.9 | 4.0 | 20.4 | 35.6 | 35.6 | 64.4 | 35.6 | 25.6 | 3.3 | 52.2 | 26.7 |
| M 801 - 1200 | 2.2 | 2.2 | 2.2 | 2.2 | - | - | 8.2 | - | - | 18.6 | 10.2 | - | 4.4 | - | 38.9 | 2.2 |
| More than 1201 | - | - | - | - | - | - | 73.5 | - | - | - | - | - | - | 1.1 | - | - |
| No Necessity | 2.1 | 63.0 | 2.1 | 2.2 | - | 77.6 | - | - | - | 42.4 | - | - | - | 95.6 | - | - |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

1 - For Drinking
2 - For Agriculcultural Purpose
3 - For Bathing and Washing
4 - Household Needs.

(Source : IRED Survey - July 1986)

ANNEXE 2.11

## WHO FETCHES THE WATER FOR DRINKING, AGRICULTURAL PURPOSES (HOME GARDENS) AND HOUSEHOLD NEEDS?

Sample Size.: 100%

| | Kadawalagama | | | Horagoda | | | Habarakada | | | Upper Mellankulama | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 1 | 2 | 3 | 1 | 2 | 3 | 1 | 2 | 3 |
| Mother | 59.1 | 15.2 | 57.8 | 60.0 | 16.3 | 60.9 | 64.7 | 13.2 | 64.7 | 51.9 | 5.6 | 51.9 |
| Father | 4.5 | 28.3 | 4.7 | 2.9 | 4.1 | 1.4 | 1.2 | 48.5 | 1.2 | 0.8 | 5.6 | 0.8 |
| Daughter | 27.3 | - | 28.1 | 21.4 | 6.1 | 21.7 | 32.9 | 1.5 | 31.8 | 40.5 | 3.3 | 40.5 |
| Sons | 4.5 | 26.1 | 4.7 | 2.9 | - | 2.9 | 1.2 | 35.3 | 2.3 | 2.2 | 3.3 | 2.2 |
| Relatives | - | - | - | 11.4 | 8.2 | 11.6 | - | - | - | 4.6 | 1.1 | 4.6 |
| Others | 4.6 | 4.3 | 4.7 | 1.4 | - | 1.5 | - | 1.5 | - | - | 2.2 | - |
| Not necessary | - | 26.1 | - | - | 63.3 | - | - | - | - | - | 78.9 | - |
| Total | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

1 - For Drinking

2 - For Agricultural (Home Gardens)

3 - For Household Needs.

(Source : IRED Survey - July 1986)

ANNEXE 2.12

## AWARENESS OF CLEANLINESS IN AND AROUND THE HOUSE

IS THERE A PIT OR A SPECIFIC PLACE TO COLLECT THE REFUSE?

(% Frequency Distribution of Responses)

Sample Size : 100%

| Village | Yes | No | No Information | Total |
|---|---|---|---|---|
| Kadawalagama | 95.7 | 4.3 | - | 100 |
| Horagoda | 14.3 | 85.7 | - | 100 |
| Habarakada | 44.1 | 55.9 | - | 100 |
| Upper Mellankulama | 8.8 | 85.6 | 5.6 | 100 |

(Source : IRED Survey - July 1986)

ANNEXE 2.13

IS THE BOUNDARY BETWEEN THE HOUSE AND THE HOME GARDEN CLEAN?

(% Frequency Distribution of Responses)

Sample Size : 100%

| Village | Yes | No | No Information | Total |
|---|---|---|---|---|
| Kadawalagama | 93.5 | 6.5 | - | 100 |
| Horagoda | 14.3 | 85.7 | - | 100 |
| Habarakada | 71.2 | 28.8 | - | 100 |
| Upper Mellankulama | 10.0 | 84.4 | 5.6 | 100 |

(Source : IRED Survey - July 1986)

ANNEXE 2.14

## ARE THERE SPECIFIC PLACES FOR WASHING OF POTS, PLATES AND TO KEEP UTENSILS USED FOR COLLECTION OF WATER

(% Frequency Distribution of Responses)

Sample Size : 100%

| Village | Yes | No | No Information | Total |
|---|---|---|---|---|
| Kadawalagama | 95.7 | 4.3 | - | 100 |
| Horagoda | 71.4 | 28.6 | - | 100 |
| Habarakada | 81.4 | 18.6 | - | 100 |
| Upper Mellankulama | 82.2 | 12.2 | 5.6 | 100 |

(Source : IRED Survey - July 1986)

