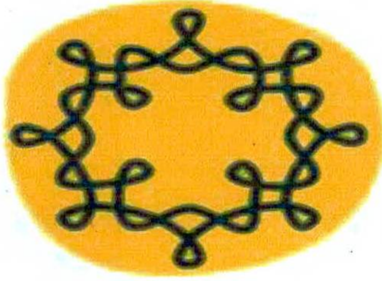

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Sanitation Activities at a Village under CHC Working Area

A Preliminary Inquiry

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2012

Source: Total Sanitation Campaign, Karnataka

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"Sanitation is more important than independence"

- Mahatma Gandhi

Source: Total Sanitation Campaign, Karnataka

Report submitted on 15th June 2012

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LIST OF ABBREVIATIONS USED

APL – Above Poverty Line

BPL –Below Poverty Line

CHC – Community Health Cell

CLTS – Community-Led Total Sanitation

CRSP – Central Rural Sanitation Program

GP – Gram Panchayat

NGO – Non Governmental Organization

OD – Open Defecation

PC – Production Center

RSM – Rural Sanitary Mart

SOCHARA – Society for Community Health Awareness Research and Action

TSC – Total Sanitation Campaign

Preliminary Inquiry

Introduction

Sanitation is a basic necessity that affects everyone's life. Proper disposal of household waste is important to prevent fecal–oral and vector borne diseases. As per the 2011 census, only 21.9% of households in rural India have access to household latrines. The Central Rural Sanitation Program (CRSP) launched in 1986 and revised in 1992 was a traditional, supply–driven subsidy–oriented program. In April 1999, CRSP was restructured and launched as the Total Sanitation Campaign (TSC) making it people oriented and demand driven. The program is implemented in a campaign mode with the district as a unit.

Report Card Status of Total Sanitation Campaign (TSC) as on 12/6/2012

STATE :- KARNATAKA

Components	Project Objective	Project Performance	%age Achievement
IHHL BPL	2889224	2015705	69.77
IHHL APL	2981691	2158788	72.40
IHHL Total	5870915[1]	4174493	71.10
School Toilet	39267	41972	106.89
Sanitary	1305	859	65.82
Anganwadi	26353	28161	106.86
RSM	290	217	74.83

Literature Review - Community Led Total Sanitation (CLTS)

CLTS is widely and correctly recognized as a revolutionary participatory approach to rural sanitation. The approach has been adopted and implemented for the past nine years with a wide spread in Bangladesh, India, Indonesia, Pakistan, Ethiopia and Kenya. Other countries that have embraced CLTS include; Zambia, Nigeria, Uganda, Malawi, Mozambique, Tanzania to mention a few. CLTS is an innovation by Kamal Kar who worked with the national NGO Village Education Resource Centre (VERC) supported by an international NGO WaterAid in a small community of Rajshahi district in Bangladesh. Kamal Kar has remained an energetic and dedicated disseminator of CLTS around the world.

CLTS is an approach in which people in rural communities are facilitated to do their own appraisal and analysis, come to their own conclusions, and take their own action. They are not instructed nor taught. With CLTS in its classic form, there is a small team of facilitators who do the pre triggering which involves community profiling of sanitation; triggering which involves assisting communities to realize their sanitation practices and the post triggering activities which involves assisting communities in solving sanitation problems. The facilitators may be government, NGOs, or leaders from their communities.

Words like target group and beneficiary have been causing communities to develop sense of dependence, expectation, and community subordination. Communities are teachers in their environment, and should not be taken as passive recipients. This is thus a triggering point to take a paradigm/approach shift from seeing communities as beneficiaries, mere participants, and passive recipients to seeing them as active partners, as teachers, as decision-makers. We should seek their consultation; involve them and empower them.

Purpose of the inquiry

The village (Budihala, Bagalkot district) in which the study is done had no latrines before the CLTS process was initiated. A practice such as latrine usage takes a long time to become one's habit. To facilitate rapid behavior change CLTS if found effective at many places. This process was started in this village to motivate people and change their behavior towards open defecation. Hence an attempt is made to understand the implementation of this process at the village level and its outcomes, and to identify the various reasons for its success or failure.

