

Formative
Research
to Develop
Appropriate
Participatory
Approaches
towards Water,
Sanitation, and
Hygiene in
Rural Areas



India WASH Forum | May 2016





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Formative Research to Develop Appropriate Participatory Approaches towards Water, Sanitation, and Hygiene in Rural Areas

India WASH Forum

May 2016



Acknowledgement

We are grateful to the World Health Organization (WHO) office in Delhi for supporting this intensive formative research on sanitation and hygiene.

We applied certain research tools that were developed specifically for carrying out this study. The research tools were essentially open-ended and were designed for examination of deeper underlying causes of people's resistance to adopt improved and safe sanitation and hygiene. The study was conducted on a wide cross section of rural communities—men, women, adolescent boys and girls, children, people with physical disabilities, panchayats, self help groups (SHGs), aged people, people with disability, school teachers, and ANM/AWWs in each village.

The research has come out with specific findings and recommendations that we hope will be useful for both States and Central Government for NGOs, researchers and anyone interested in practical implementation as well as policy making. We believe the findings of this qualitative research will be useful for a wide range of rural sanitation contexts in India and elsewhere. The research team consisted of development and WASH sector experts with extensive experience that has been pooled into generating this national level report on sanitation and hygiene for India. The Prime Minister has given a call for an Open Defecation Free India by 2019, and we hope to contribute to this purpose through this modest contribution.

We are grateful to all the people we interviewed and who patiently responded to our consecutive questions to meet our inquisitiveness about why they are not building or using toilets, what will make them do so, and what threshold level of motivation or incentives are needed.

We sincerely thank all the government officials, teachers, staffs of NGOs who partnered in this work.

Nafisa Barot | Murali Ramisetty | Depinder Kapur

– May 2016 –



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Research Methodology

Objective of the Research

India faces the twin challenges of having the most number of people in the world defecating in the open and also for the burgeoning crisis of untreated fecal waste that is contaminating our surface and ground water creating an imminent health crisis. The latest Swachhta Stats Report¹ shows an encouraging 45% rural sanitation coverage by mid 2015 as against the 31% coverage in 2010 Census. Both motivating people to build and to use toilets is emerging as a major national priority as outlined in the Swachh Bharat Mission initiated by the Honourable Prime Minister for achieving open defecation free India by 2nd October 2019.

Ending open defecation and behavior change to motivate people to build and use toilets is seen a rural sanitation challenge. Treatment and safe disposal of fecal waste generated from septic tanks and the partial sewerage systems in urban areas is seen as an urban sanitation challenge.

Different sanitation promotion programming approaches have been adopted worldwide by NGOs and international agencies specially, to encourage, motivate and also coerce

people to stop defecating in the open and to build and use toilets. A compendium of different Hygiene and Sanitation Software approaches was recently compiled by WSSCC². Most Behaviour Change Communication (BCC) in WASH till date has relied on employing typical market research approach (addressing emotional, psychological, and entertainment based stimuli) in behavior change message development. Community Led Total Sanitation (CLTS) has emerged as a popular programming tool for community level sanitation behavior change.

Most sanitation promotion approaches are only partially successful in providing short term increases in sanitation coverage and usage. BCC messages designed as marketing interventions often fail to address deeper underlying causes of resistance behind people's reluctance to adopt improved and safe sanitation and hygiene (or even physical barriers like water availability).

This study was an intensive qualitative research, undertaken with the objective of understanding perceptions, barriers, and motivators for improved sanitation behavior in rural India.

2 – http://www.sswm.info/sites/default/files/reference_attachments/PEAL%202010%20Hygiene%20and%20Sanitation%20Software.%20An%20overview%20of%20approaches.pdf

Social research is always carried out in a dynamic reality. Asking basic questions about WASH behaviours, barriers and motivators of sanitation, needs to be done regularly.

For carrying out this study, we tried to find answers to the following questions:

- Are there barriers to sanitation arising owing to lack of knowledge and ignorance about the benefits of having and using toilets or from deeper level self perception barriers of caste, class and gender?
- Who among a village habitants are adopting building and using toilets and why? What are the typologies within and across the states studied?
- At what threshold level are more people willing to adopt or change their behaviors to start building and using toilets?
- What is the role of BCC messaging and how is it perceived by the people? Why is it not working? What should the BCC messaging be, what it should reinforce and what it should encourage?

Rural communities are not homogenous; they are also very divergent across the mountains, plains, deserts and coastal areas of India with mixed caste, tribal and Dalit composition. This study investigated how different disaggregated sets of people respond to the same questions on barriers to sanitation – women, men, adolescent

1 – http://mospi.nic.in/Mospi_New/upload/Swachhta_%20Status_Report2016.pdf



girls and boys, children, old and infirm, tribal and non tribal communities, village level functionaries, etc.

For a large country like India, with different social and economic contexts, this research tried to take more than a snapshot of the rural sanitation reality of India. It tried to probe deeper into the social as well as individual level by trying to understand and identify the profound social and individual barriers if any, so as to know the ways in which different stakeholders are influenced by an interplay of different factors (self perception barriers arising out of caste and economic conditions for not building toilets, affordability, lack of interest or sheer habit of open defecation, space and physical access to water, knowledge and awareness of health benefits, gender relations, etc.).

Location and Timing of the Research

The study was conducted in Gujarat, Telangana, and Jharkhand. An intensive field research was undertaken in nine villages (three villages from each state) during July to December 2015. Field work was done by the staff of Utthan, MARI and AIDENT.

In Jharkhand, the study was conducted in three villages of Jamshedpur Block of East Singhbhum. About a decade ago, this block was declared Open Defecation Free area under the Total Sanitation Campaign (TSC) but now it has slipped back to open defecation. Unused and broken down single direct pit latrines, with no side walls, were evident in all the three villages. People complained that the toilets were built without their consultation by contractors who came with all the materials and installed toilets overnight in the village. Perhaps the whole toilet construction exercise was an infrastructure subsidy intervention of TSC that had no buy in of the community. Septic tanks are being built by a few people who can afford them (less than 2% in a hamlet), mostly those people with sufficient income (other than from farming). The septic tanks discharge liquid waste in the open. There are also “Shankar septic tanks” that are essentially sealed pit latrines built by private operators. Women are demanding toilets, and people are highly aware about the benefits of toilets. However, this demand and awareness is not translating into adoption of improved behaviors probably because of low income and less availability of cash for spending on toilet construction as a priority. People are living at subsistence level with very low income, but they do not migrate for work and undertake agriculture and other daily wage work within a 5-10 Km radius of their settlement. There is very little long term migration for work from these villages. Land holdings are small and both income and spending is at a

**The villages
can be
categorized
as:**

Majority tribal and Dalit caste villages:

Jharkhand (2), Telangana (1), and Gujarat (1)

Other Backward Castes (OBC), Dalit and Tribal villages:

Jharkhand (1), Telangana (1)

OBC, Dalit and other caste villages:

Gujarat (2)

Research Tools

Following research tools were employed:

- Village Baseline Information template
- Guiding Notes for individual interviews and group discussions

The tools are enclosed with this report as Annex 1 and Annex 2.

low subsistence level. Most villages have tribal and OBC settlements with very few other castes (upper castes). As a result, cash spending is low and is mostly for medical reasons and on social functions (marriages, deaths and births), resulting in not enough cash for spending on toilet construction.

Telangana is the newly formed state where in rural areas progress related to sanitation and hygiene, particularly for making the state Open Defecation Free, has been



stubbornly low. Three villages—two from Warangal and one from Karimnagar districts—covered under this research represent distinct social composition and thus provided rich insights in understanding the barriers to sanitation progress. Karlapalli in Govindraopet mandal of Warangal is a typical Koya tribal village with about 158 households. Yerragollapahad is the second village from Jangaon Mandal of Warangal district and is populated pre-dominantly by people from backward caste with 413 households that forms part of the drought prone clusters. Katukuru is the third village from Karimnagar district with about 800 households having a mixed population— SC, ST, Muslim minorities, and upper caste. Households with toilets is 20,110, and 487, respectively in the above three villages.

In Gujarat, the three villages selected are representatives of the State's socio-political, cultural, and physical aspects. These are Surpur (Mahisagar – tribal district), Katpar (Bhavnagar – coastal District), and Fifad (Amreli – plain land District). Surpur and Fifad are quite interior villages while Katpar is closer to Mahua town. The three villages selected in Gujarat are from three Districts: Surpur village from Mahisagar district consists majorly of tribal people with a total population of 1818—528 households of Adivasis, 10 households of SC, and 8 households

of OBC (darbars). The second village, Katpar, is situated in the coastal Mahua block of Bhavnagar District, and has a population of about 5500 with 1200 households. The village is about 350 years old. The third village is Fifad of Jafraabad block of Amreli District in Saurashtra area. It has a population of 2800 and 627 families. There are mix communities such as Muslims, Dalits, OBCs, Patels and others. More than 60% families are landless.

Methodology

The process for developing research methodology included intensive direct engagement of individuals and group discussions among the core team of three lead researchers and supporting team members. Previous experience has shown that the data collection survey based methods provide incorrect and insufficient answers to questions about the deeper level barriers and perceptions. The questions are needed to be asked in a sequential manner so that based on the responses received, one can probe deeper to understand the reasons behind their reluctance as well as ways to overcome the obstacles. This is not possible to achieve from structured questionnaires administered by professional surveyors.

The core team together developed the research tools and carried out the field research.



The researchers tried to investigate the deeper level barriers and explore the motivators for bringing change in the sanitation behavior by interviewing a cross section of people (men, women, adolescent girls, boys, physically handicapped, older men and women and representatives of panchayats, schools teachers and anganwadi workers) and organizing focus group discussions with them on the same issues. On an average, two days were required per village as approximately 50 people were interviewed each day in a village.

Limitations

This being an essentially qualitative research on the key barriers and motivators of change in sanitation and hygiene behavior, we relied on intensive but fewer village case studies (9 villages).

Care was taken not to draw general conclusions from general responses but to situate each conclusion with the context and substantiate with evidence. An attempt was made to secure responses that could be verified through triangulation process by talking to a cross section of male, female, and child participants.

An extensive internal process was followed to review and arrive at the key findings, conclusions and recommendations from this research.

Analysis Process

The study was conducted in the post monsoon period at the time when winter was approaching. In the first phase, village information templates were filled in before carrying out the intensive village interviews and shared among the team members. The research team undertook a pilot research for testing the research methodology and tools in one village in Telangana and arrived at a common agreement on the report structure. Field visits in each of the three states were scheduled and undertaken. Notes of each visit were shared between the team members. A summary of main observations from each of the three states was prepared and shared by the study team, to arrive at a common understanding of the larger context and findings from each state. This was followed by putting together the main section of key findings of the research. Finally, based on the agreement reached on the key findings, the section on recommendations was added, reviewed, and finalized.

The draft report was also shared with a few organizations for their review and to seek their funding support for printing (IRC, Arghyam and WSSCC).

Dissemination workshops are planned to take back the results to each state and even at the national level. Funding is being sought for this.

Research Team

Core Research team: Nafisa Barot, Murali R, Depinder Kapur.

Telangana: Murali Ramisetty, Rama Jyoti Ramisetty, Jayarama Rao, Saroj Tucker, Srishti Attri, and Amit Tandon

Jharkhand: Babloo and Birender from AIDENT, Depinder Kapur

Gujarat: Nafisa Barot, Tarulata Tawidad, Jayanti Patel, Mukesh Parmar, Hetal Shah, Ram Parmar, Rubina Bhatti, Ms Sangita Parel

Key Findings

Summary of the Key Findings

This section culls out the main findings of the research. These should not be read in isolation as individual findings but as part of a whole.

The study contains a rich set of findings based on primary research, these are detailed out to the extent possible for a better understanding of the perceptions and barriers to improved sanitation behaviours. We hope these will offer both theoretical as well as practical application to the emerging challenges of rural sanitation and hygiene promotion in India and elsewhere.

'**Convenience**' is the major motivating factor for those who have constructed or who are in the process of constructing a toilet at home. In most cases, convenience of elderly, chronically ill, and women was found to be the key consideration for opting toilet facility. Hence, it was observed that particularly in those families where there are members needing others' support to defecate, there is an obvious choice towards toilet construction.

The understanding of **health dimension related to sanitation** (negative health impact) is not of vital importance for the villagers. The major reasons behind this are probably lack of capacities and resources at the Gram Panchayat (GP) level as well as inappropriate language and lack of targeting in the ongoing Information, Education, and Communication (IEC). The

expenditure on health care is quite high, and diseases like typhoid, viral fever, nausea, stomach disorders, and mysterious body or muscle pains are the most common problems that are reported for which they sought medical care in private clinics. Diarrhea is reported only by a limited number. Mothers and care takers of children below five years stated reasons of safety and the necessity to observe child feces, etc. due to which they prefer children to defecate in the closest vicinity.

In the context of adapting sanitation (toilet construction and usage), **certain social barriers** such as **gender inequality** (in most cases women's demand for toilet was never given priority), **beliefs** (common people believe that defecating far from home is safe and good practice), **technical aspects** and environment (knowledge of low cost toilet design or inadequate space for a toilet), **access to water**, **affordability**, lack of **information** (these physical and economic barriers are also related to the deeper level self perception barriers derive from their livelihoods and social status), **distrust in Government**, **exclusion** (people with disability) and **lack of cadre of motivators** to undertake motivation and behavior change work for improved sanitation.

Most people believe "those who are powerful (afford) can build the individual toilets but for others village panchayat must take the responsibility for collective action".

The research findings have been categorized into five sub sections, and in each of these sections specific observations, conclusions, and recommendations are provided. These sections are:

- Perceptions of sanitation and hygiene
- Socio Cultural Barriers
- Economic Barriers
- Supply side barriers
- Behaviour change and IEC challenges



Perceptions of Sanitation and Hygiene

In all the nine villages of this study, people have a sound understanding of personal hygiene and cleanliness of home environment, yet their understanding acts as a barrier for adoption of safe sanitation and hygiene practices. Perhaps this is related to the correlation the sanitation has with impurity among mixed caste villages, where handling human feces or trying to dispose it is seen as an infringement to the purity of the human body and home of the upper caste. Tribal communities (that are devoid of caste related stigmas attached to fecal waste handling) display a higher level of cleanliness of not just homes but also of streets and their homesteads, defecating away from the home is seen as a good hygienic practice.

Cleanliness: Almost all the respondents of household interviews and Focus Group Discussions claimed that they like cleanliness and practice the same at personal and household level. Brushing teeth and cleaning tongue every day morning, bathing with soap, wearing washed clothes, applying oil to the hair and making plaits (women), cutting hair regularly as well as shaving (men), washing hand and feet after returning from defecation,

washing feet while entering home after returning from outside work, etc., are mentioned as the most commonly practiced personal cleanliness habits.

In Telangana, daily sweeping of home and open area around, sprinkling plain or cow dung mixed water in the front and back yard of the house (kallapi), mud pasting (alakadam), putting rangoli (muggu), sun drying of blankets and linens, removal of cobwebs and thorough cleaning before festival days, dumping the cattle dung and other waste away from home, avoiding water stagnation, etc., are some of the activities that are practiced to keep the house clean. With respect to defecation, urination, and child feces, their perception of cleanliness is to keep the fecal waste as far as possible from home. Unless this deep rooted perception about sanitation is clarified or corrected, it is difficult to change the behavior towards defecating in toilets.

In Jharkhand tribal villages, not just the homes but also the streets are kept spick and span by the communities. This is part of the tribal tradition of cleanliness that is different from mixed caste communities in other states. In the villages having mixed population of OBCs and Tribals, it was observed that both display a relatively similar standard of cleanliness.

‘Defecation’ in daily routine: In Telangana, some of the men in the farming families shared that they do not

allocate any specific time to defecate. They have the habit of going (by walk) to their fields (bavikadiki) very early in the morning (4-5 am) for attending livestock or farming related activities, and in that process whenever they get nature’s call they defecate in the open area around. A walk in the morning in open air with greenery around and under the early morning sun rays is perceived as more comfortable for defecating and this also seems to be synchronizing well with their daily routine. Smoking beedi or traditional cigar is an accompanying habit with open defecation practice and men expressed their reluctance to wait at home in the morning for defecating in the toilets.

It was observed that there are patterns and preferences of companionship while going for open defecation. For example, mother-in-law and her daughter-in-law generally don’t go for defecation together, similarly there are cases where the eldest female in the family goes for defecation with her granddaughter, young women prefer to go for defecation with members of their age group, male children go together for defecation and men go alone for defecation. *These patterns indicate that the families within themselves are not comfortable to have open discussion on sanitation and defecating practices which acts as a deterrent in motivating them and encouraging them in decision making towards collective behavioral change of the family.*

Children are likely to attract flies when they are asleep or when sick and when they have running nose.

Poor sanitation is therefore not the only health risk in rural areas.

As in the case of any typical traditional village, it was noted here that the houses of Dalits and some of the backward castes are located in the outskirts of the village, and thus they are closer to the areas meant for open defecation. This reduces the degree of inconvenience and embarrassment, although they are more closer to the health risks.

In Jharkhand and Gujarat villages, it was observed that open defecation is practiced as part of the daily routine of going out for work in the morning. Defecation area is usually far away from the village to ensure safety. In one fishing village of coastal Gujarat, people defecate on the sea shore but they do so by walking at least one kilometer away from the village as part of a shared consciousness of keeping their coastline clean. With growing density of population, areas of open defecation are shrinking and hence promoting people to build toilets. Where open spaces are plenty, the pressure to build toilets is often less.

Child Feces: Mothers and grandmothers are the caretakers of the children below five years. They start cultivating the habit of defecating outside home after children cross one year age. They generally feel secure and convenient to wash their bottoms, if the children below five years defecate in the closest possible vicinity. Flies on the child feces and on the children's body and their

food are not an uncommon sight. We observed that children are more likely to attract flies when they are left with poor hygienic conditions, for instance, babies with running nose or suffering from diarrhea. Moreover, babies inactive at the time of sleep or due to sickness also attract flies. Hence the flies to feces to food linkage is not the only route to diarrhea and other infections. Children's feces do not remain longer as the dogs and chicken seem to be feeding on the same, and they are generously allowed in and around the house.