ANNEXE 2.15

IS THE HOUSE FLOOR MADE ON COW-DUNG

(% Frequency Distribution Responses)

Sample Size : 100%

| Village | Yes | No | No Information | Total |
|---|---|---|---|---|
| Kadgwalagama | 71.7 | 28.3 | - | 100 |
| Horagoda | 55.1 | 44.9 | - | 100 |
| Habarakada | 67.8 | 32.2 | - | 100 |
| Upper Mellankulama | 86.6 | 7.8 | 5.6 | 100 |

(Source : IRED Survey - July 1986)

ANNEXE 2.16

IDEAS ABOUT THE USE OF WATER - DO YOU KNOW THAT DRINKING WATER CAN CAUSE ILLNESSES?

(Frequency Distribution of Responses)

Sample Size : 100%

| Village | Yes | No | No Information | Total |
|---|---|---|---|---|
| Kadawalagama | 63.0 | 37.0 | - | 100 |
| Horagoda | 93.9 | 6.1 | - | 100 |
| Habarakada | 44.1 | 55.9 | - | 100 |
| Upper Mellankulama | 52.2 | 47.2 | - | 100 |

IF 'YES', WHAT ARE THE ILLNESSES?

| Village | Diarrhoea | Vomiting | Fever | Stomach ailments | Urinary trouble | Cholera | Dental complaints | Total |
|---|---|---|---|---|---|---|---|---|
| Kadawalagama | 42.3 | - | 10.2 | 6.8 | 8.5 | 15.2 | 17.0 | 100 |
| Horagoda | 22.8 | 1.6 | 13.8 | 30.9 | 16.3 | 14.6 | - | 100 |
| Habarakada | 46.9 | - | 3.1 | 6.2 | 21.9 | 21.9 | - | 100 |
| Mellankulama | 66.6 | 16.7 | - | - | - | 16.7 | - | 100 |

(Source : IRED Survey - July 1986)

ANNEXE 2.17

IDEAS ABOUT WATER - DURING TIMES OF GOOD HEALTH, DO YOU THINK YOU AND YOUR FAMILY HAVE THE STRENGTH TO RESIST WATER BORNE DISEASES?

(% Frequency Distribution of Responses)

Sample Size : 100%

| Village | Yes | No | Total |
|---|---|---|---|
| Kadawalagama | 95.7 | 4.3 | 100 |
| Horagoda | 79.6 | 20.4 | 100 |
| Habarakada | 86.4 | 13.6 | 100 |
| Upper Mellankulama | 70.0 | 30.0 | 100 |

(Source : IRED Survey - July 1986)

ANNEXE 2.18

IDEAS ABOUT WATER - IS IT ONLY AT TIMES OF ILLNESSES THAT YOU AND YOUR FAMILY USE BOILED WATER?

(% Frequency Distribution of Responses)

Sample Size : 100%

| Village | Yes | No | Total |
|---|---|---|---|
| Kadawalagama | 78.7 | 21.3 | 100 |
| Horagoda | 69.4 | 30.6 | 100 |
| Habarakada | 62.7 | 37.3 | 100 |
| Upper Mellankulama | 83.3 | 16.7 | 100 |

(Source : IRED Survey - July 1986)

ANNEXE 2.19

IDEAS ABOUT WATER - ARE YOU AND YOUR FAMILY
USED TO THE PRACTICE OF DRINKING BOILD WATER?

(% Frequency Distribution of Responses)

Sample Size : 100%

| Village | Yes | No | Total |
|---|---|---|---|
| Kadawalagama | 25. | 75. | 100 |
| Horogoda | 30.6 | 69.4 | 100 |
| Habarakada | 13.6 | 86.4 | 100 |
| Upper Mellankulama | 11.1 | 88.7 | 100 |

(Source : IRED Survey - July 1986)

ANNEXE 2.19 A

## HOUSEHOLD MEMBERS PARTICIPATING IN VOLUNTARY ORGANISATIONS

Sample Size : 100%

| Participating Member/ Members | Kadawalagama | Koragoda | Habarakada | Upper Mellankulama |
|---|---|---|---|---|
| Chief Householder | 39.1 | 12.2 | 45.7 | 71.1 |
| Spouse | 13. | 28.2 | 17.5 | - |
| Older Sons | 2.1 | 1.3 | 11.8 | 17.7 |
| Older Daughters | 10.8 | 10.3 | 15.0 | 6.7 |
| All Family members | 30.4 | 24.6 | 8.4 | - |
| None | 4.6 | 32.6 | 11.9 | 11.2 |
| Total | 100 | 100 | 100 | 100 |

Source: IRED Survey April 1987.

