

UMAR & VARMA

41st WEDC International Conference, Egerton University, Nakuru, Kenya, 2018**TRANSFORMATION TOWARDS SUSTAINABLE
AND RESILIENT WASH SERVICES****Partnering with government and communities to achieve
open defecation free status at scale:
an example from the Indian state of Bihar***A. Umar & S. Varma (India)***PAPER 2965**

The Pusa Block of Samastipur District in the Indian State of Bihar accounted for very low sanitation coverage of 16%. This was coupled with poor understanding of roles and responsibilities amongst government functionaries as well as lack of knowledge on the benefits of safe sanitation. The AKDN Initiative demonstrated the impact of effective partnership with government functionaries and communities to achieve open defecation free status at scale. The partnership has focussed on community centred approaches, strengthening of service delivery, improved hygiene behaviours and capacity building of local institutions to improve sanitation access. A key differentiator of the AKDN Sanitation programme is the introduction of mobile monitoring tool-AKVO Flow, which allows project teams to undertake real time tracking of household sanitation coverage as well as monitor improvements in key hygiene behaviour over time. The key results of this programme has been to create ODF communities at scale and sustained hygiene behaviour.

Introduction

Improving access to sustainable sanitation and hygiene continues to be one of the most pressing development challenges for India today. In response to this challenge, the Indian Government launched the Swachh Bharat Mission, or Clean India Mission to create an open defecation free India by 2019. Since the launch of the Swachh Bharat mission in 2014, India's rural sanitation coverage has doubled to 74%¹. In 2015, to support Government of India's flagship programme, Aga Khan Development Network (AKDN) led by Aga Khan Foundation (AKF) launched its Comprehensive Sanitation Initiative. The initiative is a five-year programme aimed at facilitating access to improved sanitation and hygiene for over 700,000 people in six states. A key component is generating demand for hygienic sanitation practices, thereby tackling age-old norms and transforming long-standing behaviour change that improves the quality of life.

Since Bihar is one of the key intervention states under the AKDN Sanitation Initiative. Aga Khan Rural Support Programme (AKRSPI)-a sister agency of AKDN, with support from the Aga Khan Foundation decided to partner with the government and community to achieve sustained sanitation access at scale. Under this partnership AKRSPI has signed Memorandum of Understanding agreements with the Bihar State government to improve sanitation access in two districts. Since the key approach adopted under Clean India Mission is to ensure open defecation free status at scale therefore District administration and AKDN came together to demonstrate a community centred model to achieve Sanitation coverage at scale. A large body of qualitative research points to the fact that, above and beyond demographic factors, social dynamics can influence the decision to build (and use) a latrine (Pattanayak et al. 2009; Jenkins & Curtis 2005; Shakya et al. 2014), therefore the major focus of the intervention has been to adopt community centred approaches to trigger collective community actions.

Rationale

The Pusa Block of Samastipur District records one of the lowest sanitation coverage in the country at 16%. Ranked 633 out of 678 districts in the country as per a recent ranking released by the Indian Government, and counted amongst one of the poorest performing district in terms of sanitation coverage, the need for intervention was immense in Pusa. Indeed the low sanitation access, coupled with poor understanding of roles and responsibilities amongst government functionaries and community members; lack of knowledge of effective strategies to achieve open defecation free (ODF) status as well as lack of knowledge about the benefits of safe sanitation amongst community members, were the primary reasons for intervening in the Pusa Block of Samastipur District. Cognizant that the goal was ambitious and challenging – close to 21,272 households needed access to toilets, a key strategy adopted by the District Administration was to partner with the Aga Khan Development Network, which has successfully demonstrated participatory and scalable approaches in past to improve sanitation coverage.

Objective

The objective of the AKDN Comprehensive Sanitation Initiative in Pusa block of Samastipur district, Bihar is to demonstrate community centred approaches to achieve ODF status. The specific objectives of the Initiative are as follows:

- Increased access and use to sanitation facilities for all households in the Pusa block.
- Improved hygiene practices and behaviour amongst target communities.
- Empowered community institutions to plan, prioritize, and promote sanitation in villages.
- Promoting inclusive approaches and gender mainstreaming to Improve sanitation access.