Objectives

The preliminary inquiry was carried out with the following objectives:

i. To know the process adopted to scale up sanitation coverage and its outcome;

ii. To assess the sustainability of the outcome and identify the key issues in promoting this process for sanitation improvement;

iii. Based on these, to recommend suitable modifications for improving the activities.

Methodology

Study Design

The study was a Preliminary Inquiry into the sanitation activities that were taken up to improve the sanitation coverage.

Study Place

The study was conducted in a village named Budihala, Badami taluk, Bagalkot district. It village belongs to Katharki panchayat, having a population of ≈1000 with 140 households. It is a partially flood affected area. The village has one primary school and one anganwadi center. The people are predominantly agricultural laborers and most of the families belong to below poverty line category. Majority of them belong to Mahadiga community.

Study Participants

The inquiry was conducted by interviewing the key informants of the village and household visits.

Interview of key informants: Data was collected through interviews of stakeholders viz. District Sanitation Coordinator, members of Gram Panchayat and key village informants. Interviews were conducted to inquire about the process that was carried out to scale-up sanitation coverage in the village.

Interviews were conducted with the district sanitation coordinator, one gram panchayat member who is involved in the sanitation activities of the village and one community leader of the village.

Interview of supporting agencies: The role of two private agencies in improving the sanitation condition of the village was also explored. The two agencies which are supporting the whole process of improving the sanitation condition at the village are;

- Community Health Cell, SOCHARA, Bangalore
- HeadStreams, Bagalkot

Key informants from the supporting agencies were also interviewed to understand the process that is followed to improve the sanitation practices in the village.

House–to–house visits: All the households which had constructed the latrines as a result of this process were visited and interviewed. A schedule was used to record the usage status of latrines and the reasons for their use/non-use were inquired and recorded.

Study Period

The preliminary inquiry was conducted during May – June 2012.

Components

The following components were considered for the inquiry:

Process: The process that was followed to scale-up the sanitation coverage at the village was inquired from the study participants.

Outcome: The outcome of the process was measured in terms of number of latrines built and being used regularly.

Key Findings

CLTS Process

The CLTS process was started in June, 2010 and has been accomplished in the campaign mode. The entire process was people-centered and demand-driven. The primary emphasis was on community motivation and action and it did not make use of the subsidies or any incentives to motivate the people.

Pre-triggering

This was a very important stage as it helped to identify the community needs and fashion out an appropriate strategy. The pre-triggering stage had been devoted to community entry and booking of dates for CLTS triggering activities. Also, the pre-triggering stage included extensive participatory data collection (community profiling) on community level institutions, sanitation and hygiene situation and community leadership structure and status. The participatory data collection process helped in determining the outcome of triggering and it also helped the CLTS facilitation team assess the status of the community in terms of the sanitation behaviour and adapt strategies accordingly. IEC activities were initiated to spread awareness about sanitation among the people. This was done through wall paintings and community orientation meetings.

Triggering Stage

Great emphasis was laid on mass community presence and participation for triggering. Sometimes triggering had to be done on weekends in order to achieve this objective which made collective action easier. This confirms the notion that communities make their own plans according to what they believe they can achieve on their own.

Tools Used

Interactions with CLTS facilitators and community members pointed to the effectiveness of some of the tools that were used.

- Rapport building with the community members to make them feel comfortable and to gain their confidence.
- The "faeces calculation" tool especially when it immediately followed the Defecation Map was found very revealing by the community as members were to appreciate the level of faecal contamination in their areas.
- The defecation area transect walk (Walk of Shame) could be adopted as a 'must use tool' since it succeeded in invoking the desired effect. It was the Walk of Shame that enabled members to know the magnitude and state of open defecation in their community. The lenses through which they assessed their community seemed to change as they embarked on the walk of shame with "outsiders".
- The use of some tools such as the "glass exercise" to explain the contamination of water and the use of such water for drinking purposes greatly contributed to the triggering process.
- The cost of illness and health expenditure due to poor sanitation was also one of the triggering tools used to motivate them to build the toilets.