ANNEXE 2.20

## USE OF TUBE WELL WATER AFTER THE PROJECT

(% Frequency Distribution of Responses)

Sample Size : 100%

| | Kadawalaggama | | | Horagoda | | | Habarakada | | | Upper Mellankulama | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Yes | No | Total | Yes | No | Total | Yes | No | Total | Yes | No | Total |
| For Drinking | - | 100 | 100 | - | 100 | 100 | 20 | 80 | 100 | NR | NR | NR |
| For Agricultural Purposes | 33 | 67 | 100 | 12 | 88 | 100 | - | 100 | 100 | NR | NR | NR |
| For Bathing and Washing | 33 | 67 | 100 | 12 | 88 | 100 | 07 | 93 | 100 | NR | NR | NR |
| For Household Activities | 35 | 65 | 100 | 15 | 85 | 100 | 21 | 79 | 100 | NR | NR | NR |

Source : IRED Survey - April 1987)

ANNEXE 2.21

OBSERVATION CHART RELATING TO THE USE OF TUBE WELLS IN THE STUDY VILLAGES ON A SELECTED DAY

| Village | 6.00 a.m. to 8.00 a.m. | 12.00 noon to 2.00 p.m. | 4.00 p.m. to 6.00 p.m. |
|---|---|---|---|
| Kadawalagama | C,C,C,C,B, C,C,C,C<br>E, C, C, C, D | D, D, D, D | B, B, B, B, B, B, D<br>B, B, B, B, B |
| Horagoda | D, D, D, C, D, E | E, D | D, D, D |
| Habarakada | D, C, C, D, C, C, C<br>C, D, A, A, C, D | D, D, D, A, D, D,D<br>A, D, D, D, D | D, D, D, D, A<br>C, C, C |
| Upper Mellankulama | N.R. | N. R. | N. R. |

A - For Drinking
B - For use in Home Gardens
C - For Bathing and Washing
D - For Household Activities
E - For Playing (Children)

Source : IRED Survey April 1987)

ANNEXE 2.22

WATER USEAGE FOR DRINKING, COOKING, LATRINES AND WASHING PER DAY
(Litres)

| | Kadawalagama | Koragoda | Habarakada | Upper Mellankulama |
|---|---|---|---|---|
| For Drinking | 4.8 | 4.6 | 3.9 | 4.0 |
| For Cooking | 6.4 | 4.2 | 4.4 | 5.5 |
| For use in Latrines | 4.9 | 4.1 | 4.5 | 5.4 |
| For Washing | 4.4 | 3.1 | 4.2 | 5.2 |
| Total | 20.5 | 16.0 | 17.0 | 20.1 |

(Source : IRED Survey April 1997)

ANNEXE 2.23

PER CAPITA WATER USAGE FOR DRINKING, COOKING, LATRINES AND WASHING PER DAY (IN LITRES)

| | Kadawalagama | Koragoda | Habarakada | Upper Mellankulama |
|---|---|---|---|---|
| For Drinking | .9 | .9 | .7 | .7 |
| For Cooking | 1.2 | .8 | .7 | .9 |
| For use in Latrines | .9 | .8 | .8 | .9 |
| For Washing | .8 | .6 | .7 | .9 |
| Total | 3.8 | 3.1 | 2.9 | 3.4 |

(Source : IRED Survey April 1987)

ANNEXE 2.24

## HAS THE HOUSE GOT A TOILET BEFORE AND AFTER PROJECT

(% Frequency Distribution of Responses)

Sample Size : 100%

| Village | Before Project | | | After Project | | |
|---|---|---|---|---|---|---|
| | Yes | No | Total | Yes | No | Total |
| Kadawalagama | 47.8 | 52.2 | 100 | 69.5 | 30.5 | 100 |
| Horagoda | 75.5 | 24.5 | 100 | 77.5 | 22.5 | 100 |
| Habarakada | 37.3 | 62.7 | 100 | 66.1 | 33.9 | 100 |
| Upper Mellankulama | 7.8 | 92.2 | 100 | 13.3 | 86.7 | 100 |