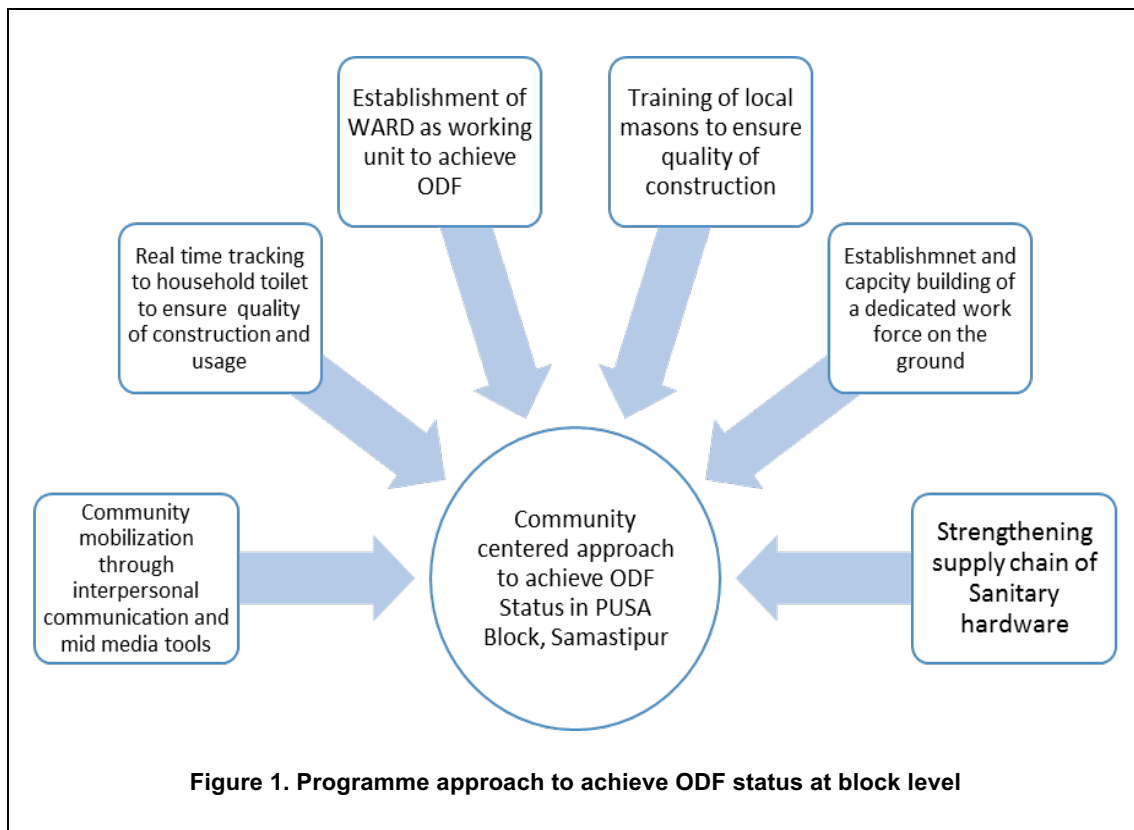
The Partnership approach to achieve result at scale

It is widely acknowledged that many non-governmental and development organizations, recognize the importance of closely working with governments in sanitation and hygiene programmes to make impact at scale. In many countries, community focused approaches are being embraced by governments as an alternative to traditional subsidy and enforcement-based approaches (Local Governance in Sanitation, GSF note 2017). The current AKDN intervention has showcased an approach of collaboration and partnership within government-civil society organisations and community level institutions. District Collector, the head of the District, acting as champions for the programme was a strategic resource for enhancing coordination, motivating staff, enlisting the support of other actors, and even leveraging additional resources to achieve the objective. The District Collector, also mobilized staff from other departments to support field level efforts in carrying out the awareness activities. The Block Support Unit (BSU) was constituted by the District, ably supported by AKRSPI. The BSU, headed by the Block Development Officer, comprised of key officials from the District administration, with responsibility of specific Gram Panchayats (GPs) to ensure the GP's achieve ODF status. In this manner, all GP's of the Pusa block had a dedicated nodal officer in charge of the progress. Appointing a nodal officer for GP's thus did two things: it not only ensured that the entire district workforce was committed and involved in the campaign, but also promoted downward accountability: issues regarding fund mobilization, and disbursement, or other such related challenges were now resolved at the BSU level itself, and did not have to be escalated to the district, reducing unnecessary delays.

