

MOMMEN & MORE

36th WEDC International Conference, Nakuru, Kenya, 2013**DELIVERING WATER, SANITATION AND HYGIENE SERVICES
IN AN UNCERTAIN ENVIRONMENT****Open defecation free Odisha: achievable or a pipe dream?
An analysis of sanitation promotions in Odisha, India***Brecht Anne Mommen & Pravin Santosh More, India***BRIEFING PAPER 1819**

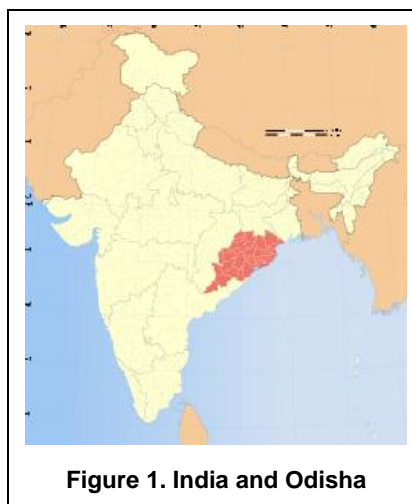
India has the largest number of people practising open defecation in the world; hence progress made by India is of crucial importance to meet the global MDGs and the post 2015 agenda. The state of Odisha has the second largest proportion of people practising open defecation in India. The paper analyses the policy, socio-cultural norms and dynamics affecting the state of Odisha and its struggle to eliminate open defecation. It covers the historical perspective on the approaches used by the Government of India and Odisha. Based on the results and the acquired insights, policy recommendations are provided to achieve an open defecation free state.

Background

The practise of open defecation has a drastic impact on child survival rates and child development. Diarrhoea causes the deaths of 1.5 million children under five globally every year. UNICEF/WHO estimate that 88% of deaths due to diarrhoea can be directly attributed to unsafe water, poor sanitation and inadequate hygiene (UNICEF/ WHO, 2009). It is estimated that 27% of under-fives globally are stunted. On-going research on Tropical Enteropathy, a subclinical disorder of the small intestine which reduces the nutrient absorption capacity, suggests that the unhygienic conditions have strong implications on the development of children (Humphrey, 2009).

India is facing a huge challenge achieving its Millennium Development Goals (MDGs). India accounts for nearly 60% of the world's open defecators globally - a staggering 626 million people (WHO/ UNICEF, 2012). India also has the largest diarrhoea under-fives mortality figure, some 386,600 deaths per year; more than a 1,000 young lives lost per day on average (WHO/ UNICEF, 2009). The nutritional status of children in India is similarly alarming: 48% of under-fives are stunted, which is higher than in countries like Democratic Republic of Congo, Pakistan and Zimbabwe (UNICEF, 2012a). This is in sharp contrast with India's economic growth and superpower aspirations. Hence, the urgency to achieve an 'Open Defecation Free (ODF) India' cannot be overstated.

The State of Odisha is one of the 28 states, and is located in the east of the country with a large tribal population. Odisha has a total population of 42 million, comparable with Kenya (42 million). The population includes, 5 million under the age of six (Ministry of Home Affairs, MHA, 2011) and 8 million Scheduled Tribes, historically disadvantaged people recognized in the Constitution of India (MHA, 2001). Odisha is lagging behind on social and development indicators and was ranked 22nd out of 23 states by UNDP using the Human Development Index values (UNDP, 2011).