IF YES

| Village | Before Project | | | | After Project | | | |
|---|---|---|---|---|---|---|---|---|
| | Pit | Bucket | Water seal | Total | Pit | Bucket | Water seal | Total |
| Kadawalagama | 83.3 | 4.2 | 12.5 | 100 | 59.4 | - | 40.6 | 100 |
| Horagoda | 94.8 | 5.2 | - | 100 | 78.9 | - | 21.1 | 100 |
| Habarakada | 81.8 | - | 18.2 | 100 | 43.6 | - | 56.4 | 100 |
| Upper Mellamkulama | 25.0 | 50.0 | 25.0 | 100 | 41.7 | - | 58.3 | 100 |

(Source : IRED Survey July 1986 and April 1987)

ANNEXE 2.25

USE OF TOILET
(% Frequency Distribution of Responses)

Sample Size : 100%

| Village | By all Family Members | By Older girls and Children | By Children only | By Elders only | By Visitors only | Total |
|---|---|---|---|---|---|---|
| Kadawalagama | 87.5 | - | - | 12.5 | - | 100 |
| Poragoda | 65.8 | - | - | 34.2 | - | 100 |
| Habarakada | 84.6 | - | - | 15.4 | - | 100 |
| Upper Mellankulama | 91.6 | - | - | 8.4 | - | 100 |

(Source : IRED Survey April 1987)

ANNEXE 2.26

HEALTH ACTIVITIES AND HEALTH EDUCATIONAL PROGRAMMES CONDUCTED BY THE PROJECT IN STUDY VILLAGES (JULY 1986 TO APRIL 1987)

(% Frequency Distribution)

| | Maternity Clinic | Immunisation Programmes | Kolakenda (Herbal Broth) Programmes | Health Education Programmes | Total |
|---|---|---|---|---|---|
| Kadawalagama | 14.2 | 28.6 | 21.4 | 35.8 | 100 |
| Horagoda | 16.7 | 33.3 | 41.7 | 8.3 | 100 |
| Habarakada | 25.0 | 37.5 | 25.0 | 12.5 | 100 |
| Upper Mellankulama | 25.0 | 33.3 | 25.0 | 16.7 | 100 |

(Source : IRED Survey April 1987)

ANNEXE 2.27

PARTICIPATION OF HEALTH VOLUNTEERS

| Village | Volunteers | Age | Educational level | Participation in Health Activities | | | |
|---|---|---|---|---|---|---|---|
| | | | | Very Good | Good | Fair | Nil |
| Kadawalagama | A | 42 | O/L | + | | | |
| | B | 21 | A/L | + | | | |
| | C | 19 | O/L | | + | | |
| | D | 18 | O/L | | + | + | |
| | E | 18 | O/L | | | | |
| Horagoda | A | 22 | A/L | + | | | |
| | B | 21 | O/L | | | + | |
| | C | 21 | O/L | | | | x |
| Habarakada | A | 29 | O/L | + | | | |
| | B | 20 | O/L | | | | x |
| Upper Mellankulama | A | 30 | Grade 8 | | | | ++ |
| | B | 18 | Grade 8 | | | + | |
| | C | 18 | Grade 7 | | | | ++ |

( ++ Husband and Father respectively particiated on behalf of these volunteers)

(Source : IRED Survey April 1987)

ANNEXE 2.28

NUMBER OF HOUSEHOLDS VISITED BY HEALTH VOLUNTEERS AND HEALTH OFFICERS

(% Frequency Distribution of Responses)

Sample Size : 100%

| Village | Whether visited by Health Officer | | | Whether visited by Health Volunteers | | |
|---|---|---|---|---|---|---|
| | Yes | No | Total | Yes | No | Total |
| Kadawalagama | 36.9 | 63.1 | 100 | 100 | - | 100 |
| Horagoda | 40.8 | 59.2 | 100 | 100 | - | 100 |
| Hararakada | 33.8 | 66.2 | 100 | 100 | - | 100 |
| Upper Mellenkulama | 10.0 | 90.0 | 100 | - | 100 | 100 |

(Source : IRED Survey April 1987)

ANNEXE 2.29

NUMBER OF VISITS TO HOUSES BY HEALTH VOLUNTEERS

(% Frequency Distribution Responses)

Sample Size : 100%

| Village | No. of Visits Per Household | | | | | Total |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | |
| Kadawalagama | 45.7 | 34.8 | 10.9 | 4.3 | 4.3 | 100 |
| Horagoda | 42.9 | 42.9 | 14.2 | - | - | 100 |
| Habarakada | 64.4 | 32.3 | 3.3 | - | - | 100 |
| Upper Mellankulama | 0 | 0 | 0 | 0 | 0 | - |

(Source : IRED Survey April 1987)

ANNEXE 2.30

## PURPOSE OF VISIT BY HEALTH OFFICERS AND HEALTH VOLUNTEERS

(% Frequency Distribution of Responses)

Sample Size : 100%

| Village | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Kadawalagama | 23.9 | 50.0 | 4.3 | 6.5 | 100 |
| Horagoda | - | 57.1 | - | - | 100 |
| Habarakada | - | 44.0 | - | - | 100 |
| Upper Mellankulama | - | 10.0 | - | - | - |

1 - For Health Education

2 - To encourage toilet construction

3 - To organise Shramadana work

4 - To provide sundry assistance

5 - To collect information for a study.