A case of successful triggering:
Ramesh (name changed) is a person affected with poliomyelitis. When asked about his defecation practices before triggering he said ***"I can't walk. My two brothers or any two persons have to carry me to the field for defecation. If no one is present I have to defecate in front of my home. This is very shameful and disgusting."***

When staff from CHC and HeadStreams approached them and motivated them to build toilet at home, the family agreed instantly and on the very same day they arranged for the materials and the toilet was built in no time.
After the toilet construction the family members said ***"We are very happy that we have our own toilet. Now everyone can use it anytime. Ramesh can anytime use the toilet with minimal help. A wonderful thing has happened to us today because of CHC and HeadStreams. We are very happy and thankful."***

Post-Triggering

The post-triggering stage was very important because implementation was not automatically smooth when communities had been triggered and drawn action plans. In cases where there was regular and concrete post-triggering support that was well facilitated, communities drew and implemented their action plans to appreciable levels. Various activities were taken up to sustain the new behavior, they are as follows;

- ***Exposure visit:*** An exposure visit to Belgaum, organized by HeadStreams, was held involving the Gram Panchayat members, staff of HeadStreams, and District & Taluk Sanitation Coordinators. This helped in understanding of the innovative ideas to improve overall panchayat governance and also the sanitation.

- ***Resource team:*** Resource team was formed by two staff members of the HeadStreams located at Badami taluk. This was formed with the objective to provide continuous technical assistance and reinforcement at local level. The resource team was trained for 5 days in CLTS to perform its functions effectively.

- ***Swachata committee:*** A Swachata committee by HeadStreams was constituted at the village level consisting of a school Head Master, Gram Panchayat members and HeadStreams staff. This works at the village level to continuously improve the sanitation status of the village.

Role of agencies

Community Health Cell, SOCHARA, Bangalore:

It is actively involved in providing support to the gram panchayat, the local network partner (HeadStreams) and also to the community directly regularly. The main areas of work of this organization include:

- Trainings – for community, local network partner staff
- Technical Assistance – construction of toilets and maintenance
- Coordination – with district and taluk officials and other concerned members
- Follow-up – to ensure sustainability of the activities

HeadStreams, Bagalkot:

It is a local agency having its unit at Badami taluk. It has its main focus on the implementation of the activities and regular follow-up of the activities and utilization. The main areas of work of this organization include:

- Implementation – activities planned for sanitation coverage
- Follow-up – to ensure action and utilization
- Replication – in other villages based on its successes

Stage	Activities	Comments
Pre-triggering	➢ Meeting with community members to introduce CLTS process.	Done satisfactorily
Triggering	➢ Walk of shame ➢ Faeces calculation ➢ Faecal oral routes ➢ Cost of illness	Successful in triggering the community
Post-triggering	➢ Follow up	Needs strengthening

Outcomes

The inquiry showed that the CLTS approach was definitely effective in terms of generating shame and disgust in people. Some community members interviewed said, "We felt ashamed of the poor hygiene status, we learned that we were eating our faeces and got to know about how germs get into our bodies". This was, however, not easy for them to admit at the initial stage. The tendency was for community members to brush over the point and rush in to indicate what plans they had put in place to rectify the situation. For communities in which people's sense of dignity did not extend to their defecation practices, it is very reassuring to note that if CLTS is well facilitated it can generate the required responses. At the end of the day the process is able to get community members to admit that they were practicing Open Defecation (OD).

Table – 01: **Community Training**		
No. of trainings conducted for the community	**01**	
Total no. of houses in the village	**140**	
No. of households attended the training	35	*25% of 140*
No. of households triggered & constructed latrines	32	*91.4% of 35*

A community training was conducted to motivate the people and educate them about the harmful effects of open defecation. 35 members were selected for the training including the school teachers, community leader, gram panchayat member and other self-help group (SHG) members. They were selected purposively so as to initiate an effective campaign against open defecation and start latrine use in the village. This group of people was having great potential for accepting the change and motivates other people in the village.

