India WASH Forum Input to the 12th Plan Working Group: Role of NGOs/CSOs in Sanitation and Hygiene Promotion

This note was prepared by Gramalaya and India WASH Forum. It presents a Framework for Behavior Change Communication(BCC) for the 12th Five Year Plan of Govt of India, with special focus on sanitation and hygiene.

This note providing the framework and Priorities for behavior change communication for sanitation and hygiene covers the following aspects;

1. Main trends in the sanitation sector: Priorities and Challenges for Behaviour Change CommunicationBCC)
2. Existing BCC/IEC component in the TSC programme: overview, key issues, lessons learnt, BCC as a marketing approach vs. a social good approach
3. Principles: Rights Based BCC Approach in promoting sanitation and hygiene
4. Recommendations for BCC strengthening within the TSC Programme. Setting up of a BCC Unit in TSC – state/district/block level structure and operational modalities

1. Main trends in the sanitation sector: Priorities and Challenges for BCC

1.1 BCC priorities in relation to sanitation progress and challenges

The progress made in sanitation improvements in terms of rural individual household toilets availability, from 1% in 1980 to 35% in 2010, has been witnessed.

There are some clear trends available in this change;

1. Increase in rural sanitation coverage has happened in all states of India. Overall for India and specially where rural IHHL sanitation progress has been the least, the increase in sanitation coverage is strongly correlated to the subsidy provided for the BPL toilets under TSC. Hence overall at the national level more rural BPL households have constructed toilets than the APL households.

2. The increase in individual household toilets in rural areas shows that the resistance that people earlier had to constructing household toilets in rural areas and accepting the need for household toilets – is not a barrier anymore (except in some instances). The threshold level of acceptance for household toilets has been crossed.

3. As the numbers of toilets constructed at the rural household level increases, issues of sustainability and usage of these toilets are becoming an issue. NGP villages that were seen as a way forward for accelerating the household toilet coverage in rural areas, have failed in the core area of inspiring all the communities in a village to use toilets constructed under the programme and its guidelines and implementation is under review and reformulation.

4. The states with the lowest IHHL coverage(Jharkhand, Chattisgarh, Orissa, Bihar, UP, MP and Rajashtan) as well as with states that showed a significantly poor IHHL coverage as per the latest DLHS survey Andhra Pradesh and tamil Nadu) – highlight the challenges in the diversity of contexts and the mounting slippages in sanitation coverage that need to be addressed.

1.2 Two major challenges in developing a behavior change communication strategy for sanitation;

A. **There is an increasing felt need for toilets at individual household level, yet why are toilets not being constructed in larger numbers and why some toilets that have been constructed are not being used?** What needs to be done to ensure that this need is translated into both construction and usage of toilets(in terms of the TSC programme priorities in the 12th Plan), of which BCC is a supporting programme strategy element and not a separate communication component.

B. **Who will undertake the behavior change communication on the ground,** how can it be organized most effectively at the district and state levels? Why is the current BCC component in the TSC not deliverying? **Addressing the institutional BCC implementation at state/district level.**

1.3 Non usage of toilets: Contracted out construction process

The experience of many NGOs and government departments in studying barriers to usage of toilets, cannot be summarized in this note. Formative research studies are needed.

Evaluations done agencies(CMS Study 2010) have highlighted **technical failures**(arising out of "poor quality and unfinished installations/toilets") **as the single most important factor for non usage of toilets in India**. Why do we have "poor quality and unfinished installations/toilets" – is not addressed in any research. It is assumed that poor implementation of TSC arising out of capacity gaps, is responsible for the outcome of poor quality toilet construction. This is only partially true.

An implicit conclusion drawn is that incentives given for individual household toilet construction are a reason for technology failure. In a later section of this Note("Suggested BCC Approach for sanitation and hygiene"), we have shown how this cannot be concluded.

Unfortunately in the TSC programme implementation in India, a major reason for non usage of toilets arising out of poor quality construction and unfinished toilets – is its contractor driven implementation.