(Source : IWTD Survey April 1987)

ANNEXE 2.31

PARTICIPATION IN PROJECT ACTIVITIES

Sample Size :100%

| Village | Kadawalagama | Horagoda | Habarakada | Upper Mellankulama |
|---|---|---|---|---|
| Use of Maternity Clinic | 100 | 100 | 100 | 100 |
| Immunisation Programmes | 100 | 100 | 100 | 100 |
| Kola Kenda (Hebal Broth) Programmes | 100 | 83 | 80 | 75 |
| Health Education programmes | 30 | 77.5 | 32 | 23 |

(Source : IRED Survey April 1987)

ANNEXE 2.32

## AWARENESS OF WATERBORNE DISEASES

(% Frequency Distribution of Responses)

Sample Size : 100%

| Village | Before Project | | | After Project | | |
|---|---|---|---|---|---|---|
| | Aware | Unaware | Total | Aware | Unaware | Total |
| Kadawalagama | 63.0 | 37.0 | 100 | 73.9 | 29.1 | 100 |
| Horagoda | 93.9 | 6.1 | 100 | 96.0 | 4.1 | 100 |
| Habarakada | 44.1 | 55.9 | 100 | 61.0 | 39.0 | 100 |
| Upper Mellankulama | 52.2 | 47.8 | 100 | 62.2 | 37.8 | 100 |

(Source : IRED Survey July 1986 and April 1987)

ANNEXE 3

## An observer's note regarding the training programme for women volunteer workers held at the Kekirawa town hall

The invitations to participate in this programme had been sent to volunteer workers by the Family Health Worker (Public Health Nurse). The participants were paid their travelling expenses and supplied with meals. Only the women volunteers from the AGA division of Kekirawa participated. The sessions were presided over by the District Medical Superintendents, Anuradhapura. The programme was directed by Mr. Ariyadasa.

**Day One**

8.00 a.m. - Mr. Ariyadasa inaugurated the programme with an introduction speech.
A lecture on child health was delivered by a doctor. Questions and a discussion followed. (Tea was served at 10.30 a.m.)

12.00 noon - Lunch.

1.00 p.m. - Slides relating to the lecture in the morning were shown and explained by the doctor. A film on child health was shown on the T.V.

2.00 p.m. - Afternoon tea

4.30 p.m - The programme for the following day was explained and a review of the mornings work was given by Mr. Ariyadasa.

Work for the day was concluded at about 4.00 p.m. The participants on this day numbered about 200 women volunteers.

Day Two

Only about 60 participated on this day. Reason was that schools reopened on this day and the majority of the previous day's participants were school teachers.

8.00 a.m. -A lecture by a doctor. At the end of questions and discussions tea was served. After tea a T.V. film on Diarrhoea was shown.

12.00 noon- Lunch

1.00 p.m.- A film on bacteria was shown

2.30 p.m.- Tea.

After tea Mr. Ariyadasa announced the programme for the following day.

As one item of the programme, the participants were divided at random into 10 groups, and each group was given a subject on which they had to collect information and present a report the following day. One subject was 'Immunisation' - what are the various types of immunisation? At what age are they given? etc. Another group was asked to comment with relevant information on the proverbs 'like applying medicine on the shoulder as a remedy for failure in the leg'. Yet another assignment was to demonstrate through drama form how to treat a diaerhoea patient with the help of a powder called 'Jeevam'.

Work for the day concluded at about 4.00 p.m. after Mr. Ariyadasa gave a review of the day's proceedings.

Day Three

8.00 a.m. - Programme began with an exercise involving mothers and children. There were, on invitation, 10 mothers and 10 children. All children were under 1 year in age.

Participants were divided into 10 groups as on the day before. Each group had to interview a mother and obtain detailed information about the health of the mother and the child. The group leader then had to submit a report to the assembly.

Next item for each group to weigh each child and learn how to prepare the Triposha card (feeding table)

Meanwhile tea was served.