In Telangana, few mothers expressed that just a casual look at the child's feces (colour, form, quantity, frequency of defecating) helps them know the condition of their stomach ('emithinnado etlaa rainchukonnado'). Women are highly averse to the idea of using diapers, and handling child feces is perceived as natural and inevitable part of child care. Hand washing with soap after child feces is reported as a regular practice only by a few young mothers. Even if the toilets are built at home, women are not sure whether they would like to encourage their children who are below five years to use the toilet for which safety and ability of the children to manage themselves were the most common concerns shared.

While the Anganwadi staff are very clear about the immunization messages and hygiene related information that they give to the mother at the time of breast

feeding, there is neither clarity nor focus on hygiene messages that need to be given to the mother about handling child feces. Children's habit of defecating in open is further reinforced when they start going to Anganwadis. Owing to lack of toilets and for ensuring children's security, caretakers are making children defecate in open in the closest vicinity. It's common to see the flies in Anganwadis, particularly when the children handle their food and eat themselves.

Health and Diseases: Health expenditure was found to be one of the top expenditures for most families. Investment in agriculture, loan repayments and social expenditures (celebration of festivals and marriages), are the other comparable major expenditure items.

In Telangana villages, typhoid, viral fever, nausea, stomach disorders, mysterious body or muscle pains and diarrhea are the commonly reported health problems. Due to various reasons, the preferred source of medical treatment is mostly private hospitals in the nearby towns or cities where they are referred to for hospitalization and medical tests by the local Registered Medical Practitioners (RMPs) or people approach on their own based on the previous contacts. People attribute such health problems to their hard work, excessive exposure to torching sun, ill fate and evil forces. Upon recovery of the sick person, the families generally

Malnutrition, hard physical labour, repeated bouts of malaria, stomach and respiratory infections, early marriages and child births - are the most significant contributors to a weak immunity and susceptibility to infections and disease. Poor sanitation is a contributory factor.



celebrate with special offerings to the god or local deity which again involves considerable expenditure. Such faith and beliefs as well as lack of understanding on the oral fecal route of contamination are the major deterrents to behavioral change towards improved sanitation and hygiene.

In Jharkhand and Gujarat villages, major illness was usually malaria and respiratory diseases and not serious stomach infections like Jaundice, Cholera, and Diarrhea. People do not attribute lack of sanitation to be the primary cause for major illness. Lack of proper nutrition, hard physical labour or general weakness of the human system over the years from early marriage and child birth, weakness from repeated bouts of malaria and viral fevers, etc., are seen as some of the most important factors for poor health condition than sanitation and hygiene borne factors. Health sector experts identify delayed breast feeding and related personal hygiene as important factors of high infant mortality in India.

Previous exposure to toilets:

In some villages in Jharkhand, we came across masons who build septic tank toilets in urban areas but do not have a toilet at home. Affordability was cited as a reason, they were not

willing or unable to spare Rs.12,000 for building a toilet with a septic tank though they knew ways of cost cutting.

In Telangana villages, some of the respondents shared impressions gathered over a period of time that reinforce barriers to using toilets. The resistance to use toilets arises from varied perceptions: toilets stink particularly when the shit and urine gets mixed up; floors are always wet; claustrophobic feelings; privacy is inadequate as people outside can hear the sounds; cannot move away from the shit (which is shared as an advantage with open defecation practice); urine and watery motion will be absorbed by soil in open defecation while in toilet the spillover may spoil clothes; not good to use the same toilets used by menstruating women; and sitting in the toilet causes lot of sweating.

Smaller size pit latrines (3x3 feet dimension) are not considered user friendly by most people.

The educated urban people, particularly, the students have mixed feelings about the toilet construction at home and their feeling is dependent on the maintenance of toilets they are using in the hostels and colleges. They do not seem to be carrying a strong belief that toilet is a good convenience or has strong health impacts, and need to be promoted for their parents in their villages. Since the youth have practiced open defecation

in their formative age, they do not feel embarrassed or discomforted in going for open defecation during their visits to their home in the villages. It is like switching back to old habits. However, in our formal conversation, they did not share any reluctance to encourage toilets construction at their home but many of them cited lack of financial resources as the barrier. Many of them also lacked proper understanding of the oral fecal route of contamination risks.

In Jharkhand villages, OBC community women had better exposure to using toilets than tribal women and hence were more willing to build and use toilets. Hence, they were more inclined to build and use toilets at home as compared to the tribal communities. Some families have restored the non functional toilets provided to them under TSC, only because of some family members who have become old or are suffering from disability and arthritis. These are old single offset pit toilets that are unlikely to last long and hence are used occasionally only.

Probably, the exposure to toilets in the outer world away from their villages has a positive impact on the willingness to build and use toilets. However, if other factors—availability of water and space to build toilets—are a challenge besides behavior change, then probably sanitation programmes of the government need to address these physical barriers first.

Subsistence livelihoods and living conditions of tribal communities and many others, generate a lower hope for improved material well being.

This in turn generates lower aspirations for improved sanitation and hygiene including a desire to build and use toilets.

Perceptions of securing government subsidy:

In Telangana, some heads of families lack the past experience of directly dealing with government bureaucracy (required for leveraging financial incentive) and managing a construction. They think it is difficult to manage and hence lack the initiative to start the process. Inaction is due to self perceived inability which may be linked to their social status and history of past dealings with the government agencies in remote tribal settlements.

In Jharkhand villages, there is a resignation among the people about building toilets as they feel they will not get subsidy again because of earlier declaration of the whole Jamshedpur Block as open defecation free area by TSC. The government of India had asked the states to revise the baseline data for toilet coverage in 2014 and this can make them all eligible for sanitation subsidy but this has not happened so far.

In Gujarat villages, people are not confident that they will get the subsidy that the government is offering for toilet construction.

Perception of sanitation as a priority:

In the villages of Jharkhand where this study was done, most tribal communities live at a subsistence level

earning less than Rs.6000 a month from agriculture labour. In such a social and economic context, aspirations for a better quality and healthy life do not include sanitation and toilet in their list of priorities. Housing, education of children, land purchase and land improvement, social costs of community life like marriages and deaths receive more priorities, hence, people spend their meager cash on these and are not willing to spend large amount to build toilets.

In the tribal villages of Gujarat, because of sufficient availability of space, people generally do not perceive open defecation as being dirty. There is a strong belief amongst most communities that defecating away from house is a clean and good practice. Mostly the old people, especially men tend to think that open defecation is an age old practice, and so there is no need to make special investment in toilet construction.

Some men and women who do see the requirement of the sanitation facilities expressed that it is beyond their means to have such facilities. They construct toilets only when it becomes very difficult to manage the sanitation needs of very old or sick people in their family. Many believe that sanitation is very costly affair, requiring at least Rs.40,000 to Rs.55,000 of investment, a perception perpetuated by the masons as was seen in Katkur Karimnagar. However, the government gives only Rs.12,000 for

a toilet, that too after a long time and lots of follow up. Petty corruption in release of subsidy was also reported as a problem by quite a few respondents.

Youth: Most young people were positive that their village will soon become Open Defecation Free (ODF). They feel it is important to create a critical mass of users who will be able to transform the whole village. They said that no mobile selling company have made them aware about using mobiles or provided them training related to managing a mobile connection or subsidy for use of cell phone. However, seeing the other users' experience, the adoption of mobile phone spread to almost every household and the use of it now is much beyond making or receiving a call. They hope to see something similar with respect to toilets also.

Penalties: Few leaders expressed that penalties are essential for checking deviant behavior and GP should have the power to impose penalties on those resisting end of open defecation even after receiving awareness input and completing toilet construction at home.

Existing penalties in various laws and formal and informal Community Based Organizations (CBOs) were referred to argue the reason behind the necessity of ensuring common good of the community.



However, not even in a single village under this study did people endorse humiliating or discriminating people defecating in the open.

This was observed in both predominantly homogenous tribal villages and community villages where aggression is not used as a behavior constraining method.

People have a high regard for individual dignity and that also translates into the social realm in tribal communities where not just the home but the street and the village is kept spic and span. This is not achieved by any force or by humiliating the violators.

Contamination of water: For drinking and other household needs, most people use a water source which is within house or close to house in the village.

In Telangana, some people shared the fear that all the houses holding fecal waste in sub surface pits is more contaminating than defecating in far off open areas where it is assumed to be getting quickly dried and decomposed.

The messages on open defecation as source of water contamination are perceived as much a threat as that of water contamination by twin pit latrines.

In Gujarat and Jharkhand villages, where open defecation is a predominant practice, its health impact and contamination of surface and ground water is not perceived as a problem.

Socio-cultural and Economic Barriers to Sanitation

The research probed the barriers that different sets of rural communities experienced in building and using toilets. Both in individual household interviews and group discussions of this qualitative research, the respondents freely engaged in a discussion and supported to dig deeper to the next level of challenges they faced in demanding and building toilets at home. These were cross checked in other interviews and group discussions in the same village and conclusions drawn based on analysis of all evidence and feedback.

The earlier resistance to building and using toilets because of cultural taboo is now not there, however issues of smell and location (next to the home) remain barriers to both construction and usage of toilets. Spending for toilets is still not a priority for most households, often quoting affordability and high cost of construction.

In Telangana, no construction work is taken up until completion of one year after death of a family member, during the pregnancy period of a family member, or if the site is not according to 'Vasthu' conditions. This is perhaps one major reason for toilet construction not being the first priority of households.

Gender barriers. Some of the men in Gujarat villages mentioned that women had lot of time, so it was "not much of an issue for them to spend time walking long distance", hence there is no need to invest in toilet by taking a loan.

In all the three Telangana villages, Anganwadis do not have functional toilets and children are introduced to open defecation in their formative age. The childhood habit of defecating in the open coupled with exposure to unclean toilets in residential hostels were found to be the reasons behind no feeling of embarrassment among educated youth resorting to open defecation during their visit to the villages.

There are many families with aged couples who are in desperate need of toilets but are unable to construct toilets without any facilitation from others due to a variety of social and cultural reasons. Although women in these Telangana villages have varying degree of decision making power, their choices are very much influenced by the thought process of men for whom building 'toilet' is not a priority. Majority of those who do not have toilets stated poverty and lack of affordability as the key reasons, while there is good evidence of high expenditure on agriculture, marriages and festivals, health, and needs such as TV, two wheelers and mobile phones.

Although men make most financial decisions including construction of a toilet, women said that they understood and agreed with the men whenever financial stress was a limiting factor. There is an acute agrarian crisis in rural India.

Furthermore, owing to a variety of administrative reasons, there is delay in sanctioning and releasing of Government subsidy from 3–12 months which is resulting in low motivation and confidence among the others in need of toilets.

Decision making power at home is mostly concentrated in the hands of male members, while the toilet is a more compelling need for women, girls, and the elderly people. It was found that despite being poor many families are borrowing huge investments for crop production, drilling of bore wells, purchasing of luxuries like two wheelers, televisions, and mobile phones. Proposal for toilet construction is declined by the head of the family, who is usually a male member, often by stating financial constraints including making investment in advance of release of subsidy/incentive from the government. Women also support the men in this decision and cite financial difficulties.

Though limited, there is evidence of women availing their SHG credit facility to invest in toilets.

Dignity, privacy, and security are perceived more as the needs of women and girls.

These are also unfortunately reiterated by the IEC messages, thus often reinforcing stereotypes of gender. This sometimes prevents men from not using the toilets

and puts forth their unwillingness to accept toilet as a common place of defecation for all the family members as was observed in the study.

In Gujarat villages, women shared that they needed the toilet as it was extremely inconvenient and unsafe to defecate in the open. Their priority was a toilet near their house. They did not feel comfortable about having the toilet inside or adjacent to the house. They said they already were living in very small rooms with big families, and if they build toilet they would have no space even for sleeping. They said there was no space in front of their house, as there were streets where there was hardly even space to pass by. A toilet near or in the house was not desired as it smells and is considered impure. Nearly 60% families expressed constraint of space as a problem for toilet construction, especially in the coastal villages.

Deeper self perception barriers (of caste and class witnessed in Bihar caste villages in a 2011 study³, where the lower castes felt that keeping themselves clean, hand washing and toilet use was contradictory to their social status) was not observed as a barrier in Jharkhand villages.

3 – <http://webcache.googleusercontent.com/search?q=cache:nFrXS3FBwfcJ:www.ircwash.org/sites/default/files/Kapur-2012-Formative.doc+&cd=1&hl=en&ct=clnk&gl=in>

The Jharkhand villages showed that sanitation behaviors among the remote tribal communities were distinct from other communities including OBC and other castes. Here it was found that among tribal communities that are living an isolated life without much out migration or even wage employment in industrial belt of Jamshedpur, the habits of open defecation are to a great extent linked to subsistence livelihoods, and the unchanging and unimproved living conditions seem to exert a constraining influence on peoples' desire to build and use toilets. Coupled with lack of cash incomes and water availability, open defecation habitlike other world view of the tribal community, is shaped from the harsh material conditions and not just from social suppression by higher caste (which is absent in Jharkhand tribal villages). The differences in sanitation adoption between OBC and Tribal people were pronounced—more OBC women and families were willing to build and use toilets than tribal women and families.

In Jharkhand and Gujarat, those willing to change (especially women and some men) found affordability a major barrier to toilet construction. It is also true that some are simply waiting for a subsidy and will not use a toilet even if it is given free.

Those who survive at a subsistence livelihood do not have a motivation for improving their sanitation behavior as there is no improvement in their livelihoods.



Toilets for the old and infirm, for the physically disabled and sick needs urgent attention by the government and NGOs, to include in the Swachh Bharat Mission as a clear time bound priority.

In Gujarat villages, there is additional burden on women as they have to fetch more water to keep the toilets clean on a daily basis.

Disability and Old Age

Gender and class differentiation is most obvious in sanitation.

Adoption of toilets is still not a priority for most old and infirm in most villages in Jharkhand, partly due to psychological barrier of not wanting to sit in a closed toilet and partly a result of affordability and cost of construction barrier. Extreme disability of the young or of the wives of earning members as seen in Jharkhand villages is seen to be more of a motivating factor for having a household toilet. Hence, this needs attention of BCC and policy makers. However, the opposite is the case in Gujarat and Telangana.

In Gujarat villages, the decision to build toilet was taken by the male children of the family for addressing the sanitation needs of their old parents who are completely bed ridden or sick.

In Telangana villages, it was observed that there is a sizeable elderly population in these villages and owing to a variety of reasons including migration of the able bodied, a large number of elderly persons and couples are living under self-care or mutual caring. Most of them are in desperate need of toilet at home. There

are cases of old people selling their assets and gold ornaments to get the toilet constructed without which they are put to extreme hardship for defecating in open. But majority of them expressed that it is impossible for them to manage toilet construction on their own. They want the Gram Panchayat (GP) or someone from the village to construct toilets for them.

In Gujarat villages too, sanitation needs of the old and infirm are now being addressed through toilet construction but only by a small better off section.

For the rest, open defecation remains prevalent and there is a requirement of more awareness and public campaigns for addressing safe and convenient seat toilets for old and infirm, menstruating and pregnant women, hence this should be a priority of Swachh Bharat. In some of the families, it was found that the toilets were locked when most of the family members were away in the city for work, barring its use by the old people. The main reason was to keep it clean.

Young boys and girls

Exposure to sanitation or toilets is high among young school going boys and girls in tribal areas who go to hostels for children and use toilets. However, this exposure does not translate into demand for toilets at home. One reason for this lack of demand could be that the toilets they have in their schools are poorly maintained, unhygienic, hence not inculcating the desired behavior change.

In Gujarat villages, the young men perceive the need for a toilet as a 'negotiable issue'. They do link it up with aspiration of a better life. However, they are unable to make toilet building their priority against other aspirations such as having a mobile or motorcycle or pursuing higher studies, etc. This is due to lack of decision making power over spending. Young girls reported that this was a 'no win' issue for them, because being younger and women they had no voice in decision making.

Some of the children in Gujarat villages said they had demanded toilets in their homes by going on strike and refusing to eat till the parents agreed to make the toilet. However, they reported that some of them were beaten up by their fathers who threatened to pull them out of school, while some parents said they could not afford building toilet.

Economic barriers

In Telangana, the villages considered under study have a good number of landless and or small land-holders who take lease of land from those who have migrated for employment, business, and other better off opportunities in urban areas. This is a relatively new category of farmers who are saving the land from being left fallow and thus doing a great service to the land and its

Many women, girls and elderly do feel desperate need for toilet, but they think that it is unreasonable to make the demand considering the financial crisis of the family and the struggle of their parents or head of the family.

owners. But with the current cropping and production systems, their net returns are very low or negative which is making them increasingly indebted. Farming for these families is more of an aspiration and a matter of self pride and this also gives them scope to borrow credit which is used for agriculture as well as for meeting the needs of their families. These families are perpetually under financial crisis and a tense life.

In conditions of indebtedness and mounting cash expenses on agriculture and social expenses, fulfilling simple aspirations of a toilet at home becomes an unlikely priority.

Peoples estimated the cost of toilet construction to be in the range of Rs. 20,000 to 35,000 in Telangana. Lack of capacity to invest in advance and or to meet the additional cost is one of the most common reasons stated by those who got the sanction but did not begin the toilet construction.

The image of toilet promoted by some of the local masons (who are found to be the main source of technical advice) is very costly as it includes RCC roof, two to three feet elevated base from the ground, and twin rooms block for bathing and toilet. There are some such toilets that very poor families build by spending upto Rs.40,000 for which the source of funding was selling of livestock and other

assets. There is a tendency to aspire for the same kind of toilet which is not within the affordable range for many families. The hand book produced by the Telangana state SBM mentioned 24 technical guidelines to be followed in constructing the toilet and local masons do not have the knowledge of the same which is resulting in high cost and inappropriate designs.