Technology failure is at best a proxy indicator of the failure of the contractor driven implementation of TSC, not its core reason for failure. If this implementation process is changed towards owner managed programme and incentives given directly to owners, the construction will be of a quality that is acceptable to the people and will ensure a higher usage.

If the toilets construction is through a contracted out construction process, it is more likely that the toilets are not as per the choice and need of the community. Not just the technology of toilet construction but also its demand, design, location and materials used – are unlikely to be as per the desire of the people.

For example if the toilet constructed by contractors along the road side, not having enough space inside for the person to sit without their backs getting grazed on the back wall, not having high enough side walls, roof and door to provide privacy to the toilet user, shallow pits that get filled up easily – could be a result of the contracted process of toilet construction, that leads to the toilets not getting used. It may later appear that the toilets were left unfinished and incomplete, thereby leading to non usage. Whereas it may be the other way around. oilets like this will not be used and will become broken and dysfunctional. It may then appear that they are not used because they are of poor quality and are unfinished.

A toilet may not be used, or partially used by some members of the family, or during some times of the year. Lack of water availability for flushing the toilet is also a critical factor undermining usage and resulting in toilets left uncared for and broken down.

2. Existing Behaviour Change Communication component in the TSC programme and suggested Approach

Information Education and Communication(IEC) forms at integral component of TSC programme, with 15% of the total IEC funding devoted to it. In practice it has been observed that this budget allocation is not fully spent or is not effectively spent for the purpose intended. One reason for this is that the TSC programme is heavily focused on individual household toilets construction. The energies of the PHED departments in the states is geared towards to completion of the construction component(toilets). The district water supply and sanitation missions(DWSMs) find it difficult to undertake the IEC programme in light of absence of standard operating budget lines for this work that cannot be standardized as in physical works, lack of staff and cumbersome procedures for recruitment of consultants.

2.1 Overview of the current IEC promotion - Various IEC Strategies using under TSC for the past 10 years:

- Handbills / Pamphlets / booklets / Calendars
- Posters
- Wall paintings
- Film Shows
- Cultural Programs
- Card exercise Flip charts
- Hygiene Transect walk
- Menstrual Hygiene exclusively for Adolescent girls
- Water and Sanitation campaigns and exhibitions
- Demonstration of sanitary wares
- Door-to-door Campaigns
- Interpersonal Communication

2.2 Key issues relating to current BCC/IEC strategies

Based on the experience of Gramalaya in Tamil Nadu, the following has been the experience of developing IEC strategies;

- IEC materials such as posters, pamphlets and flash cards printed but not circulated properly to the beneficiaries. It is stored in the block development offices or district level offices without distribution.
- Films on water, sanitation and hygiene and many other resources developed but not shared and used.
- TSC Coordinators are not aware of the hygiene messages and technical options of toilets.
- Under TSC programme, Toilet Parks are available in few districts constructed with NGO support nearby District collector office. The idea is creating awareness among the people when they come to the Collector office and they should know about the low-cost toilets and the costs involved. But TSC has no funds to maintain these Toilet Parks and now the toilet parks are in abandoned conditions.
- TSC Block Coordinator needs motivation, exposure and resources to undertake BCC and motivation of communities.
- In many places, no NGOs or CBOs are involved in the TSC implementation. As a result only hardware structures/toilets are created, that too without proper standards and technical aspects. In many states, NGOs are being used as contractors with low piece rate incentives linked to toilets constructed. Hence BCC/IEC component is not provided.
- No systematic IEC strategies with trained personnel made available to the team working for sanitation at the District-level with the DWSMs
- No follow up visits to ensure sustainable hygiene practices and monitoring of the usage and maintenance of the structures created.
- For ensuring usage of toilets by men - no strategy has been adopted.
- Lack of IEC and technical designs for construction of toilets based on the geographical location. Though technical designs are available, the staff involved are not provided with adequate training and capacity to adopt locale specific structures.
- Lack of media support to disseminate the IEC to the public.
- Lack of knowledge among cement fabricators to manufacture toilet construction materials with proper specifications and standards.
- People construct toilets with leach pit and air-vent pipe.
- Toilets are constructed with heavy expenditure, due to the septic tank models.

