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COMMUNITY PARTICIPATION IN WATER AND SANITATION

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INTRODUCTION

There is an almost unanimous general agreement to support the proposition that extensive community participation is indispensable to the success of any broad-gauged effort to transform a rural society and to meet the basic needs of its poorest families (ref. 1).

Pieno et al. define 'community participation' as "serving the interests of villagers and helping them to cooperate and be involved in the planning and implementation of water and sanitation or other local programs." They then go on to describe the different degrees and types of participation which they say will "vary from situation to situation." (ref. 2)

Concepts and characteristics of community participation will be discussed in some detail throughout this conference and it is not the intention of the author to go into much detail in defining this concept further here. However, for the sake of clarity, a brief outline of 'community participation' as applied to the project discussed in this paper will be given.

1. COMMUNITY PARTICIPATION

Since Independence great stress has been placed on community participation at all levels of decision making in Zimbabwe. The President, Prime Minister and various Cabinet Ministers have on numerous occasions emphasized the importance of involvement by all the people, all the time, in all decisions concerning their everyday lives.

Since the inception of the water and sanitation programme in the Takawira District, community participation has been a 'built-in' feature of the programme, as it was felt that the local community has an important role to play in rural water-sanitation programmes. The 'community' for the purpose of this project comprised of:

(1) Individuals - women in particular
(2) Local leading citizens
(3) Local Government officials
(4) The Mission Hospital staff and Ministry of Health staff.

This 'community' gradually overcame many 'teething' problems through a careful, patient and at times slow process.

This paper is concerned with the 'individual household' and 'community' aspects of participation in water and sanitation programmes. Participation for basic sanitation - involved mostly only 'households' in the construction of individual family pit-latrines, for the water supply the community consisted of a group of 'households' or an entire village.

2. BACKGROUND

A brief background will be given to the geographical position of the area described in this project and also to the introduction of the programme.

2.1. Geographical Area

The area that this project was carried out in is the Takawira Communal Area (formerly known as Chilimanzi Tribal Trust Land). It is situated south of Mvuma in the Midlands area of Zimbabwe. The District has a total area of 104 207 hectares. The main water supplies of the area are two rivers on the east and west boundaries. There are four main dams, used mainly for irrigation purposes.

The population as per Takawira District Council Development Plan for 1981 is 55 000 (ref. 3), giving an approximate population density of 52 people per km^2.

2.2. Introduction of Project

The protected well and sanitation project was started in the District as a result of an evaluation/follow-up on children who had been discharged from the Nutrition Rehabilitation Centre (N.R.C.) at the District Hospital (St. Theresa's Mission Hospital). On visiting the homes of these children it was soon realized that most of the teaching/discussion on sanitation, hygiene, gardening etc., which had been undertaken at the N.R.C. was more or less ineffective because the parents of these children had neither pit latrines or protected water supplies at their homes. In many instances the water that was available had to be collected some kilometers away from the village, with the result that it would be used only for purely domestic purposes and not for vegetable gardens.

The majority of the parents interviewed stated that their greatest need as far as their family's health was concerned was to

have 'clean water'. At this time (late 1975) there were very few protected wells in the area despite the tireless efforts of the local Health Assistants. There was no felt need among the people for latrines at this time, despite the fact that they had been exposed to a considerable amount of Health Education on the matter.

As a follow-up to this evaluation, the hospital staff discussed the findings with the Hospital Health Advisory Committee (this committee comprised of the following representatives - Senior Hospital Staff, Government Health Assistants, Local Councillors, School Teachers and Local Leaders including Religious Leaders). There was general agreement among the committee members that the time was now 'ripe' to initiate a 'clean water project' as there was a felt need for it in the community. It was also felt that the introduction of the idea combining the construction of latrines with the protected water supply should not be introduced at this time as it was not felt necessary by the community at village level.

3. IMPLEMENTATION OF PROJECT

Over a period of about six months a number of meetings were held with various community leaders to try and plan a suitable, acceptable programme. Many factors had to be taken into consideration in this planning, i.e. time of year when people are available for such a programme, where there were existing 'open' wells already, what type of pumps to be used, degree of involvement and contribution by the local village community etc.