12.00 noon -Lunch

1,00 p.m. -As arranged on the previous day, group leaders submitted their reports on the subjects assigned to them. These reports were discussed with a doctor joining in to help and guide the discussion.

The presentation of one report in the form of a drama too was done.

2.30 p.m. -Tea

After tea, Mr. Ariyadasa reviewed the whole 3 day programme.

The programme was concluded at about 4.00 p.m.

All the Public Health Inspectors and Public Health Nurses of the Kekirawa AGA division, the Matron of the Kekirawa hospital as well as officials involved in the project, participated in the programme.

The trainees were allowed to raise any necessary and relevant question and all questions were answered by a doctor.

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ANNEXE 4

## Integrated Basic Services Project in Anuradhapura District Implemented with the assistance of UNICEF

## Constitution of the Gramodaya Council Health Committee

1. Membership

(A) With voting rights

1. Chairman, Gramodaya Council (Chairman, Health Committee)
2. Family Health Worker (Secretary, Health Committee)
3. Chairman of village level volunteer organisations
4. Volunteer Health Workers (male or female) selected one for each village
5. Women leaders selected under the project.

(B) Consultant members - without voting rights

1. Public Health Inspector, Special Services Officer, Doctors etc.

2. Activities

1. A meeting once every month
2. At least 10% of the voting membership must be present for a quorum
3. Decisions taken on a majority vote of those present
4. Minutes of meetings to be kept by the Secretary of the Committee i.e. the Family Health Worker and copies of minutes to be sent to the Medical Officer of Health and the Assistant GovernmentAgent
5. In all activities there should be coordination with the MOH and the AGA

3. Responsibilities/Tasks

(A) To work in close coordination with the Medical Officer of Health and the Assistant Government Agent for the upliftment of the general health condition of the area.

(B) Public Health Activities

To engage in activities like holding clinics, conducting health weeks and carrying out school health programmes in close collaboration and coordination with the Medical Officer of Health and the Assistant Government Agent.

(C) Improving knowledge about health

1. Promoting good health habits in relation to environmental health, domestic health, personal health and consumption of food beneficial to health.

2. Organising women's groups to promote health habits at village level.
3. Organising and implementing health programmes for children.

(D) Protecting Environmental Health

1. Keeping the environment clean.
2. Removing waste.
3. Controlling/Preventing harm from mosquitoes, flies and other insects.
4. Using of harmless chemicals and controlling of the use of chemicals harmful to health.

(E) Water Supply

1. Encouragement of water not harmful to health.
2. Identifying suitable sites for public wells.
3. Selecting caretakers for public wells/pumps and supervising their work.
4. Supervising the using of public wells/pumps.
5. Properly maintaining public wells/pumps and reporting their defects.

(F) Latrines

1. Encouraging people to build and make use of latrines.
2. Finding out the families that require latrines and drawing attention of relevant officials to this need.
3. Arranging for the delivery of assistance provided for latrines.
4. Ensuring use and proper maintenance of latrines to safeguard health.

(G) Disabled persons

Identifying the disabled persons in the area and taking necessary steps in consultation with the Medical Officer of Health to rehabilitate them.

(H) Nutrition

1. Encouraging people to take a balanced diet.
2. Proving guidance to people in preparing a balanced diet.
3. Organising and implementing a programme to provide a supplementary diet for pre-school children.