Under the agreed partnership model, AKRSPI on the other hand brought its strength in community mobilization, masons training, supply side strengthening, to the table and built the capacity of the dedicated workforce to work on this campaign. On its part, AKRSPI recognized that two things were absolutely critical to the success of this programme: Building the capacity of trained workforce or motivators who could become ambassadors of change, and empowering local village institutions and front line health workers to take forward to task, guided by the belief that these local village institutions are a key stakeholder in the achievement of open defecation free villages. As a result, one of AKRSPI's first tasks was to organize a capacity building workshop for local Panchayat Raj Institution (PRI) members and district officials to develop a joint action plan. Intensive trainings for block and district officials on Community Led Total Sanitation (CLTS) were organised to build their capacity in undertaking this crucial sanitation action plan exercise, given that CLTS has been successful in many parts of the world (Pickering et al. 2015).

Discussions also took place on the roles and responsibilities of PRI and on the constitution of 'Nigrani Samitis'- the ward level committees, comprising village members and community leaders which need to be established once the villages are declared ODF, to ensure there are no slippages and all households use the

toilets that have been constructed. Disbursement of incentives has been one of the widely acknowledged and critical bottlenecks in the implementation of the sanitation programme following the completion and verification of toilet construction. In Pusa, however things assumed a different pace. Swifter resolution of issues was made possible by regularizing weekly review meetings chaired by the District Magistrate himself- a conscious move by AKRSPI and the Administration to ensure limited delays in implementation. Issues related to quality construction, fund disbursement and resolution of land disputes were all part of the fortnightly reviews.



Implementation strategy

Creation of an open defecation free block requires a different implementation strategy, which involves establishing partnerships at various levels to ensure quality implementation since it is widely acknowledged that defecation behaviours are influenced by contexts and culture (Christensen et al. 2015; Srivastava 2014). With the objective of achieving block ODF in Pusa, a strategy to demonstrate an integrated model that not only looks to strengthen the supply chain; but also supports the empowerment of local village institutions, includes hygiene promotion and caters to ensuring water, sanitation and hygiene access to both household and school level, was adopted. Under the agreed strategy, the following interventions were undertaken:

1. Creation of an enabling environment among all stakeholders at district/block and GP levels – By Conducting sensitization workshops for District Water and Sanitation Committee (DWSC) members and Block Functionaries, and assisting them in the preparation of Open Defecation Elimination Plan. Organizing a block level convention of local village institution members on their roles and responsibilities with respect to sanitation promotion was also undertaken
2. Strengthen service delivery and capacity of key stakeholder’s on planning and implementation - While building awareness and demand for sanitation was important, it was equally important to ensure the availability of trained masons and good quality construction materials to cater to this demand. A backward calculation was undertaken at the consultative workshop to ascertain the number of trained masons needed to address the rapid demand for toilet construction. In order to facilitate and accelerate large-scale construction of good quality household toilets, AKDN Team conducted 8 mason trainings, reaching out to over 250 masons. These trainings lent technical and theoretical expertise, and were