3.1. Health Education for Project

As previously stated there had been an 'expressed need' by certain members of the community (parents of children discharged from the N.R.C.) for such a project. It was felt by the Hospital Committee that this was probably a good reflection of the feelings of the community as a whole; nevertheless it was considered to be of paramount importance to mount a District Health Education Programme in preparation for the project.

Every opportunity was taken to inform the entire population of the District about the proposed project. The two Chiefs in the District gave their full support and encouragement and spoke at gatherings about the proposal. The hospital staff concentrated all their Health Education efforts on water-borne diseases. They used every opportunity, i.e. talks/discussions in the hospital, at the mobile M.C.H. clinics, at Parent/Teacher meetings, council meetings, religious gatherings, clubs - no opportunity was missed to discuss the project.

3.2. Financing the Project

Finance of any project is always an important issue and in particular in a rural Third World Country where there was a war as was the situation in Zimbabwe in 1976.

As the majority of the people in the District were subsistence farmers struggling with the harsh realities of a war situation and very poor soil and trying to provide the basic minimum amount of food for their families, it was decided after consultations with various community members that the hospital (which was run by Dominican Sisters from Europe) would be responsible for trying to raise funds from their home countries for the materials needed for the project.

The community at village level offered as a contribution to the project that they would provide their labour for the digging of the well, the lining of it, and where possible they would collect the pumps and slabs from the hospital in order to keep transport costs to a minimum. The labour of the community was approximately equal to the labour of two adult males working for two weeks (6 day week) in cash terms (based on the minimum wage). This would mean a contribution of about 60% of the total cost of the project. The remaining 40% covered cost of the pump and transport, these being provided by the Hospital. The cement (in part) was given by the Provincial Health Inspector from the Ministry of Health.

3.3. Technical Assistance

It was decided that the most suitable type of pump for the Takawira project was the 'Blair Hand Pump'. This simple hand pump was the result of research and technology carried out by Dr. Peter Morgan of the Blair Research Institute in Harare. The technicalities of the pump will not be described here. It suffices to say that the pump was meant to be 'durable, low cost and easy to assemble and install'. In its original design it was meant primarily for shallow well operation (approximately 6m) which was suitable for the Takawira District as it has a relatively high water table.

This district was one of the first areas to use this pump on a wide scale, resulting in Dr. Morgan visiting the project as often as he could. The project benefited from his technical expertise while he in turn did some 'on the spot' research which resulted in various alterations to the pump.

The assembling of the pumps was carried out by metal-work trainees at the Mission workshop under the guidance of Brother Charles. This workshop was also responsible for making the cement slabs, and for the repair of the pumps when they broke down; the pumps were brought

to the workshop by the villagers for repair.

The siteing of the well was carried out by the Health Assistants at the request of the villagers. The actual digging of the well, carrying of stones for the lining, sand etc. was carried out by the villagers. When the well was completed the Health Assistant sent the measurements to the Mission workshop and the villagers collected their pump which was then installed under the guidance of the Health Assistant.

The three Health Assistants in the District were inundated with requests from villagers to site wells for them and to protect wells once dug. In order to relieve the Health Assistants, the Hospital employed and trained 13 Village Health Workers (V.H.W.s) to assist and work with the Health Assistants. (The V.H.W. project was financed by OXFAM - the water project was part of their work which included an integrated approach to 'total health'.) There were some 'teething' problems initially between the Health Assistants and some of the V.H.W.s as there was no definite 'job description' for the V.H.Ws but this was quickly and effectively sorted out. However it is worth mentioning as it could cause great problems in such a project. It is of the utmost importance to have a clear 'role description' of all participants in such a programme before the programme is commenced.

3.4. Present Situation

As far as was known to the Hospital authorities there were 4 protected wells in the area before the commencement of this project. At the time of this report 302 Blair Hand Pumps have been installed and four boreholes throughout the District as part of the project. The District Administration has agreed to be responsible for the maintenance of the boreholes as the Ministry of Water Development has also installed others in the area during the past year.

It was felt that the time was 'ripe' for some evaluation of this project. A student from the University of Zimbabwe (Matindiki) evaluated this programme and submitted the results as a dissertation in partial fulfillment of the requirements of the degree of Bachelor of Social Work. His findings and suggestions will now be studied as they bring out some very important 'gaps' in the community participation of this project (ref.4).