**Figure 1. India and Odisha**

Historical overview of the sanitation sector

Odisha being part of the federal system, the implementation of sanitation promotion has been guided by Government of India (GoI) programs. The rural sanitation programme was introduced across India in 1954 with a focus on the liberation of scavengers till mid-1980s (Ministry of Housing and Urban Poverty Alleviation, MHUPA, 2007). During the International Decade for Water and Sanitation (1980s), the sector received a boost with the transfer of rural water and sanitation from the Ministry of Urban Development to the Ministry of Rural Development. The government’s Centrally Sponsored Rural Sanitation Programme (CRSP) was launched in 1986 with an objective to improve the quality of life of the rural people and provide privacy and dignity to women. Being target driven, the focus of CRSP remained on toilet construction with a subsidy for Below Poverty Line (BPL) households (Ministry of Drinking Water and Sanitation, MDWS, 2011). The 73rd Constitutional Amendment was adopted in 1993 aiming at decentralized governance facilitating bottom-up planning for various government programs.

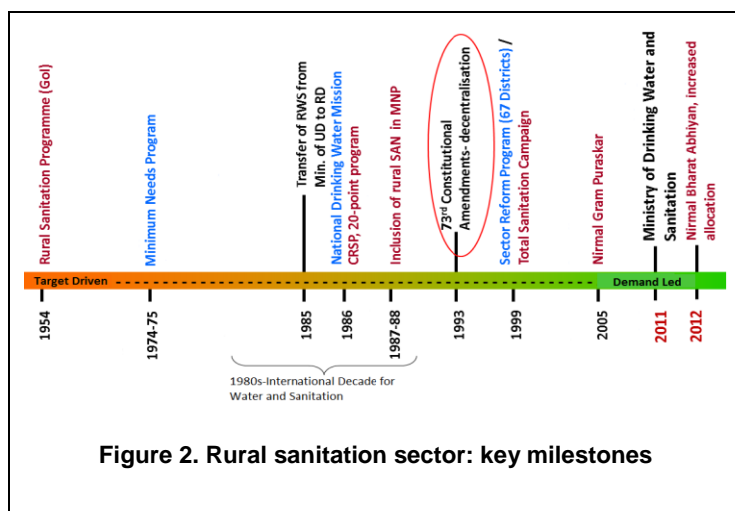


Figure 2. Rural sanitation sector: key milestones

Due to the limited success of CRSP, a demand driven approach was adopted and the ‘Total Sanitation Campaign’ (TSC) was launched in 1999. As per TSC guidelines, the toilet construction subsidy was converted into a post construction and use incentive for BPL households (MDWS, 2011). In order to give thrust to the program, the GoI launched *Nirmal Gram Puraskar* (or Clean Village Award) that seeks to reward the community achievements and efforts in ensuring complete sanitation coverage.

With the formation of separate Ministry of Drinking Water and Sanitation (MDWS) at National level, the sector has gained further prominence and priority. This also included a revision in the TSC, which has been renamed as ‘*Nirmal Bharat Abhiyan*’ (Clean India Campaign) in 2012. The key changes included: a) convergence with Mahatma Gandhi National Rural Employment Scheme (MGNREGS), b) increase in the incentive amount with a total of 9,100 INR (170 USD) allocated per household and c) further decentralization of the implementation (MDWS, 2012).

Sanitation progress in India

Across India substantial progress has been made in terms of construction of toilets. Out of the target of 126 million, a total of 90 million (71.8%) households have reportedly been covered (MDWS, 2013). However, there are concerns around the accountability of these figures as well as the sustainability of the constructed latrines. Despite these achievements, the practise of open defecation in India remains widespread. The 2011 official Census indicates that 69.3% of the rural population still practice open defecation, compared to 78.1% in 2001, a reduction of merely 8.8% over the decade. There is a huge gap of about 40% between the reported and surveyed toilet coverage, as presented in Figure 3.