Table – 02: **Mason Trainings**	
No. of Mason trainings conducted	02
No. of Masons trained	11

Once the community is triggered and ready to build latrines, it becomes very essential to provide them with technical support so that they can construct latrines in a proper way. Hence masons in the village and few from the neighboring villages were trained on the technical aspects of latrine construction. This enabled the people of the village to build latrines which are sustainable for a long time and also as per the needs of the people. The mason training was an important step in providing the community with technical assistance they needed.

Table – 03: **Workshops**	
No. of workshops conducted	01
No. of officials attended	20
No. of community members attended	80

The workshop was conducted by HeadStreams and was presided over by the Deputy Commissioner of the district. This was supported by the Gram Panchayat, Community Health Cell, Bangalore, HeadStreams, Bagalkot and the district and the taluk sanitation coordinators. This was conducted after the triggering process so that the motivation is reinforced. The Deputy Commissioner also distributed 25 pans to the households free-of-cost to encourage them to use the latrines and stop open defecation.

Table – 04: **Sustainability**		
Usage status of latrines	**No.**	**%**
No. of households currently using latrines	08	25.0%
No. of households currently NOT using latrines	24	75.0%
Total no. of constructed latrines	***32***	***100%***

Table – 05: **Reasons for non-usage of latrines**			
Sl. No.	**Reasons**	**No.**	**Percent**
1	Habit	9	37.5%
2	Bad odour from latrines	4	16.7%
3	No water	3	12.5%
4	Latrines are very small - Uncomfortable	2	8.3%
5	No one to maintain it	2	8.3%
6	No pits constructed in latrines	2	8.3%
7	No electricity	2	8.3%
	Total	***24***	***100%***

Table – 06: **Reasons for usage of latrines**			
Sl. No.	**Reasons**	**No.**	**Percent**
1	Motivation & benefits of good sanitation	03	37.5%
2	Maintain privacy of women	02	25.0%
3	Easy access to latrines	02	25.0%
4	Person with disability living in house	01	12.5%
	Total	***08***	***100%***

Key Issues

Poor participation & coordination from gram panchayat members: It was observed that the gram panchayat members are not actively involved in the sanitation activities. Consultations and coordination doesn't happen regularly with all the involved agencies and community.

Lack of technical expertise: Technical assistance is not provided for all the latrines that have been constructed in the village. Two latrines were constructed without the pits and hence being unused.

Inadequate follow-up: After the process took place and the people started using the latrines, follow-up was not done properly. This led to the increase in number of people who reverted back to open defecation though latrines were constructed and were being used initially.

Poor involvement of the community leaders: The community leaders are not actively involved in promoting sanitation practices in the village. This has led to slow progress of the sanitation improvement.

Failure to sustain behavior change: The people in the village were motivated successfully and initially were using the latrines regularly. But over a period of time, due to poor follow-up and reinforcement, the new behavior did not sustain.

APL families left out? All the families who attended the trainings and constructed the latrines belonged to the below poverty line category. This was due to purposive selection of households for the process implementation.

Subsidy by govt. – A constraint? This may be one of the reasons for excluding the families above poverty line. Currently, cash incentive is given only to the below poverty line families. This may act as a constraint

No RSM/PC: Currently there are no Rural Sanitary Marts (RSM)/Production Centers (PC) in the district. Those which had been opened in the past had to be closed down. Neglecting this aspect can create a big gap between the requirement and supply of sanitation items.

Discussion

The CLTS approach involves facilitating a process to inspire and empower rural communities to stop open defecation and to build and use latrines without offering external subsidies to procure materials and services. It transforms the community perception and understanding of sanitation and builds on local practices and innovations to provide appropriate services to meet the needs and capacity of the population. This approach contrasts in many ways to the commonly held attitudes and mindsets of government, donors, NGOs, and the private sector who wish to support and promote sanitation using the more subsidy based approach of providing pre-designed systems.

Improved sanitation contributes in the form of health, social, and economic benefits and will be an important step in ensuring the development and welfare of rural communities. A regular review of the program will help in identifying important factors that need to be strengthened, modified or rectified to ensure its success.