The experience of IEC implementation in other states, specially the worst performing states of Bihar, Jharkhand, Chattisgarh and Orissa requires much to be desired

2.2 BCC in sanitation and hygiene: Lessons learnt

BCC is not a magic wand and the following need to be considered in a new BCC strategy for sanitation and hygiene.

Behaviour change communication in itself alone as a purely communication intervention can have only a limited impact on sanitation improvement at scale. Did the BCC/IEC alone contribute to the sanitation progress in Kerala, Punjab? Behavior change communication strategy for each state and for the rural and urban contexts, has to be therefore developed to suit the requirements of the particular state/district for its development status, physical and social contexts and the sanitation and hygiene challenges. It also has to address institutional failures in deliverying the BCC/IEC component of the TSC.

CLTS and other approaches. Focus on health and hygiene outcomes, using naming and shaming techniques - have proven successful in many countries, but not so in India so far. What may have worked in Bangladesh(CLTS) may offer useful lessons for India, but should not be blindly copied for India. We should have space for different BCC approaches at a district level, alongwith strengthened institutional delivery framework for BCC delivery. CLTS should not be viewed as an option for reducing state responsibility in sanitation promotion and BCC.

2.3 Incentives in TSC : role and lessons from past

Progress in sanitation coverage has been made in India, and we do have a flagship national sanitation programme(TSC) that is based on the principle of providing incentives for individual household toilet construction. Is the incentive based sanitation programming flawed or not, as a developmental model, cannot be addressed in this Note. What is important for the DDWS and the TSC to review is whether in the implementation of the incentive based TSC programme for individual toilet construction in rural areas, what is successful and what is failing, what can be done to improve the failures.

Unfortunately today, incentive based sanitation and many other development programmes are being viewed from a narrow market efficiency lens and discarded without an adequate and a transparent review of their success and failures. It has been observed that many developmental programmes including health, education and food provisioning under universal schemes – often fail because they are not adequately financed to ensure delivery at the cost intended, and secondly because not enough transparency is built into a top down implementation. Hence failure through corruption, is inbuilt into the programmes.

In the case of sanitation programming, large individual subsidies for toilet construction under the CRSP in the 1980s are cited as an example of failure of incentive based models for individual toilet construction. What is forgotten is that the CRSP approach of pucca toilets in the early 1980s, was done when majority of the houses were kuccha and the pucca toilet looked out of place and was therefore used for purposes that appeared better for the people. The higher subsidies then for pucca toilets looked out of place, and this lead to a move towards lowering individual subsidy for toilet construction. The context however has changed now. With more pucca houses, people are demanding pucca toilets as well. Asking them to follow the Bangladesh model of basic pit latrines as the first step of a sanitation ladder – amounts to blindly copying an approach that is not suitable for India.

2.4 BCC as a Marketing approach to individual behavior change

Behaviour change communication has been reduced to an information communication delivery. It is only seen as an awareness generation input for behaviours change in sanitation and hygiene, with little focus on addressing root causes of problematic behaviours. BCC has been reduced to a commercial marketing concept of trying to address one specific behavior element of sanitation and hygiene, forgetting that something larger may be preventing the adoption of individual behaviour change. A campaign approach is also reduced to campaigning for one specific programme outcome and not for a larger social change outcome of which the particular behavior change element is one.

Public health outcomes in terms of diarrhea and disease reduction is understood as the most significant outcome of a hygiene and sanitation programme. Sanitation as a health message is not programmed adequately in other departments(health and education) work. For example the Polio immunization national campaign, has no focus on the risk of and need to control polio spreading as a result of open defecation(which is a major cause for its spread).

Commitment to improving public health outcomes requires a focus on improving sanitation and hygiene, not simply as a personal behviour change, but as a social necessity. And communication that is larger than a marketing exercise for improving individual behaviour.