There is little evidence on the positive correlation between the fund utilization and the increase in toilet coverage. A recent research by accountability initiative (Kapur and

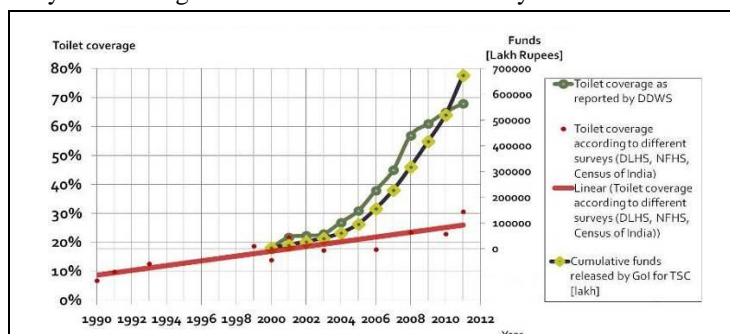


Figure 3. Reported and surveyed rural sanitation coverage VS funds released, India

Source: (<http://www.communityledtotalsanitation.org/blog/hypothesis-monitoring-system-india-s-total-sanitation-campaign>)

Chowdhury, 2013), concludes that there is no correlation between the expenditures and the actual toilet coverage. This raises serious questions about the effectiveness of the TSC across the country.

Concerns on sustainable toilet use have been registered by the Planning Commission of India. In its approach paper towards the 12th plan (2013-2018) the Planning Commission noted that the success of TSC in toilet construction was undermined by limited sustained toilet use. The paper identifies the target driven approach, top down Information Education and Communications (IEC) strategies with limited inter-personal communication and limited technological options the root causes. It advocates for community driven approach leading to a commitment of the community to improve sanitation (Planning Commission, 2011).

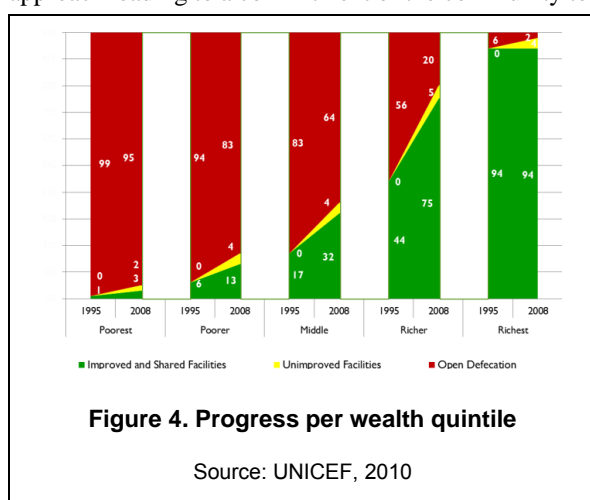


Figure 4. Progress per wealth quintile

Source: UNICEF, 2010

Moreover, the effectiveness of the targeted approach towards the rural poor is also under debate. Wealth quintile analysis using disaggregated data shows that the progress made between 1995 and 2008 was in the top three quintiles. The progress made by those in the bottom two quintiles – the targeted poor, was actually the least of all five wealth quintiles (UNICEF, 2010). This data seems to conclude that the targeted approach is not achieving the intended results.

Across the country, the results of TSC are not uniform and some states have done better than others. For example; Sikkim has been declared ODF, Himachal Pradesh and Haryana increased toilet coverage by 38.9% and 27.4% respectively

over a decade (MHA, 2001 and 2011) and the state of Maharashtra received 34% of all the Nirmal Gram Puraskar (NGP) awards since its inception (MDWS, 2013). This generates the question, of “what are these states doing differently?”. An assessment study of TSC initiated by the Water and Sanitation Program (WSP, 2010), comparing high performing states with less performing states, provides the following insights:

- States focusing on behavioural change rather than on toilet construction perform better;
- States which focus on demand creation where communities can choose their own toilet designs perform much better than those who construct toilets without proper demand creation and with a predetermined design;
- States which use the incentives to reward collective behavioural change perform better than states which use the incentives as a subsidy for individual household toilet construction.

Odisha, as a less performing state has chosen to focus on toilet construction above toilet use.