Many women, girls and elderly do feel desperate need for toilet, but they think that it is unreasonable to make the demand considering the financial crisis of the family and the struggle of their parents or head of the family. In this restraint, there is no gender bias; it's a realization that affordability is a common issue across gender.

Unresolved conflicts among the family members on the share of available house property and disputes between neighbors were some of the other reasons shared, for not being able to construct toilets.

In Jharkhand, most of the poor communities (both tribal and OBC) find it difficult to pay even Rs.5000 (either for material or for labor) for building a toilet, even though they are convinced about the need to build and use toilets. Only if family members have some income from working in the factories near Jamshedpur or if a member of the family receives some cash remittance because of serving in army or police, they can afford to pay cash for toilet

construction. Some cash incentive based on a careful selection of households, not as a general cash subsidy, can assist people who want to build and use toilets to do so. The incentive can be provided in cash (for hard labour - not everyone can do hard labour of pit digging in rocky areas) and in kind (toilet pans, cement and doors/roof) for less than Rs.2000. This may be a more organic way of sanitation promotion instead of aiming at 100% Open Defecation Free rural communities and insisting that payment is made after everyone builds pucca toilets.

In a tribal village of Gujarat, it was found that more than 90% families (tribal) were indebted for expenditures in agriculture, small business ventures, health, house alterations, and social events. The debt amount varied from Rs.25,000 to Rs.60,000 per household and amounts to a huge interest burden and insecurity. Most people mentioned that it would cost about Rs.40,000 to Rs.55,000 to build a toilet. They got this estimate from some of the families who had built the toilet in the past (mostly septic tank toilets) and calculated the amount at the present rate of inflation. Very few of them were aware of the real costs of building low cost twin put toilets and the incentive/subsidy under SBM Gramin.

Some of the men in Gujarat villages said it was difficult to pay back previous debt and felt that if they have to make a toilet and then access funds from government,



WASH Behaviour Change messages are perceived for urban audience, stereotyping rural people as ignorant and dirty.

BCC messages in WASH should begin by honouring and respecting the hard physical labour and their dirty hands and feet. Only then should the hand washing and toilets message follow.

it would add to further debt; and they would not be able to take loan for any other purpose before repaying the debt. They have heard about people having made toilets and not receiving funds for two to three years. Furthermore, they are afraid of closing down of certain schemes before they get the necessary resources from government thereby adding to their debt. In one family, there were only three people—an old mother, a pregnant woman and her husband. Both the husband and the pregnant woman have some disability. They were worried about the safe child delivery, as the lady had slipped while going for open defecation during the previous pregnancy period. Although they felt that toilet was their priority, they could not think of building it as they had previous debt, moreover, they would have to borrow again to meet the delivery expenses. They were neither aware of any government scheme about offering toilet construction subsidy or incentive, nor did they have any knowledge of additional subsidy for construction of toilets for physically disabled. Many people's response was – “only the rich can afford building a toilet and can bear the burden of money without receiving any incentive from government”. It was observed in one village of Gujarat that out of 12 people who had applied for incentive and built the toilets, there were hardly two families who got a part of the incentive from the government over a period of two years.


Institutional barriers

In Telangana, a new government order (GO) talks about the importance of engaging the local CBOs for driving the sanitation agenda, but in practice the social capital that exists in the villages in the form of different CBOs remains largely unexplored. Women SHGs and their village level federation, watershed committees, farmers' producer organization, youth clubs, school management committees, caste based associations, etc. are some of the potential CBOs whose knowledge and engagement in SBM is nil or very superficial. Moreover, GPs have not been able to sensitize or delineate their responsibility in facilitating active leadership as well as in achieving SBM objectives.

In the villages of Gujarat, government sanitation campaign had not reached their villages. Surpur and Fifad communities felt completely neglected on the issue both from the government and panchayats. School had exceptionally good sanitation facilities in Surpur. However, people do not see the relevance of toilet and safe sanitation environment to improve their health, except the teachers and those formally educated. Mostly the BCC messages on TV or radios are perceived as messages for urban areas that end up portraying a stereotype of rural people where they are depicted as dirty and lacking hygiene consciousness. People with disability

and elderly people stated that there was no mention about special toilets or access to resources for them. In a number of villages, people specially women and youth have expressed the need for a campaign and information dissemination in a decentralized (falia/hamlet level) manner, so that they could discuss their issues and ask for suggestions. The human resource engaged for BCC has not received systematic training and just talk about the 'toilet' construction and the resources available for it on individual level.

Gram Panchayats (GPs) and Sarpanches have a crucial responsibility to drive the sanitation agenda at the village level. During conversation with Sarpanches and GP members, it was noted that there are quite a few limitations because of which they are not able meet the expectations. Lack of understanding and motivation, competing priorities, lack of personnel capacities, challenges of mobilizing the entire village community when it is divided on political party lines, delays in release of funds, slow response from the government officials are some of the key constraints mentioned. Sarpanches also feel that their elected position does not really give them much power to check the behavior of the people and to provide compliance for common good. Leadership capacity, political backing, and credibility of the individuals play more significant role than the formal position as elected 'sarpanch'.



People believe that sanitation is not perceived as a priority by the Panchayat or the Sarpanch.

Swachh Bharat Mission needs champions at the state, district, block and panchayat levels.

In villages of Gujarat, panchayat members think people do not build toilet because it is not their priority. However, people think sanitation is not perceived as a priority issue by the panchayat, hence, they do not support them in securing subsidy for toilet construction.

Supply side Barriers

Supply side barriers in rural sanitation in India are encountered when we try to match peoples' desire for a 'pucca' toilet with a septic tank based on the government programme of twin pit toilets. The supply of the material for toilet construction in a remote tribal hamlet at reasonable price acts as a supply side barrier. This has resulted in the construction of more and more toilets by contractors. *More recently, the central government subsidy for individual toilets has been cut after the 2015-16 budget announcement, thereby leading to the speculation as to whether state governments will now be willing to increase individual toilet subsidy.*

When large scale construction of toilets is programmed under the new SBM approach, organizing the materials for toilet construction is left to some centralized construction process. This could be either the Sarpanch mobilizing

a contractor, or an NGO, or an SHG in some instances. Most individual households we interviewed in this research expressed their inability to secure SBM subsidy followed by the securing of materials for a single toilet construction.

Emerging supply side challenges in Gujarat

The challenge of sanitation in the coastal village of Gujarat was predominantly a planning challenge for a lane wise septage solution and not a typical rural twin pit sanitation challenge that we find elsewhere. There is no space for twin pit toilets construction, and there are many tenants who cannot build toilets. The village resembles an urban slum settlement. The need of this village is a small scale septage system and not twin pit rural toilets. This will require a WASMO type sanitation intervention to link groups of houses with septic tanks and ensure septage management and safe disposal.

The sanitation challenge here was linked to water availability. WASMO is supplying 130 lts of water per day to each household at an economical rate of Re.1 per day. This low cost is possible because of the large size of the village which constituted of 1200 houses out of which 900 are connected to the tap water supply. If the households built toilets, then their water requirement will increase at least three times the current rate which will in turn

lead to increase in the cost of water supply. Will there be three times additional water supply available from Narmada canal for all the Bhal villages to support the water requirement? Will the people be willing to pay three times the present tariff?

Supply side challenges in Jharkhand

Simply looking at supply side challenges, individually procuring pans, pipes and door from outside is cost-intensive.. There is currently no mechanism other than contractors and the Panchayats becoming contractors of toilet construction, to facilitate this outcome. Panchayats are the lowest level of self governance, elected political bodies. If they are entrusted, often without any additional human resources, responsibility of development projects implementation then this executive function can distort their governance function.

Local masons are not aware of low cost toilet solutions in Jharkhand. Most of them are conversant with building large septic tank toilets at lowest cost that comes surprisingly close to the SBM G norm. However they are not aware of low cost twin pit toilets built at Rs12,000 a unit. This was obvious when AIDENT field staff demonstrated low cost toilets construction in a village close to Jamshedpur where people came forward to invest their own money and build toilets.



There are private operators in Jharkhand that advertise and construct “Shankar toilets”. These toilets are twin cylindrical pit toilets that are sealed from all sides and from below, needing desludging septage treatment. These structures do not ascribe to the BIS standards of septic tank construction⁴ and are essentially storage tanks only. Unfortunately these are being promoted by some recent initiatives as sustainable septage solution for rural India (Septic tanks or modified septic tanks, though preferred, are expensive, leaving circular leach pits as the only quality product option in the INR 7,000-10,000 (USD 140-200) range).⁵

SBM subsidy in Telangana

Government subsidy is perceived as a matter of right, which people are very keen to claim. People get frustrated and agitated if this process of disbursement is not prompt and smooth. The mental preoccupation is getting the money rather than reflecting on the changes needed in one’s own behavior. It was noted that when the Mandal officials and GP Sarpanch and Secretary are present for the Gram Sabhas, the entire time goes in settling the subsidy related issues,

4 – http://www.indiawaterportal.org/sites/indiawaterportal.org/files/Code%20of%20practice%20for%20installation%20of%20septic%20tanks%20_%20Part%201%20_%20Design%20criteria%20and%20construction%20_%20Bureau%20of%20Indian%20Standards%20_%201986.PDF
5 – <http://wsp.org/sites/wsp.org/files/publications/Presentation-Aaroon-Vijayker-Monitor-Deloitte.pdf>

and there is neither time nor priority among the villagers for debating on the health and sanitation issues and the collective behavioral change needed.

Delayed incentive from the government: A large number of houses have incomplete toilets which cannot be used. Over the past one year, there have been frequent changes in the procedures to be followed for subsidy disbursement. Lack of adequate or dedicated staff to match the growing scale of toilets construction has caused inordinate delays in the disbursement of incentive. Families who did not start the construction and those who got the sanction in subsequent batches became suspicious of getting the incentive support, and hence they are excusing themselves by stating that they are waiting to witness the subsidy release to those who have completed or progressed in their toilet construction, which is similar to the case in the State of Gujarat also.

Lack of clarity on administrative procedures: A Lack of clarity exists among the people as well as gram panchayat officials about the subsidy schemes. Shift from NREGS to SBM has again created the confusion. Every time there is change in procedures or institutional mechanisms, there is a prolonged lag period that adversely affects the enthusiasm and motivation built at the community level.

Rural Water Supply (RWS) is following the phased manner of implementation under which in some districts one GP per mandal was selected for the promotion of Open Defecation Free India under phase I in 2015 and another GP was selected for 2016 under phase II. Many mandals have not even achieved the 2015 target that was specified to one GP. This slow phased manner of implementation is partly because of the funding limitation to meet the state’s contribution.

The lists of beneficiaries under SBM incentive of Rs.12,000 for toilet construction is currently done by the District Collector and any subsequent changes to this list should also be approved by the District Collector which in most cases takes considerable amount of time. The photo copy of AADHAR Card, bank account number, and photo of the beneficiary in the background of the newly constructed toilet are compulsory evidence required for disbursing the incentive amount which also takes lot of time.

Incorrectness of the data or survey done: *A baseline survey was conducted by SBM Gramin in 2013 to verify the real status of toilets.* We are not sure how accurate this survey has been. In the past we have seen houses with existing toilets are in the list of eligible families for new sanction while some houses without toilets are missing from the list.

BCC messaging in WASH is ineffective. The message content is either so abstract and divorced from reality that it loses meaning, often copied from commercial advertising approaches. Or it is broadcasted as news and orders.

Misleading communication: In a few cases, the toilets were constructed months back but are not being used as owner of those toilets awaited verification process which is locally understood as a precondition for the release of financial incentive. The misleading communication was that toilets already under use at the time of verification may be considered as old toilet and disqualified from the subsidy support.

Housing schemes: State Government of Telangana has announced double bed room houses for the poor homeless families. There are also families who have got sanction under previous housing schemes but have been unable to begin the construction for different reasons. In all these cases, the plan for own toilet is tagged to new house aspiration which is bound to take longer period of time and till then people have continued to defecate in the open.

Lack of water availability: Owing to scanty rainfall in the past two years, the water sources are going dry and shortage of power supply is further aggravating the water supply problems. The incomes have dropped and debts are going high. This growing crisis of water is thwarting the sanitation promotion efforts.

Restrictions on sand mining is causing short supply of sand: Masons are more attracted to build houses under government funded schemes, and hence

there is shortage of masons for toilet construction which has also become a major barrier in maintaining the pace and quality of toilet construction.

Official transfer: Transfer of officials in the implementation chain disrupts the speed and team spirit between the officials and the GPs in promoting sanitation.

Social and Individual Behavioral Change Communication

Ineffectiveness of the existing IEC and BCC materials and the inadequacy of face to face sanitation and hygiene promotion messages came out strongly in all the villages of the three states that are considered in this study.

Unfortunately, the way sanitation discourse goes on today it is either 100% Community Led Total Sanitation (CLTS) or 100% subsidy. Opponents take rigid positions and are unable to see that reality lies midway; some sort of incentive needs to be provided either in cash or in kind depending on the context of each rural community along with an effective and enabling BCC messaging. BCC should

not be carried out in a standardized manner nor propagated through mass messaging in a marketing mode, as is used for selling soap and chocolates. It loses specificities in its appeal in terms of what the people are expected to do and what support the government can give. Moreover, if the language used is alien to the language used by local people, then no communication takes place.

The absence of clear programmatic messaging is perhaps the weakest part of BCC messaging in the rural sanitation programming. The focus unfortunately remains restricted to advertisement wherein the message is designed to be appealing and is often completely divorced from the reality of rural life and livelihoods. It does not respect or understand the constraints people face including women and children, and is developed in a language that is alien to their understanding. BCC messaging from government is increasingly perceived by the people as news broadcasting at best and orders at worst.

Since this is an important lacuna of the current sanitation programme, we are highlighting this in detail.

Jharkhand

No evidence was found of any regular and effective messaging for promotion of safe sanitation and hygiene in the three villages visited. Perhaps this was

Those who can afford are building expensive pucca toilets with septic tanks(not necessarily safe disposal), cheaper toilet options are not attractive for the rest.

BCC messages in WASH should be gender sensitive. Need to break gender stereotypes. BCC messages should focus on men and boys doing household work including cleaning of toilets.

because the entire Jamshedpur block of East Singhbhum district had already been declared open defecation free. No sanitation promotion activities including new toilet construction were going on in the three villages studied. However, on our way to some villages, we witnessed new toilet construction based on the government scheme, but there was no face to face communication or other wall paintings or any campaigns conducted before the construction process. We were told that the toilet for which government provided Rs. 12000 was constructed by a contractor who had been awarded the contract from the entire panchayat. This was similar to the contractor driven toilet construction process that was followed in the three villages we studied. Since the contractor was assigned the construction work, BCC messaging was not planned at all.

The anganwadi workers and teachers were more aware of the benefits and need of toilets and most vocal about this in the village group discussions and SHG meetings. However, there was no evidence of loans given for toilet construction by SHGs; hence, one could conclude that the awareness related to sanitation and hygiene benefits by SHGs was not translating into demand, even in these villages.

For the remote tribal villages or even in mixed villages with predominantly tribal and OBC population, the

residents of the tribal hamlets were not adequately influenced by BCC to demand toilets and to pay from their own pockets to build new toilets. Those who could afford are building expensive septic tank toilets (that are not safe in terms of the effluent discharge), but for the rest, it is open defecation.

This does not mean that all tribal hamlets showed a poor potential for toilet construction and usage. In a detailed discussion with one tribal hamlet, we learnt that the men wanted to build toilets but eagerly wanted some form of cash support from the government (either for material inputs or for the hard labor of pit digging by some who are not in a position to do hard work). When probed further about the contribution they can provide for toilet construction, we learnt that it can vary and possibly be only a small amount (between Rs.1000 to Rs.3000 per household) and the rest must be financed by a government programme.

Gujarat

Generally, it was observed that except for teachers, none of the community members either spoke or seemed to be aware of harmful pathogens from the fecal material entering their system and making them sick. The primary reason behind it is that they are unaware about the harmful effects of open defecation as they go far off from the house and believe that the fecal material will dry in

the sun and become soil. According to many, defecating away from home is a good practice. We observed that many of the tribal houses were neat and clean with beautiful drawings or paintings, but the general good hygiene practices were absent, as they follow certain unhygienic practices such as taking water from the water pot by dipping the glass directly, not washing hands before food, leaving the food uncovered, etc.

On being asked about the cleanliness in the village or house, most of them believed that unlike urban areas where the space was very less and surrounding very dirty, such conditions are not there in rural areas. However, we believe this response hides the hard work that goes into a daily grind for women and girl children. Keeping your home clean in a rural area is a back breaking task done by women. It is a gendered workload that is internalized by women and they do not realize it. Such stereotypes of glorifying cleanliness as the work of women must be broken in BCC campaigns of WASH. Men should also be made responsible for this unpaid house work and sanitation and toilet BCC messaging for WASH needs to be linked with keeping the homes clean.

Sanitation awareness campaigns were carried out around the panchayat house with support from government and even in school by the efforts of teachers. But majority of families were not aware of this.



Teachers very strongly felt that people do not want to build toilets because they neither see it as a necessity nor perceive open defecation as a health problem, moreover they cannot afford to pay for a new toilet construction. On being asked if they were motivated to build the toilet after seeing or listening to those messages on TV or radio, teachers as well as youths felt that the messages given by actors Vidya Balan and Amitabh Bacchan were not for them but for the urban population. There are no awareness campaigns or efforts to reach out to different households or families about the reason behind the importance of sanitation or to the ways of making the toilet or the ways of accessing funds from the government.