2.5 Different motivating factors for sanitation improvement.

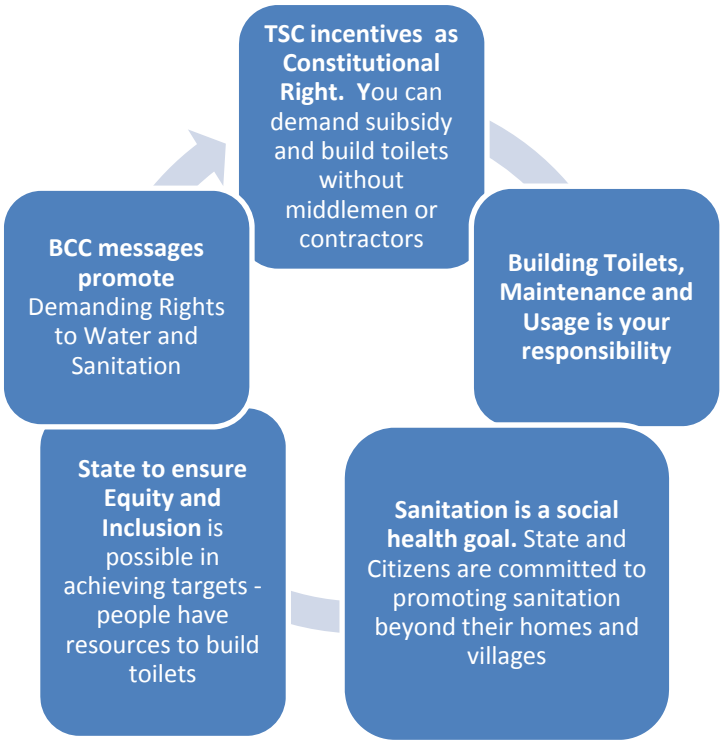
Eliminating open defecation is certainly an improved behavior change but may not in itself contribute to a significant reduction in health outcomes(diarrhea and child morbidity and mortality).

The experience of the large UNICEF Bangladesh project(SHEWA-B) has recently demonstrated that improving hygiene practices alone may not lead to a significantly improved health outcome. The review of the multi million dollar hygiene and sanitation improvement project showed that the results of the programme lead to improvement in hygiene practice, without any significant improvement in health outcomes, when compared to control areas in rural Bangladesh. Therefore, improvements in health outcomes, specially for populations that are living on the margins of extreme poverty, malnutrition, extremely unsafe and unhealthy environments of slums and filth – in such conditions, improved hygiene behvaiours alone may not lead to any significant reduction in health outcomes.

We do aspire for a 100% open defecation free rural and urban slums community, but we need to appreciate and consolidate on the gains being made through the improvements in sanitation coverage and usage in India. If more toilets are being built and if these are being used primarily by women and old people as a matter of dignity and convenience – this is a significant step forward and any BCC strategy should build on these elements to induce men and children to also use toilets.

3. Principles for a Rights Based BCC Strategy: promoting sanitation and hygiene

A Rights Based Behaviour Change Communication Approach for TSC



4. Recommendations for BCC strengthening within the TSC Programme. Setting up of a BCC Unit in TSC – state/district/block level structure and operational modalities

Water and sanitation are state subjects. TSC involves a large centrally sponsored scheme for improved sanitation, with a smaller contribution from states and individual households. Some states have provided for incentives in addition to the TSC, for individual household latrines. At the state level the State Water and Sanitation Mission, a nodal body usually constituted by the Public Health Engineering/Rural Development department, is expected to coordinate and monitor the sanitation programme. At the district level, District Water and Sanitation Missions are constituted a small team of deputed Engineers from the PHED and some consultants hired. The District Collector, as the in-charge of all development programmes at the district level, Chairs and monitors all programmes including TSC.

The CCDUs, at the State Water and Sanitation Missions, were expected to undertake both capacity development and behavior change communication to support the TSC programme. Under the revised guidelines, Block Resource Centres have been constituted to support implementation and coordination at Block level.