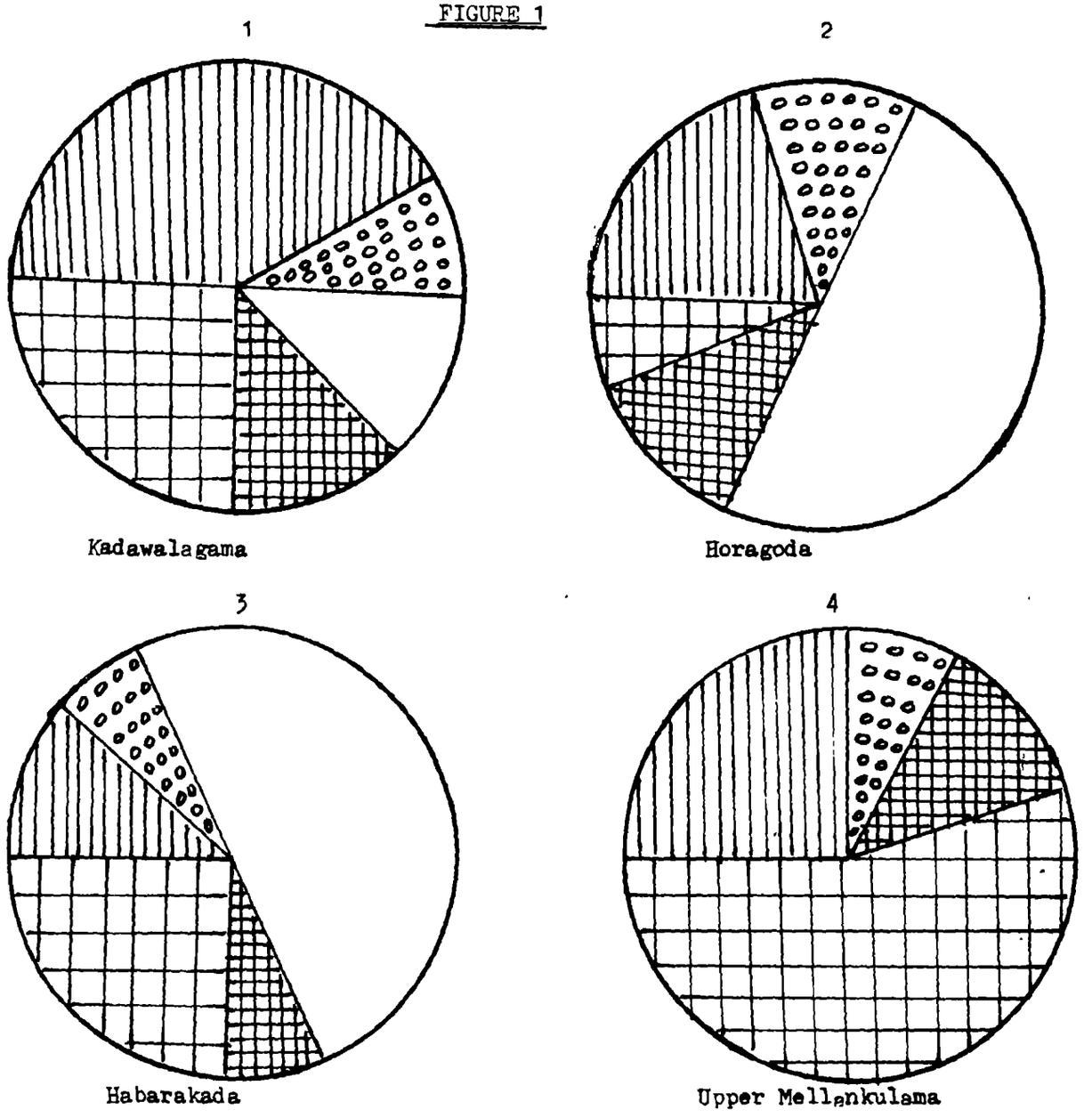
(I) Any other activity connected with health.

At every monthly meeting of the Committee the work done during the preceding month should be reviewed and a programme of work for the ensuing month should be drawn up.

ANNEXE 5

# DAILY TIME ALLOCATION OF RURAL WOMEN

## FIGURE 1




(Source : IRED Survey April 1987)

ANNEXE 6

PARTICIPANTS AT TWO VILLAGE LEVEL WORKSHOPS ORGANISED BY IRED IN APRIL 1987 TO DISCUSS THE PEOPLE'S EXPERIENCES OF DPH WATER AND SANITATION PROJECT