Telangana

One of the most common findings was that the understanding of oral fecal route of transmission of diseases is highly limited in all the villages we visited. Please revise

this sentence as follows: When we probed people further on their thoughts on why open defecation needed to be stopped, the common response was, “to live in clean (shubhram) surroundings as it is not good (manchidi Kadani) for us”. Seldom do people mention that open defecation is not good for our health (*maa arogyaniki manchidi kadu*). However, the risks of pathogens being carried by water, food, fingers, and flies were not mentioned at all by the adult respondents. The school children have some vague understanding. They were more confident in uttering these words in chorus rather than articulating individually, which reflects lack of clarity and confidence in their understanding. Unawareness about the risks associated with open defecation is the single most serious barrier for low or no efforts at individual, family, and community level on the elimination of open defecation.

The state level ‘Kara Deepika’ (hand book) on Water and Sanitation

produced by the State Swachh Bharat Mission explains in brief the problems of open defecation, oral fecal route, the tools and process for motivation and demand generation. However, the same is not reflected in the understanding of the people who need to adopt the behavioral changes.

The scanty material and efforts made by IEC and BCC created very negligible impact due to a variety of limitations.

Language: Newspaper advertisements, leaflets, posters, radio advertisements, and wall writings are some of the means of mass communication used to spread the key messages in which the language is not easily and fully understood by all the people. Mala Visarjana (*defecation*), Sampoorna (*total*), MaruguDoddi (*toilet*), Nirmanam (*construction*), Marugudoddi gala illu-ArogyanikiHarivillu (House with toilet is good for health) are few examples of the language used in

Examples of some excellent (simple and very easily understandable) and powerful messages (written on walls) developed by the local community in one of the successful programme on Open Defecation Free villages are:

*Intlovuntepayakhan—
untamudurangadawakhanaku*
(if we all have toilets at home, we can stay away from the hospitals)

*Thinadanikendukutondara—
chetulukadugumundara*
(why rush to eat, hand wash first)

*Andaruchadavali—
Andaruedagali*
(everyone must be educated, everyone should develop)

*Siri sampadalunna—
Payakhana lekapote
ammayini ivvoddu*
(let there be good wealth, but don't marry your daughter if there is no toilet in the boy's home)



IEC–BCC which is not the common language used by many people. Literacy, age, social conditions such as caste, geographical location, etc., are the key determinants of the individuals' ability or inability to grasp the messages wrapped in so called polished language.

Some of the words used (e.g., Sampoorna parisudhyam means total sanitation) are loaded concepts and people found it difficult in understanding the same. During the village visits, it was noted that even those who could read the wall writings on 'eliminating open defecation' could not grasp the meaning of the written script.

Very few people could recognize and remember the names of National and State Level Brand Ambassadors who put forth the sanitation issues in different programmes and advertisements, and the messages delivered by them are least understood by those who have limitations to benefit from other forms IEC interventions.

Content: Overloading of messages on safe water, sanitation, hygiene, solid and liquid waste disposal, etc., dilute the high priority messages related to elimination of open defecation. Pictures of the political leaders, programme related branding, details

of the organizations assisting in the implementation of sanitation issues and financial incentives, etc., are put along with messages on sanitation, and this becomes too much to read for someone who is just literate. It was noted that people tend to interpret the pictures with some pre-conceived notions rather than actually capturing the details of the printed text. IEC content is very general and not responsive to the locale specific perceptions and cultural barriers. In Gujarat, except for one village—which was pre dominantly OBC—there were no posters or other written messages on walls of other villages.

Targeting: In Katkur village, it was noted that majority of households in the Dalit colony did not have toilets. But there is absolutely no evidence of any IEC interventions targeting these households. It was observed that elderly and persons with temporary or permanent disabilities are totally neglected in the efforts to provide access to toilets. Current IEC interventions do not target sensitization on these issues. In Gujarat, both in the tribal and non tribal mix communities, people with disability felt completely left out as they never heard anything that addressed their issues.

Frequency: Behavioral change is generally slow and occurs in phased manner. One time effort of delivering the key messages does not generally give the desired result, there is need for assessing the change and identifying the

need through repeated interventions.

Change Agents: Home visits and interpersonal communication is found to be the most preferred form of receiving the key information, but this method is not followed in the current IEC and BCC intervention strategy. Currently, in the State of Telangana as well as in Gujarat, SBM implementation and demand creation is being done by Rural Development and Rural Water Supply and Sanitation (RWSS) departments, and both do not have dedicated staff or funds for IEC at the community level. Sarpanch, members of the Village Water and Sanitation Committee (VWSC), other community leaders and Anganwadi center staff have claimed that they make voluntary efforts in reaching out to individual households with key sanitation and hygiene messages. But on probing, it was understood that their knowledge and skill to do the job is very limited. Furthermore, their focus has been on speeding up the physical progress of toilet construction, informing about Rs.12,000 subsidy disbursement, and penalties of stopping ration if the toilets are not constructed. In addition, most of these individual volunteers or change agents have neither undergone any training nor do they have any material or tools for delivering the key messages.

Recommendations

The great diversity of rural India and the contextualization of BCC in WASH is highlighted in this research. From congested coastal village to transitioning tribal villages getting into cash cropping and indebtedness, other backward castes becoming landowners but surviving a crisis ridden agriculture economy – **this research was able to situate the key questions of barriers and motivators for sanitation at the larger social context as well as individual levels.**

We had undertaken this study to explore and understand if there were any deeper level self perceptions acting as barriers for the adoption of improved sanitation and hygiene practices in the rural communities. The study was undertaken in predominantly tribal communities (seven out of the nine villages that were studied) of Jharkhand, Telangana, and Gujarat, and **no significant barriers rooted into the deeper level of self perception were found, other than in the remote tribal communities.**

We found that the subsistence livelihoods of these remote tribal communities give rise to a low aspirational status. Their limitations of achieving a higher standard of living (not just increased cash incomes for material comforts but also education and health) **perhaps restrains them for investing in one element of change – the toilet.**

Primarily homogenous tribal villages do not suffer from any inferiority and a lower self perception value as compared

to other castes. Instead they have a relatively much higher standard of personal hygiene and village/hamlet cleanliness as compared to non tribal mixed caste villages in India. **Notions of purity and cleanliness (purity is not equated as cleanliness, hence higher caste and purer people may display a poor hygiene standard) are very different in some tribal areas.** A belief that open defecation is a safer sanitation management practice—not related to notions of purity—dominates the tribal communities and other lower castes that constituted the bulk of this research focus on rural sanitation.

The demand and threshold level for adoption of improved sanitation and hygiene practices was identified as an important programmatic intervention for sanitation promotion instead of relying exclusively on a zero incentive CLTS approach.

The recommendations presented in this section are for programme implementation agencies, government and donors, and researchers and students who wish to know what are the emerging priorities of sanitation and behavior change, particularly in the context of Swachh Bharat Mission and the objectives of achieving clean, Open Defecation Free India by 2019. We hope that these recommendations will be seriously considered by all implementing agencies and by policy makers at all levels.

Presented below are our recommendations.



1. No single behavior change promotion approach will fit all contexts

Swachh Bharat Mission Gramin aims at achieving 100% Open Defecation Free rural communities by 2nd October, 2019. In the last 30 years, the rural sanitation progress took place at an average rate of 1% a year in spite of the implementation of different levels of incentive regimes over the years which even increased in the last decade. The failure to hasten the pace of sanitation uptake in rural India has strengthened the call from some quarters that individual toilet subsidy per se is a problem. This diagnosis is inappropriate as it is based on the negation of the failed programme approach. It does not question the reason behind adoption and usage of toilet by some people (the higher wealth quintiles), building of more septic tank toilets in rural India over the last decade and the factors inhibiting people from investing their own money in new toilets. This diagnosis promotes a belief that those who do not build and use toilets represent deviant hygiene and sanitation behaviors, hence, proper behavior needs to be enforced and if required punishment must be given for violating the health security of all the people in their rural community. This is essentially the diagnosis and approach followed in the Community Led Total Sanitation (CLTS) approach. There are several variants of this approach in India today with similar assumptions and approaches.

This research shows that in remote tribal areas of rural India the demand for toilets is constrained by their subsistence livelihoods and the aspirational levels. In other tribal areas, villagers do not have ready cash for spending on a pucca toilet construction, yet in coastal Gujarat with congested rural village setting needing a septage (septic tank toilets) solution.

Hence, the question arises whether people resisting the construction of twin pit toilets be considered as violators of a social norm and punished for not building and using toilets.

2. Identify appropriate BCC messages in WASH from the perspective of the recipient or communities

Gender, caste and class influenced barriers (and sometimes motivators) to sanitation adoption are often not addressed in the sanitation promotion approaches.

Of late there has been an increasing reliance on commercial marketing approaches, making emotional appeals to entice and influence people to discard their old behaviours of open defecation and adopt toilet usage. Hence we see attractive BCC in WASH – Emotional Messaging Changes Handwashing Behaviours⁶.

This is backed by a belief that social sector needs to learn from the successful marketing techniques of private sector. “Skill in marketing is a scarce source in public health, especially in developing countries. The Global Public–Private Partnership for Handwashing with Soap set out to tap the marketing skills of industry for national handwashing programs. Lessons learned from commercial marketers included how to (1) understand consumer motivation, (2) employ one single unifying idea, (3) plan for effective reach, and (4) ensure effectiveness before national launch.”⁷

This is done often without trying to understand the basis of existing behaviours and what needs to be done to address deeper underlying causes of such behaviours.

It is important to identify appropriate BCC messages from the perspective of the recipient or communities and not from the perspective of the programme priorities

6 – <http://www.thehindu.com/sci-tech/health/policy-and-issues/emotional-messaging-changes-handwashing-behaviour/article5729912.ece>

7 – Masters of Marketing: Bringing Private Sector Skills to Public Health Partnership-
https://www.researchgate.net/publication/228345385_Masters_of_Marketing_Bringing_Private_Sector_Skills_to_Public_Health_Partnerships

Can't there be a bouquet of sanitation behaviour change messages that are positive, empowering and while reinforcing respect for the hard work men and women do in rural areas also urge them to wash their hands and use toilets? Have we concluded that only negative messages make people give up old habits and practices?

of implementation agencies (donor or government or NGOs) or from the skills and practices of some agencies who have employed commercial or social marketing approaches to sell products. Sanitation behavior change should not be reduced to selling toilets to people.

For example, this study shows that women share the concerns of male earning members of their family for whom money is a constraint and indebtedness is high, thus inhibiting their spending on toilet construction. In this scenario, the main concern is related to the BCC messaging that should be provided to the women.

One of the current BCC messages aired on radio says "since you will not build toilets, it is better to tell the flies not to sit on your food after sitting on feces." CLTS approach relies on generating disgust based motivation for people to suspend their open defecation behaviours and build and use toilets. More and more advertising campaigns for sanitation promotion are employing the same approach of creating disgust. Use disgust as a metaphor for sanitation promotion messaging by all means; but at the same time can't there be a bouquet of BCC comprising of WASH messages that are positive, empowering and while reinforcing respect for the hard work men and women do in rural areas also urge them to wash their hands and use toilets? Have we concluded that only negative shaming BCC messages make people give up old habits and practices?

A uniform national or even a state level BCC messaging with standardized messages and an advertising promotional approach will not motivate rural households in building and using toilets.

Messages need to be localized and sensitive to gender, caste, disability, and class. Messages should reinforce and respect peoples' lifestyle and livelihoods as well as admire and show respect to their manual labor. BCC messages should not promote a stereotype of dirty rural communities who are ignorant of the benefits of improved hygiene and sanitation.

3. Appropriate BCC messages for tribal communities that are living in remote rural areas at a subsistence level

The research has shown that poor sanitation outcomes in remote tribal areas are perhaps not the failure of BCC to motivate toilet construction and its usage. Low sanitation coverage could be an outcome of material conditions of lack of water and space for toilets, as well as a result of subsistence livelihoods (less than Rs.6000 per month cash incomes) as explained earlier in this report. People are living at a basic subsistence level off the land, without out migration to cities and other states, surviving from what they produce, from cheap ration provided by government and from wage labour in the vicinity of 5 to 10 Kms of their habitation. This lifestyle, with no possibility or potential for increased cash incomes, better education, health and livelihoods for their children - does not motivate people enough to aspire for a higher standard of living that includes having pucca safe toilets.

We are not questioning the need for BCC for sanitation in remote tribal areas. BCC for sanitation awareness and toilet usage should be contextualized to the livelihoods, to the self perception and aspirations of the local people. More compelling focus areas for a localized BCC campaign need to be identified with evidence, for effective BCC message development and dissemination. For example, if in a tribal community people already have a high sense of cleanliness and order both at the personal household level and that of a keeping the village and streets clean as in tribal Jharkhand villages - occurrence of diarrhea and water borne diseases are low - social taboos including a patriarchal society where women's dignity is seen only in terms of her possession by the male members of her family and safety of women defecating in the open is not an issue - in such circumstances you need



to find more appropriate BCC messages for sanitation promotion. BCC messages will have to be designed based on a study of what will promote adoption of toilets.

Aspiration for a toilet can be pushed up if this is creatively advocated through BCC messaging by those agencies that have influence on the choices of the local communities. These include Integrated tribal Development Agencies (ITDA), SC Corporation, BC Corporation, District Rural Development Agencies DRDAs, Social Welfare Departments, Local Banks, primary cooperative Societies, local NGOs, locally vibrant cultural and political assertion movements, etc.

4. Sanitation must be factored into the affordability threshold levels

Studies have shown and the national sanitation data confirms that some people will build toilets on their own while some will only build toilets if provided subsidy.

Incentives from other sources act as a motivator for some people to invest time and money from their own side. For example, the study observed that a minimum support of a few thousand rupees will motivate a large number of households to build and use toilets, perhaps not 100% coverage in a village but enough to secure a toilet for some to begin with and others to follow. Therefore, we need to identify the threshold level of barriers that can be broken with effective programmatic innovations backed by appropriate BCC messaging.

One of the major barriers or concerns of women especially from drought prone villages of Gujarat as well as other states is the availability of sufficient water for drinking and toilet usage.

5. Gender sensitive BCC messaging in WASH must include household cleanliness messaging and breaking gender stereotypes

BCC in WASH has so far only focused on a few critical messages – hand washing with soap at critical times, safe drinking water handling, toilet usage and safe handling of child feces. Menstrual hygiene is another issue that WASH has taken up. As development practitioners, we find that Gender and WASH are not given the priority that is needed in BCC messaging in WASH. Our research shows that BCC messages in WASH often reinforce the gender stereotyping roles of women. Most menstrual hygiene management messaging in WASH is also gender insensitive; menstrual management awareness is imparted as a functional knowledge of menstrual cycle and safe methods of management and disposal.

Unless the critical areas of women's workload in keeping the house clean is incorporated into BCC messaging for WASH, we believe no lasting change can come in BCC for WASH.

Our research shows that on being asked about the cleanliness in the village or house, most of women believed that unlike urban areas where the space was very less and surroundings very dirty, such conditions are not there in rural areas. However, we believe this response hides the hard work that goes into a daily grind for women and girl children. Keeping your home clean in a rural area is a back breaking task done by women. It is a gendered workload that is internalized by women and they do not realize it.

Such stereotypes of glorifying cleanliness as the work of women must be broken in BCC campaigns of WASH. Men should also be made responsible for this unpaid house work and sanitation and toilet BCC messaging for WASH needs

All BCC messages need to reinforce that safe disposal of feces is required.

to be linked with keeping the homes clean. We believe that **unless the larger cleaning of homes is seen as a shared work among both men and women, or else the burden of keeping toilets clean will also fall exclusively on women.**

6. Use appropriate, locally understood language for BCC messaging

Some of the words used (e.g., Sampoorna parisudhyam means total sanitation) in BCC messaging are loaded concepts and people found it difficult in understanding the same. During the village visits in Telangana, it was noted that even those who could read the wall writings on 'eliminating open defecation' could not grasp the meaning of the written script.

Local words, tone, dialects and language need much deeper attention.

State and the district authorities should proactively use the flexible programme options of the SBM for ensuring deployment of competent, motivated and well equipped change agents (preferably from the local communities) who can consistently engage in inter personal communications (IPC). IPC is an essential requisite for creating proper awareness, knowledge and motivation that contributes to desired behavioral change with respect to sanitation and hygiene. This network of change agents should be backed by a support system that constantly feeds information, innovative ideas of BCC, and facilitates cross learning.

Systems of recognition and appreciation, incentives, and monitoring should also be in place to ensure effective functioning of the change agents.

7. Need to address peoples' perception of cause of ill health and disease

Living in dirty unhygienic environment and poor sanitation, is a health hazard. However, there are other important factors for poor health rather than sanitation and hygiene borne factors. The other vital factors are lack of proper nutrition, hard physical work or availability of no work and a general weakness of the human system over the years from early marriage and child birth to perhaps poor personal hygiene and breast feeding practices, repeated bouts of weakness from malaria and viral fevers, etc. While we need to show the importance of cleanliness and its health impact, sanitation and hygiene alone may not solve all health issues.

In our research, few people are able to link sanitation with ill health. People report other more serious ailments and respiratory diseases above diarrhea. The advent of safe drinking water handpumps has perhaps made the largest dent in preventing water borne diseases.

Even in places where diarrhea and water borne infections are occurring, BCC messages in WASH should focus on making people aware of the health risks directly caused by poor sanitation and hygiene. In addition to this, **BCC messaging must highlight the causal factors that have a complementary effect on the other health risks** rooted into malnutrition, hazardous working conditions, etc.

Single messages are currently popular and are a major cause of concern. This is perhaps a result of reliance on commercial marketing and advertising strategies and proof of blindly copying this approach in development work. It assumes people are incapable of understanding more interrelated factors of poor health outcomes. The Pulse Polio advertisement using filmstar Amitabh Bachhan, had no mention of poor sanitation as a compounding factor on polio infection and transmission.



At the village level, all the concerned government functionaries [Asha worker, Anganwadi worker, ANMs, School Teachers, Technical Assistants of National Rural Employment Guarantee Scheme (NREGS), facilitators of women SHGs and the RWS&S etc] and private institutions (RMPs, Private Schools, etc) should be engaged in a well coordinated manner for delivering and reinforcing the common health and sanitation linked messages.