4.1 Major reasons for failure of the current IEC component delivery in TSC programme include;

Even though the need for BCC is recognized in the TSC, the way it is programmed as an IEC component is a stand alone sanitation promotion component. The district and state level coordination at the PHED level is geared towards construction and hardware, since these are the strengths of the implementing agency. Hence at the institutional level there is a structural gap in planning and delivery effective BCC for sanitation. Some of the critical areas are;

- Inability to adequately staff CCDUs and other similar teams at state and district levels(short term contracts, low remuneration, not enough budgets to travel and implement BCC interventions independently)
- Reticence of the District Executive Engineers in utilizing the IEC component of TSC. They find it difficult to undertake the IEC programme in light of absence of standard operating budget lines for this work that cannot be standardized as in physical works
- Lack of coordination with the TSC incentives for construction work

The experience so far has been that the state level CCDUs main function has been reduced to data collection and compilation from districts for the national level reporting for TSC. At the district level the priority always remains drinking water provisioning, specially for district level townships that do not have dedicated water supply sources and have to depend on tankers. The Engineers at the district PHED consider sanitation programme as an additional burden to drinking water priority. They do not have the contracting procedures for BCC worked out and are afraid of contracting out IEC/BCC activities.

TSC coordinators are tied up with chasing contractors and NGOs to perform and deliver on TSC targets. **There is no dedicated team on the ground, to undertake BCC work. NGOs** are expected to work on low piece rate contracts(as low as Rs.15 per toilet constructed in Bihar), and also undertake BCC.

Unless this lacunae(dedicated team for BCC) is addressed, in terms of identifying teams at state and district levels to work full time on BCC that could be consultants or local NGOs, it Is difficult to implement effective BCC for sanitation and hygiene promotion.

Even where limited staff are hired as consultants for the CCDUs and with the DWSMs, inadequate provisioning for their travel, independent planning and promotion of BCCs(in line with the TSC programme implementation) and monitoring – is not feasible on account of lack of budget and financial resources.

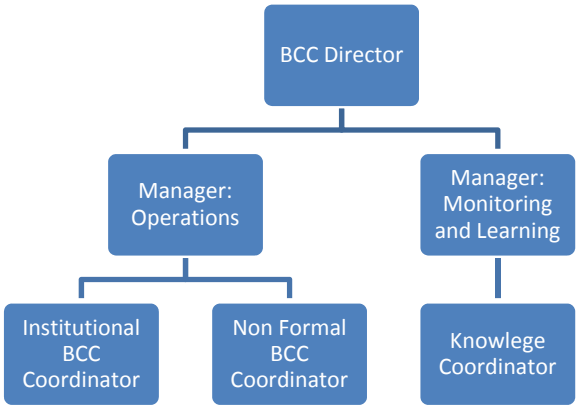
4.2 Recommendations for Institutional strengthening for BCC at state and district level

Institutional strengthening for deliverying quality BCC at the state and district level is required. Considering the limitations mentioned in the current TSC delivery/implementation at the district level, as mentioned in the previous section, **having a separate BCC Unit at the State level could help improve sanitation and hygiene outcomes.**

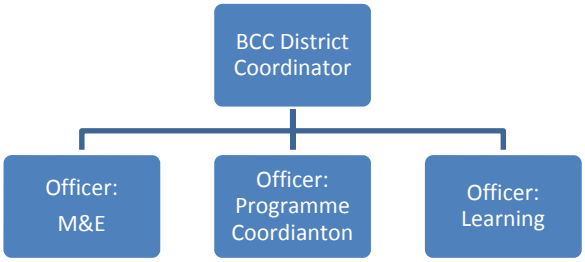
A team of dedicated BCC specialists needs to be set up at the state and district levels - to undertake and support BCC work that is aligned with the sanitation programme. This unit should be well funded to undertake BCC activities in a planned manner for a five year period.

Proposed structure of the team is presented below:

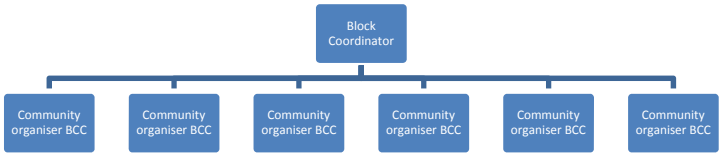
BCC Unit at the State Level – working under the Secretary



BCC Teams at the District level



BCC Teams at Block Level



A team of 6 Community Mobilisers working under a Block Coordinator(possibly one of the two BRC officers).