1. Mr. A.D. Nanayakkara (Consultant/Women's Bureau)
2. Mr. Willie Gamage, IRED Consultant
3. Mr. R.M. Jayasena, IRED Consultant
4. Mr. Sarath Digahawatura } IRED, Research Assistants
5. Mr. Sameen }
6. Mr. P.H.G. Chandrasena, Planning Implementation Officer
7. Mr. P. Hewage, P.H.I. Kekirawa
8. Mrs. T.I. Kumarihamy, Health Volunteer
9. Mrs. T.B. Dayawathie, P.H.N., Maradankaduwala
10. Mr. D.M. Wijetunga, S.S.O., 66/62
11. Mr. E.M. Tikiribanda, Chairman, No. 62 Gramodaya Council
12. Mr. Siril Wattegama,
13. Mr. N. Mohamed, Upper Mellankulama M.V.
14. Miss K.B. Anulawathie, P.H.N., Tebbatuwewa
15. Miss S. Rajakaruna, Health Volunteer, Kadawalagama
16. Miss G.C.E. Kotakadeniya -do-
17. Miss S. Elangasinghe -do-
18. Miss I.T. Chandrawathie -do-
19. Miss S. Nasuga, Health Volunteer, Upper Mellankulama
20. Miss A. Elangasinghe, Health Volunteer, Pahala Mellankulama
21. Mr. K.A. Cader, Chairman, Upper Mellankulama
22. Mr. V.G. Nimalasiri, Chairman, Pradeshiya Mandalaya, Habarakada
23. Mr. A.M.S.B. Adikari, C.S. Habarakada
24. Mr. U.S. Gunasekera, P.H.I., Yakalla
25. Mr. M. Tilakaratna, S.S.O., 44/45
26. Dr. S.P. Aberanaapu, Chairman, 44 Gramodaya Council
27. Mrs. A. Dissanayake, P.H.N. Horagoda
28. Mrs. M.P.P. Memasiri, Health Volunteer, Horagoda
29. Mrs. H.S. Sepali, Health Volunteer, Bathsirigama
30. Miss K. Premalatha, Health Volunteer, Habarakada
31. Mrs. A.P. Somalawathi, Habarakada
32. Mr. A.M.B. Adikari, Kekirawa
33. Mr. U.B.I. Samarasena, Kadawalagama.

ANNEXE 7

WOMEN'S PARTICIPATION IN RURAL WATER SUPPLY AND SANITATION PROJECT

(On behalf of the WHO)

IRED

Development Innovations and Networks

64, Horton Place, Colombo 7

April 1987

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Name..... Ref. No. [ ]

1. Composition of the Household

| | Males | Females |
|---|---|---|
| Less than 1 year | [ ] | [ ] |
| 1 - 5 years | [ ] | [ ] |
| 6 - 15 years | [ ] | [ ] |
| 6 - 15 years | [ ] | [ ] |
| 16 - 35 years | [ ] | [ ] |
| 36 - 55 years | [ ] | [ ] |
| More than 56 years | [ ] | [ ] |

2. Taking into consideration the past year (From April 1986 up to now) obtain the following information

(I) Access to water

| | Same as before | Easier than before |
|---|---|---|
| For drinking | [ ] | [ ] |
| For bathing | [ ] | [ ] |
| For cleaning Purposes | [ ] | [ ] |

(II) Use of tube wells and attitudes

| | 100% | 75% | 50% | 25% | 0% |
|---|---|---|---|---|---|
| For drinking | [ ] | [ ] | [ ] | [ ] | [ ] |
| For bathing | [ ] | [ ] | [ ] | [ ] | [ ] |
| For cleaning | [ ] | [ ] | [ ] | [ ] | [ ] |
| For cultivation | [ ] | [ ] | [ ] | [ ] | [ ] |

(III) Tube well water

| Very pure | Pure | Not used for drinking | Impure |
|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ |

3. Use of latrines and attitudes

(1) Latrines

| Existed before too | Built newly | Partially completed | Applied for not got yet | Not applied for | Not necessary |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

(II) Use

| All family Members | Elder daughters and small children | Only small children | Only adults | Only guests |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

4. Common attitudes regarding water and sanitation

Can always be subjected to diarrhoea, worm diseases and various other stomach ailments because of not using water and latrines in the proper way

| Yes without fail | Sometimes | When the body is weak (during illness) | Valid only for children | Can happen seldom | Never |
|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

5. Participation

(1) Meetings of Volunteer organizations (those who attend most)

| Number of meetings | Householder | Wife | Elder Sons | Elder daughters | Any one as time permits | Small children |
|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

(II) Health Activities

| | Relevant or not | Participated or not | Number participating | Number of times |
|---|---|---|---|---|
| X Kolakenda programmes | ☐ | ☐ | ☐ | ☐ |
| X Maternity Clirics | ☐ | ☐ | ☐ | ☐ |
| X Immunisation | ☐ | ☐ | ☐ | ☐ |

| | Relevant or not | Participated or not | Number participating | Number of times |
|---|---|---|---|---|
| X Health Education | | | | |
| X Others | | | | |

Relevant 1 Participated 1 Mark according to the earlier question

Not relevant 2 Did not participate

6. During the past year did some officer or a volunteer worker (male of female) connected with the health sector visit your home?

| Yes/No | Officer/Volunteer | Number of times | Reason |
|---|---|---|---|
| | | | |

Yes 1 Officer 1

No 2 Volunteer 2

1. Health Education
2. Water/latrine
3. For inviting to a health programme
4. Voluntary labour
5. Other assistance
6. Other