Hence, a more nuanced messaging needs to be done; simply linking disease to sanitation will not convince people. While communicating the importance of sanitation and hygiene, the individual should not be made to feel responsible for their suffering from ill health and other diseases, as is currently being done.

8. BCC messages only focus on using toilets, not on safe disposal of feces

In the tribal communities, there is a high level of understanding of personal hygiene and cleanliness. Open defecation is practiced as part of the daily routine of going out for work in the morning. The area for open defecation is usually far away from the village for ensuring safety related to health issues, and people do not mind walking more than a kilometer for defecation.

All BCC messages need to reinforce that safe disposal of feces is required. The function of a hygienic toilet should not be highlighted only as a physical structure for just providing privacy for women, but also as a health safety infrastructure.

Both open defecation and septic tanks that have unhygienic disposal of waste water and septic waste close to home are a health hazard. This needs to be communicated in BCC messages.

9. Need for more focus on safe handling and disposal of child feces

Both Health and Integrated Child Development Scheme (ICDS) departments have independent tracking systems to ensure pre and post natal health care. These two departments have the practice of organizing joint Nutrition Health Days (NHD) which plays a very significant role in ensuring the basic mother and child care. Special awareness on safe handling of child feces needs to be integrated in the practice of Health and ICDS departments along with the promotion of any other mechanisms that focus on the coordinated effort of these two departments. This should also particularly include the safe disposal of child feces in existing toilets.

10. Design and construction quality of households toilets—small sized cramped toilets not acceptable

Most of the feelings of discomforting in using a toilet are mainly: suffocation, stink, sweating, dampness, etc. This is because of the neglect of construction standards, in design and cramped toilet space. If masons are trained, the problems can be minimized. Hence, there is a need for ensuring that masons have knowledge of essential quality compliance standards.

A checklist on technical standards for toilet construction should be promoted so that it becomes a common knowledge at the community level. The current pre (final) payment verification largely takes care of financial accountability; there is less rigor on the standards that are important for users comfort. Smaller size pit toilets of 3x3 feet dimension is not user friendly, often influencing disuse.

Ongoing systems of reporting, reviewing, and monitoring designed for anganwadis, schools and hostels should include sanitation and hygiene as essential parameters.

The flexibility in the SBM guidelines must be used to implement site specific modifications which will boost the pace of construction and rate of toilet usage.

11. Need to ensure clean and well functioning institutional toilets (schools, anganwadis, and block and district level government offices)

Current practice of using dirty toilets in the institutional settings of schools and hostels is not inculcating the demand for toilets at home. The younger students and girls, typically studying in hostels (for tribal students), do not mind going for open defecation when they come home for vacations.

Ongoing systems of reporting, reviewing, and monitoring designed for anganwadis, schools and hostels should include sanitation and hygiene as essential parameters. Users must be regularly oriented on proper usage and maintenance.

The annual school development plans and local monitoring by the School Management Committees should also prioritize creation and upkeep of sanitation facilities.

Display boards with details of available WASH facilities against numbers of users, functioning conditions, rate of usage and maintenance should be provided to improve the accountability of the concerned functionaries.

12. Affordability and a perception that toilets cost a lot of money is a major barrier that needs to be addressed both in programming and BCC messaging.

The study found that those men and women who do see the requirement of toilets at home feel it is the luxury beyond their affordability. The perceived cost of toilet is from Rs. 30,000 to Rs. 50,000 which is based on somebody's actual experience related to the expenditure incurred for building toilets, information shared by local masons, their own imagination and combination of all the factors. Majority of the families begin toilet construction without clear estimation of cost, and they get stuck when the actual costs go beyond their means. Local source of guidance on making reliable cost estimates is required particularly when the user's family decides to customize the standard recommended toilet design. Adding bath room, western commode, RCC roof, increasing the size of the room, raising the basement level, internal tiles, septic tank, sintex overhead tanks, etc., are the added features.

Local masons should be equipped with an approximate expenditure chart for guiding people on the cost estimates. Popularizing the tablet based and now SBM online template for toilet construction and costing options (developed by Water for People) is a welcome step that needs to be implemented on the ground.



13. Sanitation priority for differently abled old and infirm should be target and time bound priority under SBM

Local NGOs can also be engaged in demonstrating the safety of toilets that can be built at low cost. **Addressing the toilet access needs of old, disabled, and pregnant women** is a major challenge. The study found that about 15% households have members with special needs because there are people who are physically challenged, mentally challenged, elderly, etc., and so are in urgent need for toilet facility at home. During the study period in Telangana, we came across an elderly person (YerraGollapahad) who sold their assets and gold ornaments for constructing the toilet without which they were facing extreme hardship related to defecating in the open. It is impossible for such elderly people to manage toilet construction on their own. They want GP or someone from the village to construct toilets for them.

Till now, not enough has been done in the national sanitation programme to address this challenge. The Ministry of Drinking Water and Sanitation (MoDWS) has only recently come out with guidelines for toilets and water points that are accessible by people with physical disabilities. However, implementation of the same needs a **decisive action from the state governments** in the form of operational guidelines and capacity building of the ground level personnel who are responsible for implementing SBM as well as for monitoring it, so that they can ensure compliance to the guidelines. **Additional financial incentives** for adoption and implementation of toilet designs for disabled people should be implemented. **Local SHG federations or any other appropriate CBOs or the GP should be assigned with the responsibility of assisting the disabled and aged to construct toilets at their home.**

The most recent thrust of SBM Gramin for targeting 150 districts GPs to become ODF within a year should include

special section on people with special needs. There can be a target for ensuring 100% toilet coverage for all households having people with disabilities by 2nd October 2017. Achieving such goals will be a moral booster for SBM and make it popular.

14. Swachh Bharat Gramin Guidelines should relook exclusive promotion of twin pit latrines, and should address emerging septage management challenges

Over the last few decades, rural communities have had a varying level of exposure related to building of toilets. This exposure includes septic tanks, sewerage systems, and pit latrines. More and more septic tank toilets are coming up in rural areas.

Some villages are becoming congested, resembling urban settlements where there is no space for twin pit toilets. They may need decentralized septage solutions and not pit latrines as provided in the SBM national sanitation programme. In some villages, people may need proper Rural Drinking Water Supply which requires one time financing. In these villages, there can be decentralized septage management infrastructure, where groups of 10 to 50 households share a common septic tank and the septage is safely handled and disposed. The allocation of common land for constructing individual toilets in the rural areas needs to be considered seriously and even promoted.

In the long run, safe septage management is the answer to India's sanitation challenge in both rural and urban areas. The time has come to start planning for what it will take to promote decentralized septage management in rural areas in the coming 10 to 20 years. The present vision of Swachh Bharat that sees 2019 as a deadline for Open Defecation Free India is good but should not limit us from addressing emerging challenges.

There is also an immediate need for MoDWS programme guidelines on safe septage management. Masons who have experience of constructing septic tanks in urban areas are promoting the same in their own villages and some affluent households in villages are opting for the same. Appropriate technical solutions remain a concern, given the commercialization of septic tanks construction that is not following any standards. Congested lanes make it difficult for the emptying tankers to access and suck the septage from the filled in septic tanks. In such eventuality, the overflowing septage is just going into the open drains thus polluting the environment.

15. BCC campaign strategy needs to be developed at the district level and implemented by teams at the block level

There is a need to establish groups of young (interested) volunteers as 'Area Resource Group' at the block level through a systematic process of cadre building. The group of motivators and promoters of sanitation and hygiene can be formed at the district level from universities, colleges, schools, and private sectors including doctors as well as other professionals, and NGOs. Promoting toilet construction and usage without understanding peoples' deeper self perception barriers and physical constraints will not work. It is one reason behind the failure of the previous attempts made at creating a plethora of institutions: Community and Capacity Development Units (CCDUs), Village Water and Sanitation Committees (VWSCs), Water and Sanitation Management Organizations (WSSOs), and Block Resource Centres (BRCs).

It will also require allocating sufficient financial resources for BCC work and not simply relying on social marketing messaging.

The strategy should include developing a plan for appropriate and decentralized campaigns at the block and village level. For example, the number of villages that can be covered within a year long BCC campaign under Phase 1, 2, and 3 in order to plan, implement, and sustain Oral Defecation Free practices.

It is also important to plan, identify and address in a time bound strategy: the different types of barriers with specific focus on the needs of pregnant women, adolescent girls, old, infirm and disabled.

16. Support of Gram Panchayat in the implementation needs priority

Ward members and other panchayat members should take responsibility for providing appropriate information and support to the people who demand toilets through proper documentation of the subsidy, technical design and operations, and maintenance.

GP could facilitate the process of approval, verification, and reimbursement of the subsidy. GP should urgently address the issue of toilet repair for anganwadi and water provision for school toilets so that children learn the habit of using toilets.

Political will is required not just at the Prime Minister level but at all political levels – Zila Parishad members, Block Panchayat members, Members of State Legislative Assemblies and Members of Parliament. Unless there is political participation, encouragement and will at the district and block level, GPs cannot be supported to implement and achieve ODF goals.

17. Self Help Groups should prioritise sanitation or toilet construction

The potential of SHGs network should be effectively tapped for promoting sanitation and hygiene. This is linked to poverty reduction and women's development objectives.

Specific areas of engagement of SHGs could be based on developing village sanitation plan, generating demand, peer monitoring on toilet usage and practice of hygiene behavior, providing soft loans for construction of toilets, managing the revolving loan fund meant for assisting Above Poverty Line (APL) families, procuring construction material collectively, promoting local entrepreneurship for village sanitary mart, assisting the needy families in managing construction, and representing the implementation issues to the concerned authorities.

This requires capacity building of the SHG leaders and providing appropriate space and opportunity in planning and implementing the processes at the village and block levels.

Zero interest bank loans for SHGs exclusively for promoting toilet construction at home can be done by the government.

18. Droughts and water scarcity constrains toilet construction and usage

Pursuing sanitation and hygiene development in isolation from village water security is neither sustainable nor does it contribute to the health outcomes. The scarcity of water is bound to push down the usage of toilets. Efficient functioning of current water supply systems, water harvesting, water conservation, efficient water usage, recycling of water, balancing demand and supply, etc., must be promoted particularly in the villages facing high levels of water deficit.

Sanitation must be promoted as part of larger water security plan for the village or GP. States should prioritize capacity building, allocation of financial resources, and enabling Panchayats to implement and achieve progress on water security plans. There should be harmonization of macro plans and programmes such as river basin management plans and the village water security plans.

While BCC is important in the rural sanitation context of India, water scarcity is emerging as a major constraint. The summer of 2016 is considered a major water crisis in India. Water scarcity is partly related to uncertain climate change along with reduction in the level of ground water in India which is a long term phenomenon.

From the Gujarat drinking water supply programme WASMO, it is evident that there is no 24x7 drinking water supply; rather there is a meager water supply once in three days and that also for only one hour as per the study village. The water is supplied from the exogenous Narmada river, and the water supply in these villages of Gujarat is insufficient for flush toilet usage. WASMO is supplying 130 lts of water per day to each household at an economical rate of Re1 per day. This low cost is possible because of the large size of the village with 1200 houses out of which 900 are connected to the tap water supply. If the households built toilets then their water requirement will increase at least three times the current rate which in turn will increase the cost of water supply. Will there be three times additional water supply available from Narmada canal for all the Bhal villages to support the water requirement? Will the people be willing to pay three times the present tariff?

In Jharkhand and Telangana too water scarcity and large scale failure of hand pumps and village water supply schemes is a growing concern for universalization of sanitation target till 2019.

Owing to scanty rainfall in the past two years, the water sources are going dry and the shortage of power supply is further aggravating the water supply problems. The incomes have dropped and debts are going high. This growing crisis of water is thwarting the sanitation promotion efforts.



Village Reports

Gujarat

Surpur village, Dahod district

Physical / Environmental

About the village: Surpur is an interior village situated in Santrampur block of Mahisagar District of Gujarat. This district has an extremely low coverage of toilets. Total population of the village is 1818, consisting majority of tribal population. The total number of households is 528, consisting of 10 SCs, 8 OBCs, and the rest are tribal. Agriculture is the main occupation, and a few do business in a nearby town of Santrampur. The major crops are paddy, maize, redgram, black gram, etc. Although situated very close to a river, the entire agriculture is rain fed. The availability of ground water is hardly enough for drinking.

The land holdings are approximately two to three acres per family. Private agriculture land holding has not been assigned to all households, mainly because of the lack of execution of inheritance property. Hence, there is always a conflict in the families over accessing resources or benefiting from the government.

There are 150 bore wells created by the Panchayat in different falias (hamlets). Water scarcity exists from almost March to

July in the year. The quality of water from some of the bore wells is not so good, and hence, some of them have to walk for long distance to get water from a private open well. There is government multi village scheme of piped water supply, but no water comes in the village. There is acute water shortage problem in the village. There is one private bore and one Panchayat owned well, which has water in good drinking condition. Though the village is situated on a hillock very close to a river, this source somehow has not been tapped by the government and the plan is to bring drinking water from a long distance. There is a lot of anxiety in a community, especially among women. There is no clarity as to how the water from the bulk water supply will be distributed to scattered tribal households. Hence, for most of the families access to enough potable water was a priority over and above securing a toilet. Moreover, in places where there is hard rock, people are not sure about the ways of building twin pit toilets.

Majority of people are engaged in agriculture, and some are involved in unskilled labor. Moreover, almost 40% families migrate for about five to six months in other parts of Gujarat. The average income of the household is Rs. 12000 per year from agriculture. They grow their own vegetable. From the work outside the village, they are able to earn about Rs. 2000 to Rs. 5000 depending on the number of members who can work from the family. People report spending very high amounts on health issues every year (Rs.15,000 to Rs 20,000) and almost similar amount for social functions.



Almost all families are indebted, ranging from Rs.30,000 to Rs.40,000 with an annual interest rate of 60% to 120%.

There are a total of 20 toilets in the village. Most of them are of families engaged in business or teaching. Almost 70 % households have mobile phones, and about 30 % have TV and motor cycles. About 150 houses have been built under the government housing scheme. Almost 100% children are enrolled in the school (middle school) but about 5% children are absent during the migration period. Good sanitation facilities are available in school with access to water.

Awareness and IEC (beliefs, practices, culture): Members of the rural community seemed unaware about the dangerous pathogens from the fecal material entering their system and making them sick. They believe that going for open defecation far off from the house is a safe practice. Fecal material in the open becomes dry and turns into harmless organic material or soil. Many said that defecating away from the house was a good practice. Most of the tribal houses were neat and clean with beautiful drawings or paintings, but other good hygiene practices were absent, such as taking water from the water pot by dipping the glass directly, not washing hands before eating, leaving the food uncovered, etc.

Most people believe that unlike urban areas where the space is very less and the surroundings very dirty (slums settlements), they do not seem to have the same problem in their villages. For safety of smaller children, they are not sent far from home to defecate; some soil is used to cover their feces. There were no sanitation awareness campaign posters or wall writings in the village except for some posters on the outside wall of the school and panchayat building. The messages were more about water safety (drinking clean water). Children are aware of the health problems due to open defecation and like using toilets in their school. But they could not convince their parents to build toilets based on the issue of health benefits alone. Teachers as well as village youth felt that the BCC messages on sanitation and toilet usage that are aired

on television and radio by film actors—Vidyabalan and Amitabh Bachhan—were not for them but for the urban population. There are no awareness campaigns or efforts to reach out to different households or to remote hamlets of the village. There is no campaign to promote the importance of sanitation and also the ways of availing sanitation subsidy given by the government.

Social context: Women recognized open defecation as well as the issue of walking far away from home for defecation as a problem. Most said they had to walk for at least half to one and a half kilometers (near the river). Affordability and the decision making on toilet construction by men were identified as the two major barriers for not building toilets at home. Few women have toilets in their houses (mainly OBCs). The motivators for them were old and ailing old in-laws (mother or father), and not their own need or demand. Young girls and boys shared that they realize the need of a toilet but could not press their demand on their fathers. The male earning members raised the issue of competing demand for spending on agriculture or other economic priorities (including social and community expenses in a village, illness and health, repairing the house, farming mainly by the tribals or starting some small business by OBC families). Young people also had their own aspirations to meet, such as buying a mobile, motorcycle, higher studies etc.

Affordability: Indebtedness is very high. We found that more than 90% families (almost 100% tribals) were indebted for agriculture or small venture business, health, house alterations, and social events. Indebtedness of any individual varied from Rs.25,000 to Rs.60,000. Most people believe that a new toilet construction will cost Rs.40,000 to Rs.55,000. Awareness of government subsidy for individual toilets was low. Most families expressed their inability to increase their debt by taking additional loans for toilet construction. Keeping money aside for emergencies (health and social) is higher on their agenda than borrowing cash for building a toilet. There is a major mistrust in securing government subsidy not only for toilets but also for any other social welfare entitlement.

Fifad village

About the village: Fifad is situated in Jafrabad block, Amreli District of Saurashtra. It has a population of 2800 with 627 households. More than 60% families are landless or are marginal land holders (less than 1 hectare). Wage labor is the major source of livelihoods (agriculture and non-farm wage labor).

The village is composed of mix community both caste and region wise, namely, Dalits (including Devi Pujak, Vankar), Muslims, and OBCs (Bharwads, Rabaris, Thakore, Koli Patels). People complain about not receiving adequate government attention for welfare and development interventions.

Physical Environment and sanitation facilities: Groundwater is saline, and there is an acute drinking water problem in the village. A swajaldhara scheme was implemented five years back for drinking water but is incomplete. There are 10 to 12 handpumps, but they do not give adequate drinking water. Less than 5% or 35 families in the village have individual toilets or sanitation facilities. The village is prone to floods and mud houses of many families are broken from the recent flood. For open defecation, they have to go at least one km away from the village. There is also space constraint for building individual toilets.