4. EVALUATION OF WATER PROJECT

This project which was commenced in 1976 was discontinued temporarily in mid-1979 due to the deteriorating security situation in the District. By this time, however, it became apparent that there had been no provision made in the project as to who would be responsible for the maintenance and repair of these pumps. Villagers started bringing broken pumps to the Mission workshop for repair and in some cases pumps were just removed from the well and not brought for repair as people were expecting the Health Assistants or V.H.W.s to go to the villages and do the repairs.

After Independence the project recommenced and it was hoped that villagers would begin to feel responsible for the maintenance but this did not happen. Early in 1982 consideration had been given to the idea of having courses for training villagers to do their own repairs but this did not materialize until the findings of Matindike's report were made known to the Hospital Authorities.

The following are some of the suggestions which Matindike (ref. 4) makes. They are of interest to the Hospital and all participants in the project and also may be of help to others considering such a project.

(i) "There should be short courses on how to maintain water pumps." These have already been commenced but there were problems in this area in so far as that the commercial firm now supplying the pumps wants to sell the pumps assembled which means that they are glued together which makes for 'local repairs' a complex problem.

(ii) "There should be specific water committees to supervise proper use of the protected wells and also to repair the pumps promptly." For the first part of this suggestion it may be possible to get the local (village) health committee interested.

(iii) "The communities should be encouraged to save some money for buying spare parts for the water pump or for buying a new pump when the first one provided by the Hospital is completely worn out." This too is a very important consideration and it is the plans of the education committee to try and integrate this project with other 'community projects' i.e. the co-operative buying of fertilizer etc.

The community participation aspect in the maintenance of the pumps had not been seriously considered at the time of the implementation of the project, but it is a most important area which should not be left out in any planning. It will now be more difficult to introduc e this new concept of community responsibility for maintenance and repairs; nevertheless it is seen as an absolute necessity so that the community feels

totally responsible and 'self-reliant' in this project. Plans are under way to prepare the ground for this important phase which should have been a built-in part of the project right from the time of its inception.

5. LATRINE PROJECT

As mentioned at the beginning of this paper the water project was meant to be part of an 'integrated health and sanitation programme' in the minds of the authorities concerned with the health of the local population. However due to the apparent lack of interest by the community in the latrine aspect of the programme it was felt that the introduction of one concept - the water project - at any one time was sufficient.

Early in 1981 when the majority of the villages had a protected water supply with a simple hand pump installed it was felt that the time was 'ripe' to introduce this next phase of the programme. The same methods as used in the water project were used in motivation, creating an awareness of the importance of latrines etc. As the country was now Independent and people were building up their homes with the hope of a brighter future this new concept of having a latrine quickly caught on. However, it was soon apparent that people were only interested in 'household latrines'. They were quite explicit that 'village' or communal latrines would not be acceptable, mostly from a cultural and hygienic point of view. With this in mind the construction of the 'Blair Ventilated Privy' was commenced with the family providing the labour in digging. Construction was carried out with the aid of the Health Assistants, V.H.W.s and the raw materials were provided by the Mission Hospital.

At the time of writing this paper 580 latrines have been completed in the District. As this project is still in its 'infancy' no evaluation has yet been undertaken but from 'on the spot' checks it would seem that the problems of maintenance etc. of the water project will not be a problem in this case. The community is aware of the fact that the initial material help in this project is a 'one time only' contribution and that for the future, latrine construction will be entirely the responsibility of the family, consequently they must consider this as an integral part of their home budgeting and planning for the future.

CONCLUSION

With the party political structure of Government in Independent Zimbabwe 'community participation' and 'self-reliance' is part and parcel of the everyday life of the people. The party structure includes District Health Committees where the members are appointed by the community. This structure and these goals can be a most important vehicle in the future for all health programmes and in particular for such projects as described in this paper.

Despite the failure of community participation in the maintenance aspect of this project we are hopeful that in future programmes this problem can be prevented by foresight and careful planning.

It has been said that "Women hold the key to the success of new water supply and sanitation projects in much of the developing world" (ref. 5). The scope of this paper has not permitted general comment on the degree of participation by the men and women as groups. However as a final comment I would like to note that without the enthusiastic support and hard work of the women of Takawira District this project would not have gotten off the ground.

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