BCC Teams at District and Block level could be given out to NGOs. The BCC team at the state level could also be an NGO, reporting to the Director who should be from the state government.

The proposed team structure of a separate BCC Unit with State, District and Block level teams, is proposed for a 5 year period. They will need dedicated budget for their operational costs of travel, monitoring, as well as for programming aspects of learning, research, communication materials, campaigns, monitoring, etc. The budget for BCC Unit can be met from the current 15% TSC budgets for IEC, it should be met 100% from the central grant for the first five years.

4.3 Functions of the BCC Team at the State, District and Block levels:

1. **State BCC Unit.**

   The BCC Unit at the state level should consist of a team of 2 Managers and 3 Coordinators working under the Director of BCC and a Manager.

   Main role of the State BCC Unit will be Planning and Coordination with the TSC Programme to ensure;

   a. Designing the State BCC strategy and budget
   b. Ensure coordination with TSC - incentives for toilet construction are preceded with awareness generation
   c. Facilitate specialized support agencies at state and district level to support BCC implementation. Supporting district and block level teams in planning the annual BCC components, in supporting training of trainers and in monitoring progress in behavior change.
   d. Ensuring that construction of toilets is owner lead and not contracted out with no engagement of the communities.

e. Undertake Formative research and assessments on key behavior change barriers is done as a start up activity. Conduct/Commission research studies and documentation.
f. To provide a repository of knowledge base over the years. That is missing in the current system where all knowledge and behavior change learnings are with external agencies and donors
g. Partnerships with Resource organizations, NGOs and informal BCC methods
h. Monitoring of outcomes – mid term review and studies to assess impact.

2. Teams at district level

A District Coordinator and three Officers. To report to the two Managers at State level and support the community mobilization for improved behaviours at the block level.

Key functions of district team;

a. Strengthen the BCC input coordination, M&E and Learning.
b. Develop annual work plans to undertake the demand generation for hygiene behaviours and construction of new toilets, repairs of old non usable toilets.

3. Block Level teams

Each Block should have atleast 10 member team working under a Block Coordinator.

Key functions;

a. Implement the BCC strategy in the block.
b. Facilitate demand generation, door to door interaction and BCC work, monitor regular use of toilets and improved hygiene behaviours.

4.4 Operational modalities of effective BCC in the TSC

The TSC guidelines on IEC strategies are vividly narrated right from the dangers of open defecation, to the hand washing practices. Very elaborate guidelines are provided with regard to the IEC interventions for what purpose and to whom it should be provided. The major problem is that reaching the communities especially women, children and men who are family heads.

Strong commitment is required right from the top officials at the District-level to the grassroot-level staff to be involved in the TSC program.

District-level Water and Sanitation Mission should comprise one third of NGOs representatives with other voluntary organizations, service providers, bankers and government officials.

Pooling of IEC funds of TSC for the BCC Unit operations. TSC funds will need to be sourced for this. Operating procedures on procurement and hiring will have to be developed to ensure BCC work.

Retain flexibility in targets and construction component. Ensure that a mechanism is in place for this coordination. Sanitation targets are important, but excessive focus on this will not allow for effective and flexible programming of BCC for sanitation and hygiene improvements. In a demand lead, people owned programme, monitoring targets at district level, should be flexible based on the targets set by the BCC Unit.

For promoting hygiene education, demands creation, construction, usage and follow up of sanitation facilities, the role of NGOs is vital with proper guidance at the District-level. **The NGOs should be provided with adequate financial support** for involving them from awareness creation, demand creation, construction and follow-up. As suggested in the previous section, the NGOs could be given the charge of implementing the BCC work at district and block level. The BCC Unit at the State level could also be constituted by an NGO, reporting to the Director who should be from the state government.

There should be regular monthly review meetings conducted with the chairmanship of District Collector, PO DRDA and District Coordinator along with Block Coordinators. District Coordinator and Block Coordinators should work closely with NGOs in achieving the target.

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