Results in Odisha

In Odisha, out of 7 million targeted, 3.9 million (55.9%) rural household toilets have reportedly been constructed. However, the 2011 Census shows only 14.1% of rural households as having access to sanitation facilities. With 84.7% rural households practicing open defecation, Odisha is among the states with the lowest household toilet access along with Jharkhand (91.7%) and Chhattisgarh (85.2%) (MHA, 2011). Between 1993 and 2011 toilet coverage in Odisha increased from 1.4% to 14% - an annual increase of around 0.7% (Figure 5). At this pace the MDG target of reaching 50% of the rural households with improved sanitation will only be reached by 2061.

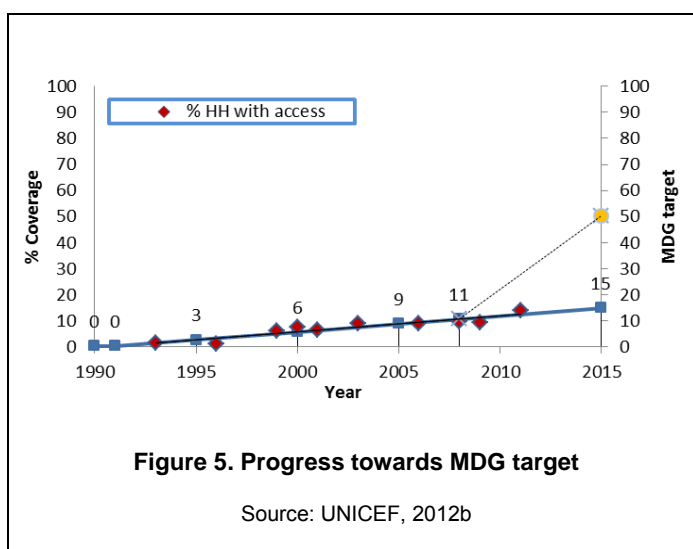
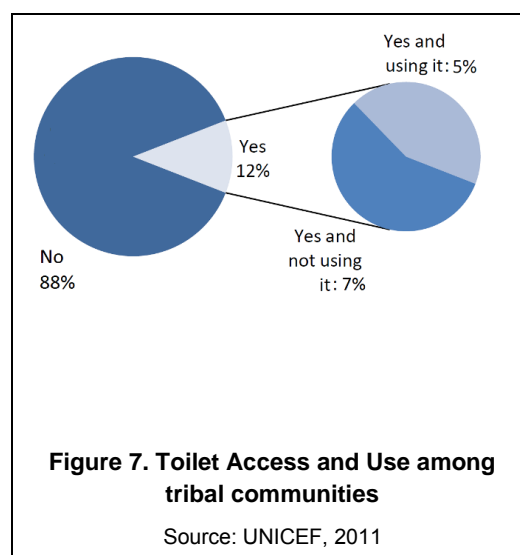
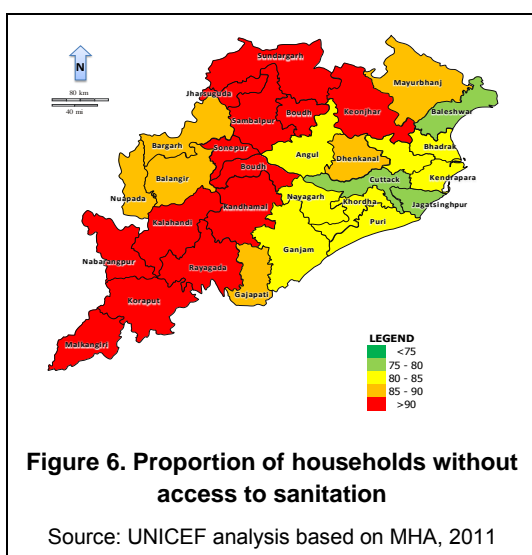


Figure 5. Progress towards MDG target

Source: UNICEF, 2012b

The lack of ability to accelerate access to improved sanitation and meet the MDG, poses a huge challenge. The progress so far, both at national and state level reveal a fundamental challenge in switching over to demand led approach focussing on behaviour change, i.e. the motivation to use a toilet prior to constructing a toilet. Unless this issue is addressed it is expected that the current trend will continue.