Like most land ownership, individual household toilets are mostly built by the upper caste people. Within Muslims, there are 17 families (Bukharisunni sect), and all of them have toilets even when some of these families are poor, mainly as a social practice of keeping women in purdah.

The older generation has never used a toilet and is reluctant to use a toilet now, in the last stage of their life. Some felt that if women had to go far for defecation, there is nothing wrong as they have a lot of time. On asking them if they would ever use toilet of their relatives or neighbours, almost all responded negatively stating that that it was a question of their self respect and pride. There was no personal motivation for building a toilet from their resources other than securing government subsidy for toilet construction. Moreover, location of toilet was preferred far away from home.

Women are preoccupied with the anxiety of collecting enough drinking water; hence they feel that they could think of toilets only after their water problem is solved.

Awareness, IEC effort: People do not recall any sanitation awareness messages or remember any campaigns for behavior change promotion related to sanitation in their village. There are no posters or wall writings giving messages of safe sanitation in the village. Communities were not aware of any change apart from the programmatic changes made in the national sanitation programme from that of the Total Sanitation Campaign to Nirmal Bharat Abhiyan. Presently Swachh Bharat Mission focuses on the individual toilet subsidy offered and this a major change in the program from the previous ones. They are aware of the sanitation promotional campaign on TV and Radio but see them more as advertising campaigns. There are very few people who have ever used a toilet as shown in the TV campaigns and so are not aware about the ways of building and using these toilets. A common response we got in this village was that “We are born poor and would always remain without toilet facilities.” Most of them believe that going for open defecation far from the house is a good practice. They did mention the occurrence of illnesses in the village including typhoid, diarrhea, and few others. However, they did not connect open defecation and these diseases. Most people are not aware of the individual toilet subsidy or incentive or support of Rs.12,000 per toilet from the government. People estimate that a new toilet will cost them at least Rs.30,000.

Drainage was a major problem in the village. Women felt drainage problem as a vital issue along with other solid waste dumped around the village which is becoming a major inconvenience during monsoon. Panchayat was not paying much attention to the issue. Especially youth from the village said that if proper information and guidance is given, then many households in the village will make the toilets.

Affordability: Most families were landless and dependent on daily wage and had huge debts of about Rs.30,000 to Rs. 35,000. They expressed their helplessness in securing additional loans for individual toilet construction. Most of poor households (except the Patels and Saiyaad) have mud houses. Subsistence livelihoods based on daily wage labor (agriculture on shared or contractual basis or migration) is the norm. Health expenditures are high.

People want the government to provide cash incentives or construction material for building of new toilet. They are willing to contribute their labor.

Katpar village

About the village: Katpar is situated in the coastal area of Bhavnagar District, Mahua block, in Gujarat. The total population of the village is 5500 with 1200 households. The village is about 350 years old. There are about 1190 Kolipatels' families (OBCs), and the remaining constitute of five Muslims and five SCs. There are about 20 women headed households. The major occupation is fishing, and there is a social cohesion in this village based on age old traditions of mutual aid and sharing. Money is not given on interest.

Social context: Almost 20% families had one or the other type of disability. However, none of them have toilets and face tremendous problems, as the family members handled their defecation in a very unsafe way. Apart from these families, there are many single women, who have lost their husbands in the sea during fishing. No resistance came from men or families as everybody seemed to be interested in having toilets.

Almost all houses have a small temporary space for bathing, sometimes in the same room where the entire family stays or right besides the entrance of the house. Women and girls face problems not only when they have guests but also any time when they have to use the bathing place.

Almost five to six people share a single room and about 30% lives in houses of their relatives. The lanes are narrow and there are no backyard or front open spaces. Fishing is the main occupation of the villagers as the village is located on the coast, and people are landless as there is no agriculture and associated social hierarchies.

Accordingly, perhaps there is a need to pitch for WASMO type sanitation solutions where alternate saline ground water is used for putting in place a sanitation flush water supply system. A large septage based sanitation for the village will require another WASMO type intervention at high capital cost to build group septic tanks or Dewats tanks and to repair pipeline linkage with each household.

Sanitation and water status: Katpar faces challenges of cyclones, underground saline water, and presence of hard rock. The village is densely populated with back to back small houses (less than 30sqmts) surrounded by narrow lanes and so there is lack of space for people to build pit

latrines. There are many tenants in the village, as family and friends of original habitants who have moved out of the village occupy the houses of the original owners without any monetary transaction in the form of rent.

In the entire village, there are about eight toilets and those toilets were mostly built from their own funds, except for few new ones which are under construction, and people are hoping to get government resource. Many families have expressed their willingness to even take additional loans to build the toilet if they get proper technical guidance and timely support from the government.

The village has a WASMO water supply scheme that provides tap water to almost 100% households (except some new households coming up recently).

Few toilets are there in the village probably because of the small size of houses with lack of space, the relatively high tenant occupied houses, and a large coastline for open defecation. The open defecation area is earmarked for men and women and is located atleast a kilometer away from the village for ensuring safety.

There do not seem to be any deep-seated individual perceptions or social barriers for adopting improved sanitation behaviors. The reason behind it is probably that the village is predominantly OBC population with no traditional hierarchy of upper caste prejudice. Lack of space is a real constraint, and the people are building toilets at the entrance of their houses because they do not have any constraint about the social taboos of feces and dirt. Furthermore, there is no space at the back of their houses to build toilets.

The challenge of sanitation in this coastal village is predominantly a planning challenge because of a lane wise septage solution and not a typical rural sanitation twin pit sanitation issue we faced elsewhere. The need of this village is a small scale septage system and not twin pit rural toilets. This will require a WASMO type sanitation intervention to link groups of houses with septic tanks and ensuring septage management and safe disposal.

Finally, sanitation challenge is linked to water availability. WASMO is supplying 130lts of water per day to each household at an economical rate of Re1 per day. This low cost is possible because of the large size of the village with 1200 houses out

of which 900 are connected to the tap water supply. If the households built toilets then their water requirement will increase at least three times the current rate which in turn will increase the cost of water supply. Will there be three times additional water supply available from Narmada canal for all the Bhal villages to support the water requirement? Will the people be willing to pay three times the present tariff?

Awareness and IEC efforts: Peoples' awareness of benefits and health impacts of safe sanitation is high. Women's groups in the village are also active and represent a good understanding of sanitation and hygiene benefits.

Women, girls, elders, and people with disabilities expressed their hardship of not having toilets. Most of them said that the panchayat had made an effort to create awareness about the sanitation program of government. However, none of them have the clarity in terms of technical aspects for ensuring sanitation systems in their village.

The IEC efforts were more in terms of building the toilet and the resources available from the government for building twin pit toilets, and completely ignored the reality. There are a number of coastal villages in Gujarat having similar condition but the technical issue remains unresolved. Therefore, despite people having a strong demand for toilet, the village remains without toilets. Though there is a GR stating that individual toilets can be built on common land, no clear information about it was available in the village or with the panchayat.

Toilets for people with disability have been completely excluded in the IEC efforts.

Affordability: Fishing is the major occupation. Almost 70% young people migrate for three to four months in a year for working as agriculture labor. The average income of each family is about Rs.150 per day when the fishing season is on. However, alcoholism and reliance on cash are high. For four months in a year, there is no fishing. There is high indebtedness of Rs.20,000 to Rs.75,000 per family. Mainly the debt is due to their social purposes (marriages, deaths and social borrowing), illness, investment in different implementations etc.

Affordability per se is not a barrier for building toilets in this village. Physical constraints of space and tenant occupied houses are the major barriers.



Simuldanga Village

(Devghar panchayat, Jamshedpur, East Singhbhum district Jharkhand)

Social Context and access to water and sanitation

The village is perhaps 125 years old consisting primarily of tribals who were native residents. The OBC (Gorai) community came afterwards and settled in the village.

A predominantly OBC and ST populated village, the village has a total population of 750. Out of the 155 households, 88 households are OBC and 68 are ST. There are 10 women headed households and seven people with physical disability in the village.

The OBC households look relatively better off economically and also in terms of better access to handpumps in their part of the village. This is also affected by their accessibility to sanitation or toilets. Only four ST households have toilets compared to 22 OBC households. Interestingly, all the 26 households have septic tank toilets and not the twin pit toilets. Out of the 15 handpumps in the village, seven are defunct and only six deliver water throughout the year. These functional handpumps are all located in the part of the village.

Land ownership is quite even, 141 out of the 155 households own land. Tribals own more land than OBC. However, nonfarm livelihood in terms of labor in factories near Jamshedpur is the norm and is the primary reason for the relatively better off OBC communities and their exposure to toilets with septic tanks.

Cancer, TB, malaria, jaundice, typhoid, and diarrhea are the prevalent diseases which show the magnitude of the health problems in the village. Malaria and jaundice is the most intense. Last year there were three deaths due to TB and five due to cancer. This signifies that water borne disease burden is not as significant as others.

Sanitation status: Till about five to six years ago, there were no toilets in the village. Toilets have been built by individual households spending their own money based on the exposure they have had to outside world. Hence, the perception that the relatively better off only build toilets because they can afford to build expensive septic tank

toilets. Open defecation spot is at least half a kilometer away from the village next to a river. The OBC settlement is congested and therefore they preferred building toilets.

The few septic tank toilets we observed in the village have three chambers of large underground septic tanks (12ftx10ft) built by the village masons and not outsiders. People told us the septic tank can last 10 to 20 years without being cleaned. Since it has been only five to six years, so far no septic tanks have been emptied. However, the septic tanks we observed were discharging the outflow in open area creating a stinking pool of water close to the house which is causing potential health hazard.

There was one household with a “Shankar septic tank” that a local company is promoting. This septic tank toilet consists of a larger circular ring based tank (10ft deep, 3 ft wide) and a smaller secondary ring based tank (5ftx3ft) for outflow. The private contractor charges Rs.12,000 for digging out and placing the two tanks, the superstructure cost must be borne by the household.

Affordability: We were surprised at the huge cost of construction of septic tank toilets that were mentioned. Most households who built these toilets with septic tanks could afford to spend more. The estimate they gave us ranged from Rs.40,000 to Rs.60,000 per toilet.

Over the last few years, an engineering college has come up near the village and some OBC families have sold their land to the college. From some tribals, we came to know that the selling of land by OBC families was the reason behind the septic tank toilet construction boom in the village in the last five to six years. Otherwise cash income is negligible for people to invest in toilet construction.

A local mistri (mason) who builds septic tanks gave us an estimate of Rs.13,000 for septic tank toilet:

- Rs.550 (for pan, pipes, seat, foot rest and water seal)
- Rs.5500 for bricks (1500 bricks)
- Rs.2500 (cement 7 bags)
- Rs.1200 (half a tractor of sand)
- Rs.2500 (labor)
- Rs. 800 (door)
- Rs.200 (pipes)

Perhaps, the people are spending more on the superstructure, large toilets cum bathrooms. There is also a perception that these toilets are more expensive than they actually cost.

The part of the village with ST families constituted of nearly 60 households with no toilets. Only about four households near the road have toilets. They told us pit latrine toilets were built by contractors some years ago that were never used and became defunct. Their priority was water and not toilets because they have to secure water from the OBC tola handpump in summer owing to drying up of their own handpumps.

BCC and IEC: There were no sanitation and hygiene promotion messages or wall writings in the village. No one had come to promote sanitation and hygiene, perhaps because the entire block was declared Open Defecation Free area a few years ago.

The OBC women on being asked about health benefits of toilets were unable to answer clearly about any direct health benefits. Convenience of a toilet close to their home and diminishing open defecation spaces were major motivating factors. Women demand toilets, but men make the delay stating that toilets will be constructed only when they can afford to pay. ST women have prioritized the problem of drinking water, and the men wanted full subsidy to build toilets. It was obvious to us that toilets even if built on subsidy would not be used by the ST community because it is not their priority.



Eddalbera village

(Devghar Panchayat, Jamshedpur block, East Singhbhum, Jharkhand)

Social Context and access to water and sanitation

People told us that the village is perhaps 270 years old consisting primarily of tribals who were native residents. The OBC (Gorai) community came afterwards and settled in the village.

The village is predominantly populated by OBC, ST, and SC communities with a total population of 816. Out of the 130 households, 73 households are OBC, 53 are ST, and four are SC. There are nine women headed households and four persons with physical disability in the village.

In the tribal part outside the village, there were no households with toilets except the village pradhan. This toilet was built under TSC five years ago and consisted of a single pit latrine with no side walls. It was renovated and made functional by the pradhan but used only by women and guests for occasional need.

For open defecation, a routine is followed in which men go out first in the early morning to a place close to the river and then the women go out around 8a.m. for ablutions as well as for bathing and washing of clothes in the river.

A very basic subsistence livelihoods pattern prevails in the tribal tola or hamlet where people do not go for wage labor beyond a radius of 5–10 kilometers from the village. The cash earning per family is only Rs. 5000 to Rs.6000 per month but people are satisfied with this because all other food needs are met from their farming and from cheap rice supplied by PDS.

Sanitation status: For these remote tribal hamlets at a subsistence livelihood base, it was obvious that there are no behavioral sanitation and hygiene barriers (lack of awareness of health benefits, disease burden, convenience and pride, etc.) or deeper self perception barriers (low social status in a mixed caste village where poor sanitation and hygiene status is equated with a poor social and economic status within the village as given and unchangeable). Water availability is not

an issue as this small hamlet has one functional hand pump. Unless there is a major improvement in their livelihood and income, there is no compelling incentive for them to change their sanitation behavior, so there is no demand for toilets.

For the rest of the village with predominantly OBC community, there is a demand for toilets but affordability is an issue. Here the women have exposure to toilet usage when they go out of the village. Moreover, water availability is also not a problem, as there are four handpumps in a tola of 50 OBC households.

Affordability: Lack of awareness and knowledge of health benefits do not inhibit OBC community in building and using toilets, and this perception was shared in a women's group meeting. The perception that a toilet cost upto Rs.30,000 seemed to be a larger barrier to toilet construction. Being enquired about the amount the villagers can spend on toilet construction, they said they could pay for Rs. 12,000 for a toilet. This is the cost that AIDENT helps local people with to build their toilets.

Older generation still prefers to defecate in the open and will take time to change. Younger generation and specially OBC women expressed an overwhelming desire to build toilets.



Barbil village

Social Context and access to water and sanitation

Barbil village constitute of mixed OBC and ST communities and falls in the Jorisa Gram Panchayat, Ghatsila Block of East Singhbhum. It is about 200 years old with 319 households and a population of 1513. There is a majority OBC population (198 households) followed by ST, SC, and others. There are 13 women headed households and six households having persons with some physical disability.

Landlessness is a major issue with more landless households than land owning households in this remote border lying block (bordering West Bengal and having forest and mountains). About 19 households (mostly OBC) migrate for long term work to Maharashtra and Tamil Nadu. Younger adults work in factories of Jamshedpur.

Out of the 13 handpumps in the village, only three handpumps provide drinking water throughout the year. The rest are dysfunctional or provide intermittent water supply. But the village has a functional water supply scheme that provides tap water to 236 households. Water supply quantity however is variable; it is inadequate to ensure flush toilet operation by all.

People reported that they majorly suffer from serious respiratory problem, stomach illness (Typhoid and Jaundice), and malaria. There was one jaundice death in the last year. Two children are declared suffering from malnutrition by the AWW.

Sanitation status: Only 22 households out of 319 have toilets and all of them were built by the owner (not TSC or SBM). Majority of the toilets are built by the upper castes, only two ST households and five OBC families have toilets. All the 22 toilets are septic tank toilets and not pit latrines. The rest defecate in the open.

In an OBC tola we visited, people told us that under TSC a contractor led toilet construction programme was undertaken nearly a decade ago. One cement bag, toilet pan and rings and four ft tin sheet was made available per toilet for each household and a contractor was assigned the job of construction. This led to construction of toilets with shallow pits and people did not use them. Only two to three households in the village have renovated the old toilets and are using them because there is an elderly or ailing family member who needs a toilet. However, there are some who are better off and so have built septic tank toilets.

Habits or any other deeper self perception barriers were

not cited as a reason for not building and not using toilets. People are aware of health benefits as well as about the convenience and risk reduction from snake bites and bad weather. Women were mostly silent in the discussions.

Affordability: People estimate the cost of septic tank toilets to be anywhere between Rs.25,000 and Rs.35,000. They cited unaffordability as a reason for not building and using toilets.

When probed further as to the minimum that people can contribute to building a toilet on their own (with some external support), people articulated in great detail the financial difficulties. They reported indebtedness is high, and cash income from agriculture is low. Social costs of supporting the neighbors during marriage and deaths with cash contribution, medical expenditures are high; hence cash for toilet construction was not a priority.

When the local NGO AIDENT gave a detailed explanation of the possibility of building a safe twin pit toilet in less than Rs.12,000, a middle aged man on a cycle gave a detailed account of their impossibility toward contributing even a few thousand rupees from their own pocket for beginning work. Even a small amount of government subsidy or incentive for either material purchase or for labor to dig in hard rock soil will help many people to come forward and build toilets. Perhaps not 100% sanitation coverage will be possible with this fraction of subsidy but atleast many people who are now sensitized to the benefits of using a toilet will build one.

We visited another tribal tola or hamlet in the village and found that people are not interested in building toilets. There are vast open spaces and people seemed reluctant to building toilets. There were remains of the TSC toilets in the village that were dysfunctional and broken. It was clear that no amount of motivation would break their disinterest and convince them to build and use a toilet.

BCC and IEC: There were no IEC or BCC messages displayed in the village and hamlets. But people were aware of the benefits of using toilets. The middle aged man we met in the tribal hamlet told us that he had attended training programmes on toilet and hygiene by an NGO in Kolkata and was aware of the benefits. It was affordability and high indebtedness that was the main detriment for atleast some people who wanted to build toilets but could not.

He said that there was a need for the elected representatives (village, block and district level) and people with influence to use all their persuasive powers as well as any official and administrative powers to make people build and use toilets. Without constant long term persuasion and campaign, it will not be possible to make people give up open defecation.