- conducted in batches of 40 masons over three days, producing a cadre of skilled masons. To ensure that the increased demand does not lead to surge prices of construction materials, project team with support from district magistrate also facilitated a dialogue between local vendors such as concrete ring pit and door manufacturers and the district administration.
3. District level CLTS trainings were also organised to build the capacity of block and field officials to adopt participatory approaches of planning, implementation and follow up
 4. To promote access and awareness of safe drinking water in the communities, AKRSPI established a mini drinking water laboratory in the Pusa block to develop community's understanding of the need for safe drinking water as well as to develop a sense of ownership and practice to routinely maintain their drinking water sources.
 5. Community led approaches are innovative methods for mobilising communities to eliminate Open Defecation. It targets a multitude of community-level sanitation behaviours aiming at collective action (Kar & Chambers 2008). The project thus focussed on collective behaviour change to achieve result at scale. Project teams organized trainings for various stakeholders including teachers, students', self-help group members, women's groups, adolescent girls, mother's groups as well as youth forums. AKDN also actively involved and trained front-line health workers to undertake hygiene promotion. A range of communication tools such as puppetry, rallies, cleanliness drives, home visits, community meetings, morning follow up visits have immensely helped in collective actions and to ensure improved hygiene behaviour. Project teams also introduced contextualized communication materials for targeted Behaviour Change on personal hygiene, importance of toilet access, clean village environment and safe water handling practices.
 6. Gender mainstreaming and inclusive approach: In addition to designing specific interventions for addressing the needs of women and girls vis-à-vis sanitation, health and hygiene, women's groups have also been actively involved in sensitization efforts. AKDN has also introduced specific training module to lend technical support to strengthen Menstrual Hygiene Management (MHM) efforts. Building on this partnership, training and awareness sessions are organized with adolescent girls and self-help groups to strengthen knowledge and practice with respect to MHM. Women's groups are also engaged in community sensitization efforts and several groups have taken the lead to promote sanitation access in project villages.

Table 1. Key behaviour and socio-economic indicators using AKVO Flow		
Key behaviour and socio-economic indicators	1. data as on 2/23/2017	2. data as on 9/1/2017
Knowledge and practice on Key Hygiene behaviour	32%	45%
Usage by Elderly	98%	98%
Usage by differently abled	98%	98%
Motivating factors for constructing toilets		
Convenience	13%	31%
Per pressure	12%	02%
Safety	20%	21%
Health Concerns	21%	16%
Correlation between economic category and technology		
Above Poverty Line-: Double pit	44%	58%
Below Poverty Line: Double Pit	85%	89%
Above Poverty Line: Septic	40%	38%
Below Poverty Line: Septic	12%	8%

Results

Today, the block has formally been declared ODF- and the focus is now on ensuring that these efforts are sustained, people continue to use facilities and adopt hygiene behaviours. One of the key objectives of the programme was to increase sanitation access and coverage at scale. Through collective efforts, this has now been achieved and all 21,272 households in the Pusa block have access to household toilets. Further, data also reveals the impact of sustained behaviour change and hygiene promotion efforts: the above table demonstrates improvements in key hygiene behaviours such as knowledge in handwashing and water storage practices from 32% to 45% over the project period. Further, while the intervention has focused on universal access, it has adopted inclusive approaches to prioritize the needs of the most marginalized categories of potential users, thus bridging the gaps in access to and use of appropriate sanitation and hygiene services for differently abled; old aged and children under-five. Data informs us of the high rates of usage by both elderly and differently abled: out of 641 differently abled members and 2134 elderly members surveyed, 98% differently abled and an equal number of elderly members responded were accessing the facilities. The high percentage of usage by vulnerable groups clearly reflects the adherence to quality and adoption of standards norms of construction by the field teams.

Recognizing that the presence of facilities alone will not support improvements in hygiene behaviours, AKDN team has also initiated a programme in schools, where through the active involvement of teachers, students and the wider community it is ensuring regular hygiene promotion classes are conducted in schools, and children become ambassadors of change in their communities. One of the key results of this programme has been to create ODF communities at scale that has led to a series of direct and indirect impacts. By ensuring sanitation coverage at scale, anecdotal evidence suggests that sanitation access has particularly helped reduce the stress, indignity as well as safety concerns that accompanied open defecation amongst women. Women have also discussed that they now have more quality time to devote to income generation activities or household and child-care.