Community-Led Total Sanitation (CLTS) is a new approach to sanitation promotion that encourages community self-analysis of existing defecation patterns and threats, and promotes local solutions to reduce and ultimately eliminate the practice of open defecation. CLTS initiatives do not stress latrine construction per se, and avoid the use of hardware subsidies. Instead, mobilization efforts focus on helping communities and individuals understand the health risks of open defecation and use disgust and shame as "triggers" to promote action, which ultimately lead to the construction and exclusive use of locally-built low-cost household latrines. The ultimate goal of CLTS is that communities achieve and maintain "open defecation-free" status and improved hygiene practices.

Conclusion

CLTS is one important strategy for stopping open defecation and leads to sustainable behavioural changes. It has significant potential to empower many people to construct low cost latrines and therefore to improve the coverage for sanitation.

The CLTS process undertaken in Budihala since 2010 has demonstrated that it can rapidly change perception and attitude of communities towards sanitation practices and inspire actions to take up improved services. This has offered an opportunity for creating the momentum needed to accelerate and sustain access to improved sanitation across the village.

There are still a number of challenges in ensuring the sustainability of the community support services necessary to maintain the sanitation improvement momentum. The efforts to fully engage the institutional set up for sanitation improvement in the development and application of the CLTS approach is a sure way to achieve wider acceptance and commitment among key stakeholders.

Recommendations

Develop team effort: During the campaign, the community and the governmental and other agencies must work as partners. The government staff and officers must take the initiative, and participate in IEC activities. Emphasis must be given to develop a sense of team work for improving the sanitation condition of the village. All the members of the community, gram panchayat, local leaders, and supporting organizations must work together for the purpose.

Encourage women participation: Women play important roles as beneficiaries, targets, and resources during the campaign. Women must be encouraged to perform various roles as fund raisers, motivators, initiators, surveillance workers, and implementers. Women participation and leadership through SHGs, gram panchayat membership, as well as teachers play an important role in improving the sanitation condition.

Reinforce behavior change: There must be constant follow-up in the village to ensure sustainability and reinforce the new behavior and make it a habit. This must be done collectively by all the members of the team and the responsibility to ensure follow-up activities must be entrusted to one particular agency.

Provide technical assistance: Technical advice is essential during the construction of the toilets and

Regular monitoring & follow-up: A mechanism for regular follow-up and continuous reinforcement of behavior change must be developed so as to maintain sustainability.

Establish RSM/PC: Efforts must be made to establish rural sanitary marts (RSM) and production centers (PC) to ensure sanitary materials at reasonable cost.

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Further Reading

1. Cairncross S. Sanitation in the developing world: Current status and future solutions. Int J Environ Health Res 2003;13:S123.31.

2. Curtis V. Talking dirty: How to save a million lives. Int J Environ Health Res 2003;13:S73.9.

3. Registrar General and Census Commissioner, Government of India, Census 2011. Available from: http://www.censusindia.gov.in

4. Making sanitation work. Jal Manthan Water and Sanitation Programme 2002:5.

5. Department of Drinking Water Supply. Ministry of Rural Development, Government of India. Guidelines of TSC. Central Rural Sanitation Programme 2004.

6. Sanan D, Moulik S. Community–Led Total Sanitation in Rural Areas. An Approach that works. Water and Sanitation Programme 2007:6–8.

7. Ismail O, Tripathy L, Patjoshi P. Women's participation in TSC–The Orissa experience, UNICEF, India: Colombo, Sri Lanka: 32nd WEDC International Conference 2006.

8. Scaling–Up Rural Sanitation in South Asia: Lessons Learned from Bangladesh, India, and Pakistan. Water and Sanitation Programme 2005.

9. Rajiv Gandhi National Drinking Water Mission. Mid–term Evaluation of Total Sanitation Campaign Programme. DDWS, Ministry of Rural Development, Government of India. 2005;23:187–200.

10. Rural Sanitary Marts and Production Centres–An evaluation. Water, Environment and Sanitation Section. New Delhi, India: UNICEF 2004:3 .7.

11. Kar K, Pasteur K. IDS Working Paper 257. Subsidy or self–respect? Community led total sanitation. An update on recent developments. England: Institute of Development Studies 2005:4.5.