Telangana

It was clear that a high intensive promotional campaign in the village may be able to motivate many, though not all for building and using toilets.

Yerragollapahad village

Jangaon Mandal, District Warangal

Yerragollapahad village with a total population of 1992 and predominance of OBC families has a total of 413 households. Majority (380 households) own lands (average 2 acres) while 33 families are landless. As per population Census, 2011, the village has a total number of 522 households with a population of 2291 of which the total SC population is 264, and the total ST population is 573. Their livelihoods basically depend on agricultural production. Most of the younger generation is educated and migrating out to the cities for work. Out of a total of 35 households where individuals have migrated, 22 households belong to OBC, followed by 10 households belonging to SC population. The preferred source of medical treatment is carried out mostly in private hospitals nearby Jangaon mandal where villagers are referred to for hospitalization and tests by the local RMPs.



Current situation of WASH

Toilet coverage is almost 25% in the village (110 toilets for 413 houses), the rest 303 households do not have toilets. Out of the total 110 households with a toilet at home, 81 belong to OBC, 18 to SC, 10 to other castes and only one belongs to a ST. The water supply in the village is through pipeline with 289 houses having water taps in their households for about 6 hrs per day and the respondents (basically SC and BC) rate quality of water from good to average. Additionally, out of the total 18 hand pumps in the village, only 12 are functional, whereas six are defunct. As a result of a successful ongoing watershed programme (by MARI), the village does not face water scarcity and unlike their neighboring

villages, deep bore wells are not dry despite low rainfall this year. There are two anganwadis in the village. One anganwadi does not have a toilet while toilet in the other needs repair and as a result the toilet has not been used for the past two years. In both the cases, little kids are made to defecate in open, which is supposedly play area for the kids. The ones who have toilets constructed don't use them; instead they use it as store houses.



Key findings:

- Sarpanch, ward members, and anganwadi center staff have limited knowledge and skill to work towards improving sanitation and hygiene in the village.
- There is limited awareness and understanding of oral fecal route of transmission of diseases amongst the villagers. As a result no efforts are made at individual, family and community level on taking any initiative to eliminate open defecation in the village.
- No major IEC or BCC initiative has been taken up by the village GP, as no specific wall writings addressing sanitation issues have been identified.
- For villagers, sanitation is limited to taking bath, washing hair, brushing teeth and keeping the household clean etc. With respect to defecation, the general perception of cleanliness is to keep the fecal waste far off from the home.
- For the villagers, defecation is something which has synchronized well with their daily routines. An age old habit that they feel difficult to change.
- The villagers, especially women follow preferences of companionship while going for open defecation.
- Children below five years are mostly made to defecate in open around the house, and the habit is still taken over at anganwadis where the children are made to defecate in open in the vicinity. The anganwadi teachers lack clarity on hygiene messages to be given.

■ The expenditure incurred for treatment of various diseases or illness which included typhoid, viral fever, nausea and diarrhea are the common health problems, but these problems are way too high for the villagers.

■ Claustrophobic feelings, inadequate privacy, fear of spillover in toilets which may spoil clothes and smell as a result of improper ventilation are some of the reasons stated by the villagers for not even considering the priority of constructing a toilet.

■ Villagers perceive toilet as something too difficult to manage, and hence lack the initiative to start the process. Especially women feel that cleaning toilet will be an additional workload for them. Aspirations perceived for better quality and healthy life do not include a toilet as a priority.



Socio-cultural and economic barriers

■ Construction and use of toilet at home is not considered as a priority in the households.

■ Dignity, privacy, and security are perceived more as the needs of women and girls, and hence, men don't use toilets even if they have one at home because of their unwillingness to accept toilet as a common place of defecation for all the family members. They prefer using these only at a time when going out to the field is not feasible, for example, odd hours of the day like middle of night or during heavy downpour, etc.

■ Schools have toilets, but they lack water and are not clean. Therefore, most children including girls go out during school recess time for relieving themselves. Children feel afraid to bring out the subject in front of their parents.

■ Decision making power at home is mostly concentrated in the hands of male members who themselves don't feel the need and state financial constraints and lack of awareness on technical knowhow (maintenance and repairs) as the reasons for not taking up the construction.

■ The sarpanch, the ward members, and women SHGs lacking in their leadership qualities have failed to sensitize the villagers for active engagement in achieving SBM objectives

In one particular case, a toilet was constructed five years back at the time of son's wedding for the newly-wed bride as she was from a city. Till date, she is the sole user of that toilet, others including educated siblings (one of them being a 20 year old sister) are still continuing with the practice of open defecation.



■ Since the young have migrated to the cities for better opportunities, a considerable number of elderly population have been left behind to live under self care or mutual caring. Although, they are in dire need of toilets, but it is impossible for them to manage toilet construction on their own. Similar is the case with people having disability, as in spite of their situation majority of the respondents didn't have toilets. They felt that the design of toilets being constructed was not suitable to their use, as the toilets have Indian squatting pan and lack any type of wall support. They take support of the wall or trees or their walking sticks and stand in a bent position, which is the most comfortable posture to attend to their nature's call. They are unable to sit for squatting. Moreover, during night they try to go as close as possible to their house.

■ A number of landless or small land holders have been leasing in land from those who have migrated for employment, business, and other better off opportunities in urban areas. These families are under financial crisis and live a stressed life. In such conditions, aspiration of having toilet at home is unlikely to be a priority.

■ People estimate the cost of toilet construction to be too high. They feel incapable of making an advance initial investment and consider it as the biggest reason for not beginning the toilet construction even after receiving the sanctioned amount.

■ The local masons promote image of an expensive toilet, but they themselves lack adequate knowledge of the same which results in high cost and inappropriate designs.

■ Many women, girls and elderly do feel a dire need for toilet, but they think that it is unreasonable to make the demand considering the financial crisis of the family.

■ Unresolved conflicts among the family members on sharing of available housing property and disputes between neighbors were the reasons shared by some members for not being able to construct toilets.

■ Delays in release of funds and slow response from the government officials are some of the other constraints.

Supply side Barriers:

■ According to the Sarpanch, government subsidy is perceived as right which people are very eager to claim.

■ A large number of houses have incomplete toilets which cannot be used, where the construction was left mid-way because of the delay in getting incentives.

■ Lack of clarity exists on the administrative procedures among the people as well as among the GP officials about the subsidy schemes. Shift from NREGS to SBM has further added to this confusion adversely affecting the enthusiasm and motivation behind toilet construction.

■ In a few cases, the toilets have been constructed but are not being used awaiting verification process which is locally understood as a precondition for release of the financial incentive. The misleading communication is that a used toilet may be considered as an old toilet and might get disqualified for the subsidy support.

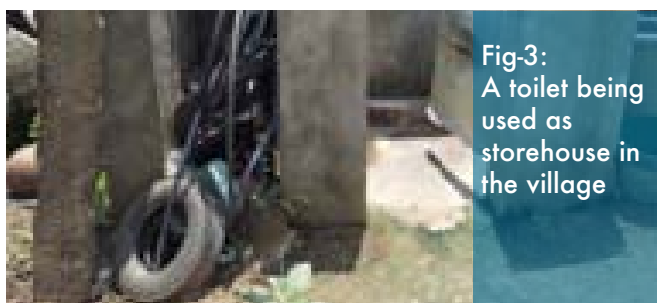
■ Due to scanty rainfall, the water sources are going dry and shortage of power supply is further aggravating the water supply problems. The incomes have dropped and debts are increasing, keeping sanitation off the priority chart.

■ Restrictions on sand mining is causing short supply of sand and further the shortage of masons for toilet construction has delayed the process and affected quality of toilet construction.

Motivators

Old age, illness leading to physical disability and weddings has been identified as the main motivating factors behind the ones who have gone for toilet construction. Another reasons stated are avoiding public embarrassment especially when the relatives visited them. Hence, it can be inferred that either because of social pressures or because of physical needs people have constructed toilet. Others constructed just because the government is providing incentives for construction but this hasn't ensured usage.

Konda Siddahiah lives with his wife Mallamma who has been mentally sick from past 25 years because of poverty and crop loss conditions which forced her into depression, and this gradually worsened with time. So, her husband, despite his poverty, constructed a toilet for his wife's protection from societal denial, so that she might not fall or lose her path and also to lessen their suffering.



Katkur village

Karimnagar

Katkur is a large village located in Bheemadevarpalle Mandal of Karimnagar district in Telangana. There are total 1065 families who are residing in 738 houses. The Katkur village has a population of 4189, of which 2082 are males and 2107 are females (Census 2011). The village has substantial population of SC and ST. ST constitutes 30.8% of the total population and SC constitute 16.54% of the total population in the village.

In Katkur village, out of the total population, 2244 were engaged in work activities. 87.52% of workers described their work as the primary work while 12.48% were involved in marginal activities (as per census 2011). According to the information provided by Sarpanch, agriculture is the primary livelihood of the people in the village, where approximately 80% of the population is engaged in farming and 20% is engaged in dairy farming. In the village, there are 30 to 40 landless farmers and predominantly people are small and marginal farmers. Total cultivable land in the village is 2000 acres of which 800 Acres are rain fed, and 900 acres are irrigated land and the remaining 300 acres are fallow land.

Table 1. Demographic information (Census 2011)

Particulars	Total	Male	Female
Households	1065 (738 houses)		
Population	4189	2082	2107
Child(0-6)	408	203	205
Scheduled caste	693	346	347
Scheduled Tribe	1260	642	618
Literacy	54.11%	63.54 %	44.79%
Total workers	2244	1188	1056

Table 2. House wise water, sanitation infrastructure

Total number of houses	Houses connected to pipe water supply	Total number of toilets	Houses with toilet but not being used by even one member of the family	Houses not having toilet
738	531	487	10-15	251

Current status of WASH

Due to lack of rainfall in the contemporary year, the village is facing acute shortage of water. The local water ponds, dug wells and handpumps have dried up. There are 531 houses which are connected to pipe water supply that is fed by panchayat owned borewells. The water is supplied once in four days for two hours, and during the lean period water is supplied once in ten days. There are also community water points which are fed by panchayat borewells. The water supplied by the panchayat is utilized for domestic purpose as well as for drinking. Most of the families purchase RO water from two water stations.

With respect to toilets, 487 houses have a toilet facility and 251 houses opt for open defecation. Among 251 houses, 113 have got the subsidy amount sanctioned under SBM (G) and shall be constructing toilets soon. Most of the toilets which have been constructed have twin pit and single pit latrines while a few have gone for septic tank construction. There is lack of toilets in anganwadi centers and the toilets in schools were not having running water supply. Though there is some awareness regarding MHM practices among adolescent girls, there isn't adequate infrastructure to support them.

Key Findings

IEC and BCC effort

- There hasn't been any structured IEC activity conducted with the community on sanitation. The IEC material developed by Water Supply and Sanitation Department hasn't reached the GP and the community.
- Misleading information has been provided to the community. For example, if they do not build toilet, then their ration cards, pension scheme, etc. will be stopped. Hence, threats have been used as a mechanism to get toilets build.
- With respect to IEC and BCC, children received better information through schools. For them sanitation is about keeping classroom clean, not littering, forestation, banning of plastic, avoiding stagnant water, not throwing waste in neighborhood, toilet in every house, and washing hands before eating food.
- An IEC campaign for children was conducted in the school with respect to hand washing. Significant awareness was observed on the subject.
- Masons and self-knowledge of construction is the source of information and knowledge with respect to construction of toilet, technology to be used, and material to be purchased.
- The information or perception which is prevalent within the community is that the toilets shouldn't be used unless the visit is done by the government officials, and money is transferred to the beneficiaries account.

Social and Cultural Barriers

- Gender inequality related to assertion of rights within the family is seen and one of the important barriers for construction as well as usage of toilets.
- Concern of dignity has been associated with gender and not with person as part of IEC material. Furthermore, in the socio-cultural fabric gender acts as a determining factor for usage of toilet, so male population largely deter from using toilet.
- Marriage as an institution has been seen as motivator for construction of toilets.
- The cultural perception related to sanitation is that human feces should be kept away from house, hence, people opt for

open defecation and keep their house clean by putting cow dung in front yards, washing floor, putting rangoli, etc.

- Elderly and disabled wish to get toilet constructed at their house, but in many cases when the younger generation has migrated for livelihoods, there is not adequate support for them to get toilet constructed by themselves.
- Death in family is considered to be inauspicious, and hence, they avoid constructing any new structure in the house.

Economic Barriers

- Economic conditions in the village have been perceived as one of the major barriers in the construction of toilet. It was inferred from the interviews that the average cost of the toilet is Rs. 35,000, while the subsidy is Rs 12,000 only.
- Lack of rain has resulted into lack of agriculture and livelihood, and hence, building toilet is not a priority. People are also getting into debt cycle because of loss in agriculture.

Supply Side Barriers

- Delayed incentives from government have been a deterrent for construction of toilets. Many people are getting into debt cycle since they haven't received the subsidy amount and had taken debt to construct the toilet.
- Owing to scanty rainfall and lack of water supply, people don't have enough water for cleaning and flushing in toilets.

Table 3. Sanitation infrastructure in public buildings

S.No.	Name of the institution	Availability of a toilet
1	3 Aaganwadi Kendras	1
2	GPO	Yes
3	ZPHS	Yes
4	Primary school	Yes
5	Sub-centre	No
6	Telephone exchange	No
7	FPO (Farmer's Producers Organization)	Yes
8	Dairy centres: Vijaya Mulkanoor	Yes No
9	Weekly Vegetable market (Tuesdays)	No
10	5 community halls for each community	No

Karlapally village

Panchayat Karlapally, Govindraopet Block, Warrangal District Kariapally is a relatively homogenous (majority Koya followed by Lambada) tribal community with a population of 610 that comprises 130 Koya households, 25 Lambada, and three OBC.

It is also a relatively better off tribal village as people have large irrigated agricultural lands. Land holding is almost equally distributed among the villagers. People also earn from forest produce. There are less than four landless families and very little migration for work to far away urban and rural areas take place.

Sanitation and water status

- There are eight handpumps in the village and a well. At least five handpumps give good supply of water all the year. Water supply is not a problem.
- People get together to secure pipe water supply (2 private schemes supply water to approximately 24 families from bore wells). There are three public handpumps. The cost per family on borewell supply was only Rs.4000.
- Water and lack of space are no constraints for building toilets, yet less than 20 households have toilets. Majority of the 20 households who have toilets are relatively better off economically.
- As open areas are decreasing, the tribal community is living along the road and not in the forests, the need for toilets is felt more acutely by women.

Major source of income is agriculture; most of the households have small land holdings, that is, less than two acres of land; only four households have more than five acres of land. And there are only four landless households who migrated to Hyderabad due to absence of agricultural labor work.

Women earn Rs.5000 to Rs.6000 in a year from transplanting work(rice). However, if the women want to spend this on anything, they need concurrence of men. Men have the last say if there are different priorities for spending.

Medical expenditure constitutes a high toll on family income, at least Rs.4000 to Rs.8000 a year per family. Malaria, typhoid, dengue, chikungunya, and a respiratory illness were mentioned as the main health related problems. People gave a rough

estimate of their expenditure on medical issues. According to the villagers, if you earn a net cash income of Rs.10,000 a year then as much as Rs.7000 is spent on medical care.

People did not link open defecation with poor health outcomes or impact. Stagnant water and the hard manual work that women do have been mentioned as the morbidity factors for general fevers and illness.

Findings

- Toilets are not a priority for men; girls and children want toilets but are not demanding the same.
- Kuchha bathing areas in the open space of a homestead with a thatch enclosure are built for women and men to bathe, but a similar kuchha superstructure for toilets is not desired.
- In the absence of subsidy or incentive or loan support, the cost of gathering materials (bricks, cement, pans and pipes) to build home toilets is a major hurdle for people.
- Smell and additional burden of cleaning the toilets were mentioned as other key barriers along with affordability.
- People want to build good quality pucca toilets. A twin pit toilet costs a minimum of Rs.20,000. This costing was done with the assistance from the villagers, and this cost was found accurate.
- Indebtedness could be high (from Rs.40,000 to Rs. 1 lakh per family) with resultant interest burdens, thus making cash expenditure on toilet construction difficult. As more and more cotton cash cropping takes over and new borewells are dug, indebtedness is likely to increase.

BCC messaging for WASH

- Resistance to build and use toilets is not there with a younger educated and some english speaking youth in the village.
- More awareness of health and social benefits from a more intensive face to face awareness raising and messaging (not from posters and radio television) is desired by the community.
- Having toilets in houses is still not an accepted norm and is a key barrier. Defecating far away from the home is seen as an improved hygienic behavior.

■ Affordability is a major reason that acts as a barrier for building toilets, as cited mainly by the male members of the family.

We need to be sensitive to understand the reason of shyness of the tribal community behind making and using toilets while taking pride in keeping their homes and surroundings very clean.

People can be motivated to build and use simple low cost toilets without expensive pucca superstructure, like their bathing enclosures in each home. If subsidy can be provided in stages, as is there in Telangana, and materials purchasing is facilitated then many people can build toilets in Karlapally. The low cost base level toilet could cost between Rs.5000 and Rs.7000.

BCC messages should be more enabling, positive, informative, and motivating. Negative messages make people feel insulted.

Simple sanitation BCC messages from the people:

“problem to hai”

“ghar wale mantenahi, toilet banate nahi”

“jab paisa hoga to banayenge”

Typical cost of a twin pit toilet;

1. Cement rings	(Rs.250x10 rings) Rs.2500
2. Pits (2) digging labour	Rs.1000
3. Base Bricks (50)	Rs.750
4. Base cement	Rs.350
5. Construction material	Rs.5000 / toilet, Rs.7000 /bathroom
6. Bricks super structure	Rs.2600
7. Pan and pipes	Rs. 900
8. Door frame and sheet	Rs.2100
9. Sand , cement	Rs.3000
(Rs.1200 transport), cement (4 bags)	
10. Asbestos roof	Rs.1200
11. Iron rods for base	Rs. 400
TOTAL	Rs. 19,600

Annexures

ANNEXURE 1

Village Information Template

Formative Research to Develop Appropriate Participatory Approaches for Water, Sanitation, and Hygiene

This village information template should be administered with a group of representative, both men and women of the village who belong to different social and economic categories and have vivid knowledge about their village. This could include the VWSC and Panchayat representatives. We are not looking at accurate numbers and data, but on the general pattern of key information in the village.