Conclusion

One of the chief reasons for the success of the programme has been the robust partnership between the Governments, civil society actors, local community based organisations and empowered local village institutions. A key learning of the programme has been to empower local village institutions and premise the key role played by key government officials. Taking note of the key role played by local institutions and government officials, the Indian State governments recognized the importance of empowering local institutions to promote community-based action for sanitation and hygiene. This was done by incentivizing communities once ODF Status is achieved. That has led to collective community action to achieve ODF status, an approach that resonates with research, which affirms that participatory, collective efforts of people have resulted in positive changes at community level (Akter & Ali 2014; Bisung et al. 2015; Sigler et al. 2015; Hetherington et al. 2017).

The programme also showcased the key role played by women led self-help groups in motivating behaviour change at the grass-root level and its impact on a community led sanitation programme. With over 21,000 households that required to construct household toilets within a set time frame and in recognition of the need to ensure the same quality and intensity of messaging in not just in one but in all 13 GPs, the programme successfully leveraged the platform of women Self-help groups to undertake sanitation messaging. Owing to their personal experiences, the women SHG members were strongly committed to spreading the message of hygiene and sanitation and became key voices on the ground. Regular household visits to explain the negative impacts of open defecation on health, encouraged their fellow community members to construct household toilets and also suggested ways in which they could accumulate funds for the construction.

Another key lesson under the Initiative was to introduce a robust mobile based monitoring system to improve implementation and track sustainability. Data collected through mobile tool Akvo, was reviewed through weekly reviewed meeting chaired by the District Collector, which ensured objectivity and timely feedback on the quality of implementation.

Indeed, the Sanitation program in India is has made huge strides since 2015. However, progress continues to be inconsistent across geographies, especially in geographies characterized by dense population, high water table conditions, and vulnerable sections. This programme has successfully demonstrated that in such difficult terrains, it is the coming together of key stakeholders such as government officials, local village institutions, women's groups, and the facilitation by external players, can improve sanitation coverage at

scale, and make a difference to the National campaign, helping India meet its commitment to the Sustainable Development Goal -6.

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References

- Jenkins, M.W. & Curtis, V., 2005. Achieving the “good life”: Why some people want latrines in rural Benin. *Social Science and Medicine*, 61(11), pp.2446–2459.
- Pattanayak, S.K. et al., 2009. Shame or subsidy revisited: Social mobilization for sanitation in Orissa, India. *Bulletin of the World Health Organization*, 87(8), pp.580–587.
- Shakya, H.B., Christakis, N.A. & Fowler, J.H., 2014. Association Between Social Network Communities and Health Behavior : An Observational Sociocentric Network Study of Latrine Ownership in Rural India. *American Journal of Public Health*, 104(5).
- Kar, K. & Chambers, R., 2008. Handbook on Community-Led Total Sanitation, Available at: <http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/cltshandbook.pdf>.
- Ministry of Drinking Water and Sanitation –India (2018) <http://sbm.gov.in/sbmdashboard/Default.aspx>
- Christensen, G. et al., 2015. Pilot cluster randomized controlled trials to evaluate adoption of water, sanitation, and hygiene interventions and their combination in rural western Kenya. *American Journal of Tropical Medicine and Hygiene*, 92(2), pp.437–447.
- Pickering, A.J. et al., 2015. Effect of a community-led sanitation intervention on child diarrhoea and child growth in rural Mali: A cluster-randomised controlled trial. *The Lancet Global Health*, 3(11), pp.e701 e711
- Akter, T. & Ali, A.M., 2014. Factors influencing knowledge and practice of hygiene in Water, Sanitation and Hygiene (WASH) programme areas of Bangladesh Rural Advancement Committee. *The international Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy*, pp.1–10.

Notes

Block is a development and mid-tier administrative unit in rural settings of India. Within a block there are number of Gram Panchayats and on an average the population of one block ranges between 125,000 to 200,000. Gram Panchayat is lowest tier of administrative unit in rural India.

¹ Data available with the Ministry of Drinking Water and Sanitation, Government of India: <http://swachhbharatmission.gov.in/sbmcms/index.htm>

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