Similarly the progress in Odisha is not uniform across districts with some districts performing better than others. The best performing districts are more developed and located near the coast, while the interior districts mostly inhabited by tribal communities are poor performers. This trend is also confirmed by the national statistics, as tribal communities predominantly fall under the lowest quintiles.



The tribal context in Odisha

In 2011, UNICEF supported Government of Odisha through a Knowledge Attitude and Practice (KAP) study (UNICEF, 2011) to assess the uptake of sanitation and the associated barriers among the tribal community of Koraput District. The key findings included:

- More than half of the population is aware about the negative health aspects of Open Defecation but continue to practice the same.
- While 12% of households have access to a toilet only 5% of households use the toilet.
- A major reason cited for not using the toilet is the difficulty of changing longstanding cultural practices.
- The messages and communication materials are not seen as relevant to the audience (people do not recognize themselves as the target audience).

Open defecation being a longstanding cultural practice / social norm emerged as most critical issue. Field observations by the authors and interactions with the community on several occasions revealed that the constructed toilets are used only for ‘emergencies’ such as: during diarrhea, rains or in the middle of the night. Many reported that they feel shy to use the toilet as ‘family and neighbors know what they are doing there’.

In the presence of the constrained circumstances, UNICEF has supported various Community Approaches to Total Sanitation (CATS) in the tribal district of Koraput; these are presented in the Box 1.

Box 1. Community approaches to Total Sanitation

Self help group led sanitation promotion: As a demonstration, women's Self Help Groups (SHG) in the district were mobilised to promote sanitation in their respective villages. The SHGs were provided with technical support and revolving funds to organise sanitation supply chains. Local masons were trained in toilet construction. Though not all SHGs were successful, the majority have shown that transformation is possible. The members decided on location of the latrine, use of construction material and technology and so far one village has been declared open defecation free.

Community-led total sanitation: The CLTS approach was used in another community to trigger collective behaviour change. The community showed its resolve and demonstrated the success within a week. The government is now supporting the community financially and technically on household latrines as a long term solution.

Both the approaches seem to achieve better results than the conventional approach. The unique feature of both the approaches was that the community chose to move forward collectively by distributing the financial support amongst all community members and individually picked suitable sanitation options. UNICEF is in the process of documenting these approaches for the purpose of learning and sharing.

The process of change in Odisha

The revision of TSC into NBA and the limited progress during the past has provided a window of opportunity for change in sanitation promotion in Odisha. At the time of writing this paper, UNICEF is supporting the Government of Odisha in developing the state specific implementation guidelines for NBA. Consultations are being organized with the government and non-government stakeholders. The aim of these consultations is to develop alternative approaches based on the lessons from the past experience and potential/ tested innovations.

The key reflections from the consultations (UNICEF, 2012c) are- a) there has been mismatch between the policy guidance, which advocated for demand driven approaches with 'no to low subsidy', while the implementation focussed on the toilet construction with gradual increase of incentives (read subsidy); b) In the past, the IEC initiatives were event based and focused on mass media, posters etc.; and c) programme monitoring was primarily built around financial and physical progress reporting instead of outcomes, i.e. ODF communities. Although work is on-going, the following observations are made by way of recommendation:

