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The water and sanitation programme in Bangladesh - success or failure?

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1. Introduction

At the dawn of the UN Water Decade, World Water, in its December issue 1979, referred to the water programme in Bangladesh as "successful". The count of public tubewells stood at approximately 520 000 by June of this year, which implies less than 200 people per tubewell. Sanitary latrines are owned by 1% of rural families.

Recently, the donors of the water and sanitation programme have become disturbed by the fact that despite the apparent high per capita coverage of tubewells, the incidence of water-related diseases in Bangladesh has remained more or less unchanged over the last ten years. The International Centre for Diarrhoeal Disease Research in Bangladesh lists diarrhoea and dysentry as the most frequent causes of death.

2. Community Surveys

To discover the actual coverage and distribution of the handpumps as well as of the sanitary latrines, a number of socio-economic surveys were started in mid-1983. Based on these studies, experiments with village involvement in planning, implementation and daily operation and maintenance of the handpumps will be undertaken. More affordable latrines will be constructed through village self-help activities, built from locally available materials, instead of relying on costly subsidised materials.

Though these studies and experiments are still in progress, and thus incomplete, some points have emerged relevant for the planning of water and sanitation programmes in general and not only for Bangladesh.

3. Programme Problems

To highlight the issues involved we will draw on three examples.

1. Most handpumps are located more according to the power structure in the village than according to the UNICEF/Government site selection criteria. About one-third of all public tubewells are placed in the inner yard of the pump caretaker, thereby making access difficult for the potential users.

2. The water seal latrines which are promoted by the government and UNICEF are mostly affordable for the relatively well-to-do rural families. Landless families, who constitute about 60-70% of the rural population with a yearly income of approximately US$ 100 (per family), cannot afford to pay $ 6 for a latrine, excluding the superstructure.

3. Health awareness is extremely low. Though 25% of the villagers in a study mentioned contaminated water as a cause of diarrhoea and cholera, nobody mentioned the use of tubewell water as an activity which could promote good health. Presently, no health education is integrated with the water and sanitation programme.

Until very recently the programme was looked upon primarily as a technical activity, i.e. how many tubewells could be sunk and how many latrines could be sold within a given time. Today some of the results of this practice are known:

- 30% of all public tubewells are sunk in the backyard of some influential village persons;
- 20% of all tubewells have been out of order for more than 6 months; and
- 3% of the tubewells are 'temporarily' out of order.

4. Community Participation

Village participation in development projects is today mentioned by all well-meaning development agents as the panacea, the cure to all problems. But even if the government and the present power structure supported such an approach - and did not pay only lip service - it would not automatically solve our problems.

Surely it must be assumed that given appropriate organisational arrangements which would enable the villagers (including the primary users of the water supply, the women) to decide on the site location of the handpump it would result in better accessibility and consequently higher water usage, which is one of the conditions for improved health.

It also seems self-evident that consultation and discussion with the villagers on how to meet their sanitation needs would result in more appropriate latrine technologies than the water seal latrine type used today. At least it might lead to the villagers getting a choice between different types of latrines.

It is also highly probable that health education could have more impact on the formation of 'healthy' attitudes and changed behaviour patterns if health promoters were selected from the villagers, in connection with the water and sanitation programmes.

5. Food and Clothes, Not Water and Latrines

For villagers to participate they must be motivated. Water and sanitation must be perceived to be important problems for them.

In one of the surveys undertaken it was found that water supply and sanitation in most cases were not perceived as important problems for the families. More important were shortage of food, inadequate clothing and lack of agricultural land. However, it was significant, but not surprising, that more women felt water and sanitation to be problems, though never very high-ranking ones.

6. Conclusions

What conclusions can we draw from these few observations mentioned above? The message seems to be that water and sanitation should not be separated from other development activities. Increased impoverishment has rendered water and sanitation of less importance for the villagers than food and clothing. If we want to sell the inputs for the water and sanitation decade, we need to wrap them up with income generating activities; that means reorganising most water and sanitation programmes. Initially, this will lead to a reduced rate of completed projects, but for those who evaluate the success of a programme by its social impact and not by the number of wells sunk/latrines sold and funds spent, it may be worthwhile giving it a try.

The answer to the questions raised in the heading of this paper will therefore depend much on the willingness of the Bangladesh Government,as well as the donors involved, to reorganise the programme and perhaps for a short time proceed at a slower implementation speed.