To be completed prior to the in-depth group discussions on sanitation behaviors:

1. Investigation related

Name of Village:

Panchayat/Block/District/State:

Visit Date:

Name of the principal investigator:

2. Demography:

2.1 Total Population:

2.2 Total Households:

2.3 Average size of a household (not joint family):

2.4 How old is the village:

2.5 Caste and Tribal Composition (number of households)

Total Households	SC	ST	OBC	Indigenous tribes	Others

2.6 Women headed households :

2.7 Households with members suffering from physical disability that affects their toilet use (squatting toilet use):



3. Livelihoods

3.1 Land ownership:

Total Households	Landless	Owning Land	Total

3.2 Description of livelihoods:

Please list out any information on indebtedness, incomes, migration, major types of occupation, etc.

Estimation of the number of households having a TV, Fridge, Motorcycle, Cycle, etc.

3.3 Migration

Who migrates:

Total Households in village	Migrating Households			
	SC	ST	OBC	Others

Where do they migrate and for what work:

Duration of Migration

Total Households	Less than 3 months in year	More than 3 months in a year	Stay in the village for less than 3 months

3.4 Does migration affect sanitation behavior (yes or no);

their ability to construct use of toilets on a regular basis any other impact

4. Water availability and access

Main drinking water source (please tick appropriate):

Handpumps Village pipe water supply scheme Others

4.2 Perception of people on quality of water supply:

Perception	SC	ST	Tribal	Others
Good				
Average				
Poor and unfit for drinking				

Narrative description:

4.3 Drinking water access (please fill appropriate source):

Handpumps

Total Handpumps in the village	Handpumps functional all the year round	Handpumps not working for up to 3 months in a year	Defunct non functional handpumps

Village pipeline scheme

Total Households	Water taps in households	Frequency and duration of water supply in a day	Sufficient for toilet flushing

4.4 Description of water stress periods:

5. Health, Disease, and Morbidity Profile

5.1 How many times in 2014 there was an outburst of:

Diarrhea
 Typhoid
 Cholera
 Jaundice
 Malaria
 Dengue
 Other diseases

5.2 What affects the children most in the village?

Diarrhea
 Serious stomach infections(Typhoid, Cholera, Jaundice)
 Respiratory diseases
 Eye and Ear infections
 Skin infections
 Others

Please note the order of priority

5.3 Access and treatment sought

5.4 Deaths if any in 2014

5.5 Status of malnutrition (check with ANM or AWW)

6. Sanitation status

6.1 Toilet coverage:

Total Households	Total Toilets	Households with Toilets but not being used by even one member of the family	Open defecating Households

6.2 Toilet ownership according to social categories:

Total Households	SC	ST	OBC	Tribal	Others

6.3 Types of Toilets:

Total Households	Single pit latrines	Twin pit latrines	Septic Tanks	No Toilets

6.4 Major source of water for the household toilets:

Hand pumps for how many households Piped water supply for how many households Others (please specify)

6.5 Who built the toilets?

Households Contractors Panchayat NGO Government Others

Please provide a brief narrative.

6.6 Brief description of when people started building toilets and why.

Results and reasons for achievement or failure till date.

Guiding Notes and Questions for Individual and Group Interviews on Sanitation and Hygiene Behaviors and Practice study

Key considerations

1. Questions to be addressed to individual women, men, and children, separately as well as later in groups. Sometimes more honest responses come in groups because individuals are less self-conscious, sometimes it's the other way around.
2. Start the interviews or group discussions with questions on their lives and livelihoods, larger problems, aspirations, fears and hopes.
3. Ask indirect questions on sanitation behaviors in a conversation mode. The aim is to move beyond simple direct responses to deeper beliefs and barriers for improving sanitation behaviors (toilet construction and use).
4. Select individuals from a cross section of individuals representing different caste, class, and tribal communities.
5. Respecting their individual choices and behaviors by seeking prior consent.
6. Explain the purpose of the research as:
 - a. Trying to understand people's way of living as well as their lives and priorities based on their priorities, their biggest problems, and future of their children. This is the main part of the interview. If we are able to make rapport and understand the priorities, fears, and aspirations of individuals, we can better handle their deeper level of self-perceptions and behavior conforming beliefs, which in turn will help us in understanding their sanitation related behavior. For married women, understanding their pre-marital lives is important. Children are the most difficult to interview. Hence, it is best to playfully ask them serious questions.
 - b. After understanding their lives, priorities, and beliefs, we can inform them that we have come to understand their sanitation behaviors in terms of toilet construction and use. And inform them that the study is not for any project intervention but for a WHO research. Furthermore, invite them to ask any questions on our research and seek their consent to conduct the interview.

The whole interview must take place in a conversation mode and not through question and answer pattern.

Key Guiding Questions

1. Understand their livelihoods and daily routine

■ What work the individual does?

If the men or women are doing hard labor in the fields or on construction work, then try to know from them the effect of food and water availability on their health. How do they eat their food in the fields or on construction work sites? Where do they defecate?

If the women are doing household work and looking after children and staying at home, then ask them about the thing that they find most difficult to manage and clean. What takes most of their time? How much time do they have for themselves? Is water available?

■ Other general questions

When does she/he wake up and what are the things the individual does? How do they spend their day? Try to understand their daily schedule.

What would they like most to change in terms of more time for themselves and what would they like to do with this additional time or money?

2. Indirect questions on behavior change

Start by asking the individuals and groups about **other peoples' sanitation and hygiene behaviors, rather than questioning their attitude towards sanitation**. Try to know from them what they believe others do and why.

■ Village details – Please recount from the VI questionnaire and check with the interviewee or group.

■ How is your village different or similar to other villages?

■ We have been around in the village and have seen that some houses are kept cleaner than others. Is it due to laziness or due to insufficient income?

■ Who is the most better off and who are the most worst off people in the village? Why?

■ Are the better off people also more healthy and educated? Do they keep their homes neat and clean?

■ Why do some people not take bath regularly and observe personal hygiene (hair, nails, body cleaning)?

- Why do some people not worry about the quality of water they drink?
- Why do some people not wash their hands after defecation and before cooking as well as eating food?

Finally, ask them questions related to sanitation and hygiene.

Sanitation profile and history of the village

- Who built the first toilet(s) in the village?
- Why?
- Till date how many toilets have been built?
- In houses having toilets, do all members of their family use toilets everyday?
- Do women use home toilets in the daytime because they are afraid to go out for defecation or urination? Do women go out for defecation early morning and late night?

Narrow down your questions to know about the individual or group

- If you do not have a toilet, why did you not build one till date?
 - Search for deeper level answers and do not leave it to first responses received. What are the barriers to toilet building and using? Are there deep seated social and self perception barriers like low caste people are not expected to live like upper caste and well off people? Is it due to physical objective barriers such as lack of water, space, additional workload on women? Is it due to any other reasons?
- Will you build and use toilets in future? If not, then why will you not build a toilet or use the existing one?
 - Search for deeper level answers as above.
 - If you want to build and use toilets, then what type of toilet will you want to build—a simple 3x3 feet toilet with single or double pit and kuchha superstructure or any other type of toilet?
- Ask any other relevant questions as per your preference.

Profile of Collaborating Organizations

Utthan



Utthan was founded in 1981 by four women professionals who were inspired by Professor Ravi Mathai's famous 'Jawaja' experiments in Rajasthan.

For over 30 years, Utthan has worked in the coastal areas of Ahmedabad, Bhavnagar, Amreli, and extremely deprived and conflict affected tribal districts of Dahod, Panchmahals and MahiSagar, covering about 810 villages with the assistance of its local teams. Its major thrust areas have been a) Access to safe water and sanitation as a basic human right; b) Integrating perspective of gender equality and women's empowerment; c) Conflict prevention through conflict transformation, peace, and justice; d) Livelihood security through protection, conservation, and augmentation of natural resources; e) Promoting and strengthening institution building. Its major focus groups have been women, youth, Dalit, religious minorities, Adivasis, other poor and marginalized sections of the society and children. It has been also facilitated through the establishment and growth of a large number of community based institutions such as women's village level sangathans, federations, youth groups, area resource groups, and several committees such as Nyay and Shanti Samitis (justice and peace committees), livelihood committees, savings and credit committees, water and sanitation samitis, watershed committee, land rights committee, etc.

With more than three decades of experience in the sector of water and sanitation, Utthan has established 'People's Learning Centre for WASH' basically to facilitate learning through capacity building on *Inclusive, Gender and Justice Approaches* for different sections of the society such as NGOs, Government, Teachers, children, other leaders, panchayats and village level WASH committee members.

The organization has the capacity to work with government and take up advocacy at the state level and when required to meaningfully engage with the state to bring about change.

Utthan has been promoting the idea of decentralized people centered water and sanitation with community participation in planning, implementation, and monitoring in all its intervention in this sector. Learning from facilitating demand driven and community centered approach for adopting WASH, the organization along with panchayats and community play an important role in planning, implementing, operating, maintaining, and making a sustainable contribution greatly in the policy changes at National and International levels.

Utthan has been innovative in its work on water, sanitation, livelihood, land rights, women's rights, conflict resolution, and peace and justice. It has been able to come up with new ideas, develop detailed process on the implementation, state the various deviations in performance, and ensure accountability through monitoring of key indicators. These experiences stress on seeking solutions through understanding the needs from various contexts by linking up with different networks, institutions, and civil society partners as well as having a constant dialogue with government to enable change.

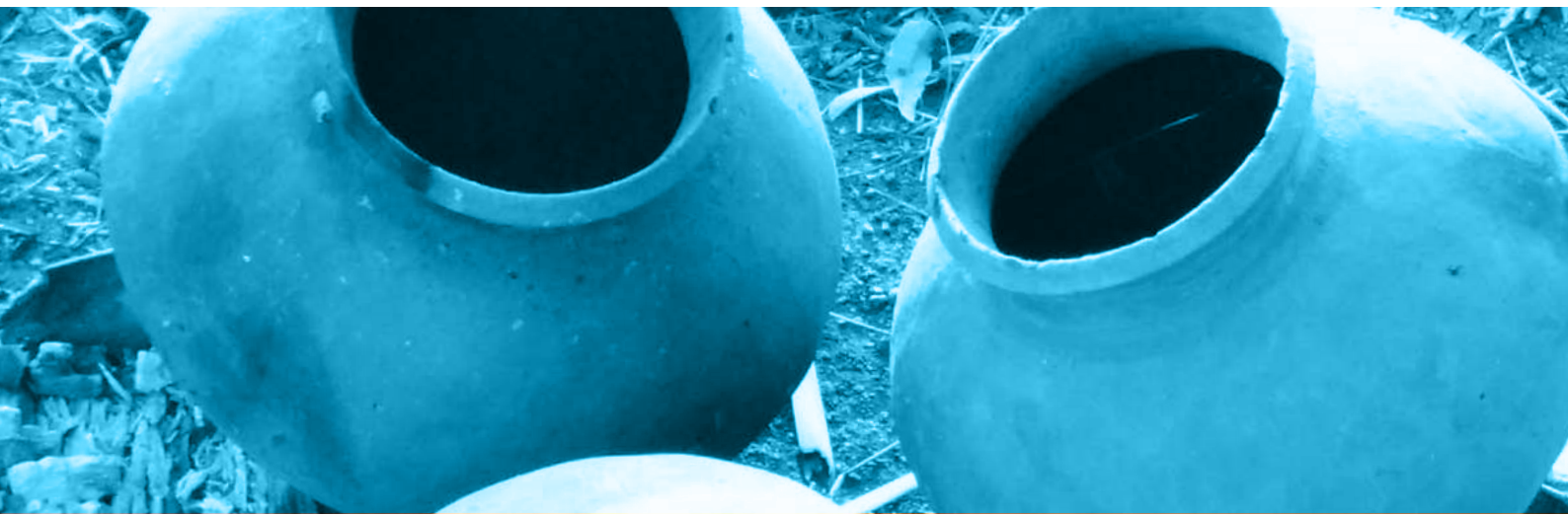
The organization has been able to learn from the grassroots and influence policy. In the process, it has build capacity to work with a wide range of stakeholders that include communities, village level governing institutions, administrative bodies, and policy makers. Through active participation in various networks for advocacy on various issues, the organization is connected and its presence is marked at the State, National, and International level.

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India WASH Forum (IWF)



India WASH Forum is a registered Indian Trust since 2008 with trustees from all over India. It is a coalition of Indian organizations and individuals working on water, sanitation, and hygiene. The coalition evolved out of WSSCC support to national WASH sector advocacy.

The mandate or charter of India WASH Forum is Hygiene and Health outcomes from sanitation and water sector.

Promoting knowledge generation through research and documentation which is linked to and supported by grassroots action in the water–sanitation–hygiene sectors. Special emphasis is given to **sector-specific and cross-cutting thematic learnings**.

Supporting field-based NGOs and networks in their technical and programmatic work. The IWF would also consistently highlight gender and pro-poor considerations and provide a national platform for interest groups working in the sector to come together.

Undertaking policy advocacy and influencing work through

■ Monitoring and evaluations

■ Media advocacy and campaigns

■ Fact finding missions

■ **Undertaking lobbying and networking to promote common objectives** in the sector.

Since 2010, IWF is actively engaged in the Global

Sanitation Fund (GSF) and currently hosts Programme Coordination Mechanism (PCM) for the **GSF in India**. The role of the PCM is to provide a governance oversight to the GSF Programme in India. The Programme is being implemented by an Executing Agency called Natural Resources Management Consultancy (NRMC) that provide NGO sub grants in the two states of Jharkhand and Assam. The Programme is managed directly from WSSCC Geneva with the support of the PCM and an Auditor (called the Country Programme Monitor), that is, KPMG for India.

A unique feature of IWF is its non-hierarchical set up. Most of the trustees of IWF are represented in their individual capacity and do not represent the organizations they are associated with. The agenda and activities that IWF undertake are determined by the initiative of the trustees and supported from organizations and individuals.

DEPINDER KAPUR

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Modern Architects for Rural India (MARI)



Modern Architects for Rural India (MARI) is a registered (1988) not to profit organization. MARI is promoted by young team of professionals, who are currently engaged in multifarious development initiatives covering about 800 villages in Warangal, Karimnagar, Adilabad, Medak, and Khammam districts of Telangana. Enabling local communities to access water and sanitation services and adopting hygiene practices has been one of the core areas of focus for MARI. A broad continuum of programmes have been undertaken so far to ensure improved quality of life for the rural population. MARI's work is mainly focused on improving agriculture, animal husbandry, education, health, and environmental conditions in rural as well as tribal areas. MARI has also worked to strengthen the resilience of rural populations by providing expertise for managing their natural resources effectively. Research and Innovation, Information, Education and Communication (IEC), Development of Alternative Rural Livelihoods, strengthening the local governance and policy advocacy to defend the interest of the poor and most marginalized communities are the key priorities of the organization. With a prominence to innovate, design and implement programmes in collaboration with government and donors, it has been consciously involved in feeding its grassroots learning into policy formulation. MARI has been extensively engaged in NGOs networking for policy change not only within the State but also at National and International level. MARI is currently hosting the Regional Secretariat of Fresh Water Action Network South Asia (FANSA). MARI can be reached at

RAMISETTY MURALI

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AIDENT



AIDENT–Social Welfare Organization (ASWO) is a not for profit, non- political, organization established by a group of people representing different social and professional streams. This organization came into being with the idea of working towards the overall development of the marginalized section of the society in all spheres. The basic philosophy of AIDENT is to use Education, Health and means of livelihood as the basic enablers to help the target population. AIDENT endeavors to evolve and implement development strategies that are environmentally sound, socially relevant, gender impartial, economically viable, and sustainable in our dynamically changing society. In such a scenario, we take a holistic approach towards development strategies, where the focus is to give a humane touch to the ongoing process of social reconstruction and community building.

Thematic issues or priorities

- Health and Sanitation
- Education
- Public Health
- Child labor
- Livelihood & Sustainable development

AIDENT has been partnering with Government, Private, and Foreign Agencies in the implementation of various programs related to the above thematic areas. The interventions of AIDENT include implementation of National Child Labor Project, implementation of AIE and Vocational Centres, Bhatta Schools under SarvaShikshaAbhiyan and seven Targeted Intervention Projects on HIV or AIDS in five different states. We are also partnering with the HIV or AIDS Alliance in Gurgaon, Haryana to create a facilitating environment for people living with HIV and AIDS. AIDENT is also running Stri Shakti Kendra (Gender Resource Centre)

under Mission Convergence of Government of NCT of Delhi. Mission Convergence aims to bring all Government Development programs under one roof. With the support of Terre Des Hommes (TDH), Germany, we are running an intervention programme in the field of education and vocational training in Panipat for adolescence population.

It was in the field of health and sanitation in general and Total Sanitation Campaign in particular that the achievements of ASWO have been prolific. As a **partner of the GSF or NRMC**, we are implementing a programme “Promoting Sustainable Sanitation in Rural India” in the Dumka District of Jharkhand. This programme has been designed to engage the people of Dumka to the whole spectrum of sanitation which included everybody from individual to family living there. As a part of this programme, we are trying to create an enabling environment for the people to adopt and adept safe sanitation practices. This collective approach of villagers brings them towards our cherished goal of a village which is Oral Defecation Free. This momentum created by their march towards Oral Defecation Free is used and sustained through making washing of hands a part and parcel of their life. Till now, we have been able to reach out to more than 1000 villages and around 250 of them have made Oral Defecation Free.

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