- Achieving collective behaviour change towards ODF communities should be the core of NBA or any other sanitation promotion campaign and ought to be reflected across all levels and approaches.
- Incentives should be awarded at various stages for achieving collective behaviour change rather incentivising individual household constructions. The evidence suggests that targeted benefits do not reach the intended beneficiaries. The prioritization of government schemes, such as piped water supply, could further incentivise collective achievements, without the requirements of additional funds;
- IEC activities, should be tailored to suit the local context and move beyond awareness creation towards collective behavioural change. An emphasis should be given in interpersonal communication, focusing on changing the social norms, perceptions and behaviours. Community Approaches to Total Sanitation (CATS) should be adopted;
- Technology choices should be left to the communities; engineers should facilitate these choices and ensure that sanitation options are safe and provide adequate privacy;
- Outcome monitoring should be emphasized; currently, there is limited experience on outcome monitoring. Research and documentation on effective monitoring mechanisms including independent verification is recommended.
- Adopt a continuous process of bottom up planning, learning and sharing. There are various examples of success in the districts, which have not been shared. A systematic process of documentation and sharing could support the scaling of these initiatives across the state and shape the enabling environment.

References

- Humphrey, Jean (2009). *Child undernutrition, tropical enteropathy, toilets and handwashing*. The Lancet, 374 (September) 2009.
- Kapur, A. and Chowdhury, A. (2013). *Total sanitation campaign GoI 2012-2013*. Budget Briefs – Sanitation Sector, 4 (2), 1-8.
- Ministry of Drinking Water and Sanitation, (2011). *Guidelines, Central Rural Sanitation Programme, Total Sanitation Campaign*. New Delhi: Government of India, 2011.
- Ministry of Drinking Water and Sanitation, (2012). *Guidelines: Nirmal Bharat Abhiyan*. New Delhi: Government of India, 2012.
- Ministry of Drinking Water and Sanitation (2013). *Nirmal Bharat Abhiyan physical progress report*. <<http://tsc.gov.in/tsc/Report/Physical/RptPhysicalProgressStateWiseDistrictwise.aspx?id=Home>> [accessed 6 February, 2013]
- Ministry of Home Affairs, (2001). *Census of India, 2001*. New Delhi: Government of India, 2001.
- Ministry of Home Affairs, (2011). *Census of India, 2011*. New Delhi: Government of India, 2011.
- Ministry of Housing and Urban Poverty Alleviation (2007). *Evaluation and impact assessment of integrated low cost sanitation scheme*. <<http://mhupa.gov.in/FinalRepILCS.htm>>. [accessed 4 February, 2013]
- Planning Commission (2011). *Faster, sustainable and more inclusive growth: an approach to the twelfth five year plan*. New Delhi: Government of India, 2011.
- UNDP, 2011. *Orissa economic and human development indicators*. http://www.undp.org/content/dam/india/docs/orissa_factsheet.pdf [accessed 5 February, 2013]
- UNICEF (2010). *Progress for children: achieving the MDFs with equity* – Number 9, 2010. New York: UNICEF, 2010.
- UNICEF, (2011). *Study to assess gaps responsible for low utilisation of TSC amongst tribal population in Odisha*. New Delhi: UNICEF 2011.
- UNICEF, (2012a) *State of the world's children*. New York: UNICEF, 2012.
- UNICEF (2012b). *Analysis based on Census of India (2001 & 2011); National Sample Survey (49th round-1993, 52nd round-1996 and 65th round-2009); National Family Health Survey (1993, 1999, 2006), Multi Indicator Cluster Survey (2000); District Level Household and Facility Survey (2003, 2008)*, New Delhi: UNICEF, 2012.
- UNICEF, (2012c). *Report on the consultative workshop on formulation of state specific guidelines of Nirmal Bharat Abhiyan*. Bhubaneswar: UNICEF, 2012.
- WHO/ UNICEF (2009). *Diarrhoea; why children are still dying and what can be done*. Geneva: WHO/UNICEF, 2009.
- WHO/ UNICEF (2012). *Progress on Drinking Water and Sanitation, 2012 update*, pp.20
- Water and Sanitation Program WSP (2010). *A decade of the Total Sanitation Campaign: rapid assessment of processes and outcomes*, New Delhi: WSP, 2010.

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Both the authors are employed by UNICEF India Country Office. However the views expressed herein are those of the authors and do not necessarily reflect the views of UNICEF.

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