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REACHING THE UNREACHED: CHALLENGES FOR THE 21ST CENTURY

Learning from half a Century'

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EARLIER THIS YEAR. CARE celebrated its fiftieth anniversary. CARE started by distributing food, "CARE packages", to a devastated Europe but in the late 1940s activities expanded to countries outside Europe. CARE's early activities in what is now known as the developing world were primarily food related and food aid continues to this day as the largest part of CARE's portfolio. The first water projects were not implemented until the late sixties. Projects initially involved working with poor rural communities to construct shallow wells, handpump-equipped boreholes or simple gravity systems with parallel programming in other sectors and in other geographical areas. The next stage of project evolution was the inclusion of relevant programming from other sectors, notably health and hygiene education, sanitation interventions such as latrine construction, and watershed protection. Most recently, emphasis has shifted to those elements that ensure sustainability and impact. These elements have included increased cost recovery (self-financing) for water and sanitation facilities; recovery of operation and maintenance costs; the training of community managers, hygiene educators, community mechanics and caretakers; local availability of spare parts and legal recognition of community management structures.

Anecdotal evidence suggests that this process of evolution has been extremely valuable within country programs. CARE's most successful country programs did not address the difficult sustainability issues at the outset but evolved through a series of projects which benefited counterparts and staff and established growing credibility with communities. There is insufficient time for this evolutionary process to be adopted for new programs but it raises the question of how to move rapidly to an approach which is likely to deliver sustainable services in an adverse sector environment.

Community participation.

Water supply programs start with an inherent advantage: communities are usually highly motivated to undertake and support resolution of critical water supply problems. Without exception, CARE's more successful water and sanitation projects have had significant contributions and involvement of the community. This includes projects implemented under emergency conditions as well as development projects. The strength of community leadership and the existence of community institutions experienced in developmental activities have been used as prior indicators of community participation by projects with an emphasis on sustainability. Mobilization of the community and a positive experience of working together have often led to other developmental activities providing further confirmation that water and sanitation projects can be effective first steps in promoting more permanent community development structures and attitudes within a community.

Demand

Most projects have attempted to provide reliable and convenient access to water, and constructed new water sources that were either closer or provided more water than existing sources. Partcipation has been uniformly high. When the objective has been to improve the quality of an existing and convenient source, there has been much more reluctance to participate and little enthusiasm for contributing community resources towards construction.

When piped water supplies have been constructed, there has been demand for house connections. House connections are an expensive option but in Latin America and East Asia, the marginal cost of house connections over the basic cost of street standpipes has been largely covered by the users. This has reduced the per capita cost provided by the donor to an acceptable level. House connections have greatly facilitated management and acceptance of a fee-for-service payment system. In Africa, communal delivery systems such as wells and standpipes have been the norm. The extent to which users in Africa have been offered house connections, more standpipes or more wells at higher prices is not clear but most projects have been pressured by the users to improve access and limit the number of people using each water point. Users prefer the most private access available, one that is within their control from a technological and social standpoint.

In most integrated projects, water supply activities have taken precedence over other components such as sanitation, hygiene education and watershed protection. The demand from the community has been primarily for water supply, this has been the source of motivation and the principal objective of the community. Projects that directly linked all components to water supply construction, even to the extent of making the completion of other components a pre-condition for water supply construction, have generally been more successful in achieving the targets for other components. (Note that in the past, targets have been more concerned with completion of physical structures or completion of training events than sustained use or behavior change.) Overall, projects that have been able to involve communities and respond to demand in the choice of technologies, level of service and the design of activities are credited with a higher success rate in target achievement and impact.

Health education programs

All current CARE water and sanitation programs have an associated health or hygiene education component. This reflects the importance of the linkage in order to achieve an impact on health. The association has often been problematic. In addition to the priority of most communities for water, much time needs to be invested in each community to achieve hygiene behavior change. The time requirement frequently conflicts with the clear, short timeframes of water supply construction. For example, problems occur when health educators are required to move on to new communities in response to construction schedules. Health education is personnel intensive and the costs are not readily recoverable from the users. Many projects have used volunteers from the community as trainers but without adequate incentives, their level of activity rapidly declines after project completion. Health components are also difficult to evaluate. Evaluations frequently refer to the lack of data to measure progress. Results have often been inferred from the presence and continued operation of a new water source. The more successful projects have overcome these problems through several mechanisms. First, they have convinced donors to allocate sufficient funds to the health education component and been very careful in designing the linkages to the construction phase. Second, they have much more participation from the community, often through health education volunteers, in collecting information, in designing the component and in developing the initial intervention messages based on local beliefs and customs. Finally, projects have begun to make use of effect level indicators such as handwashing rather than impact indicators such as disease reduction which are difficult to measure and attribute.

Gender

Recent projects have targeted women, particularly through specific health messages and encouraging them to act as volunteer trainers at the community level or within community management structures. Most evaluations have recommended greater involvement of women in the design process and all aspects of implementation, operation and financial management. This desire to expand the role of women has been tempered by the realization that excessive pressure from outside on conservative societies can create problems for the project. Progress has been greatest in the areas of hygiene and sanitation where women have been responsible for much of the impact. Participation in other areas has evolved as women have gained confidence.

Operation and maintenance

CARE has had some notable successes in this area. By the mid 1980s in Latin America for example, water systems installed with assistance from CARE were being managed by village cooperatives. Despite this success, two problems are still faced in many locations. First, communities often consider water systems to be the responsibility of government or donors, particularly in countries where the government does not have a clear policy on ownership of systems and communities do not have or cannot obtain legal status. Second, it is difficult to sustain access to spare parts in situations where demand is too small to interest the private sector or where government or other agencies provide limited quantities of spares free or at heavily subsidized prices. A recent CARE study in Latin America of systems between five to ten years old found nearly every system functioning but a wide range of management problems, most of which could have been resolved if one or two days technical assistance had been provided each year.

¹ This discussion paper draws extensively on a personal communication from Mike Godfrey, currently CARE Country Director in Guatemala.