India WASH Forum

WASH News and Policy Update
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India WASH Forum News

India WASH Forum stands for an independent credible voice in the water, sanitation and hygiene sector. WASH News and Policy Update is a bi-monthly e newsletter of the India WASH Forum. It is an open platform for engagement on contemporary issues in WASH sector in India and elsewhere. We are pleased to share the 31st Issue of our bi monthly Newsletter. Our newsletter provides an analytical perspective on contemporary WASH issues.

We are conscious of the need to engage with and understand other larger debates in the social and economic development scenario, of which drinking water and sanitation is a part. Hence we include in our news analysis and policy updates, events and developments from other related development fields, besides the WASH sector. We invite readers to share their experiences and reports that can be disseminated from this WASH Policy Newsletter.

Its been six month since Perween Rehman was gunned down. The **loss of Perween Rehman should not be forgotten. The upcoming SACOSAN V in Kathmandu** could be an opportunity for civil society groups to commemorate her work and commonly shared goals of a life of dignity for the urban poor. **Pablo Solon, another fighter from civil society who has made it to the UN General Assembly Representative of Bolivia,** has also not received the recognition from international development agencies and civil society that is due to him. When civil society talks of womens leadership in Sanitation or when we talk of Right to Water and Sanitation, civil society and international aid agencies often forget to acknowledge the representatives of the people who have braved all odds and instead end up facilitating women bureaucrats and heads of states. Completely forgetting what they preach, that Gender is not about being man or a woman in terms of sexual orientation, its about power relations. Acknowledging womens leadership by facilitating women bureaucrats or heads of state is still a common norm. While this is an understandable act of political accommodation by Bilateral Aid agencies and others who are mandated to work with the government as their main partners, what is perturbing is the civil society organisations and UN agencies shying from giving recognition to people like Perween Rehman and Pablo Solon.

For some of us who knew Perween or had met her, were struck by her passion for defending peoples own initiatives to bring basic drainage and sewerage in the kuchhi abadis or the slums of Karachi. Sometimes we wondered if this self help work of OPP project was covering up for the irresponsible state commitments to water and sanitation. In this interview we bring in this issue by Rina Saeed, we see that sewerage and drainage was only of the many other things that people like Perween Rehman stood for and worked for. She never denied the role of the state as a provider of basic services. Her point was that since the state is abdicating its responsibility, people have to do something themselves and they can do this as best as they can.

“She would often describe Orangi’s population of 1.5 million people as “a great example of self-help initiatives”. The people of Orangi on a self-help basis (and with technical guidance from the OPP) established modern underground sewer lines and built latrines in their homes. The government only contributed by building the main sewers or nallahs. In Orangi, the people and the government became partners in development. The people of Orangi set up 650 private schools and opened 700 medical clinics, while establishing 40,000 small enterprises in various homes. Around 60 per cent became self-employed. Orangi consists of 113 settlements inhabited by various ethnic groups: Pathans, Balochis,

Muhajirs, Biharis, Punjabis etc. It was set up in the 1960s by the government but it expanded very fast in 1981-82 when refugees from former East Pakistan began to settle there."

We continue the discussion from the previous issues of the IWF Newsletter, on BCC in WASH, that continues to feature on the Community Practice WSSCC discussion list on Linkedin closed Group.

Measuring success/failure of BCC in WASH is often done for evidence of health outcomes of Project Outputs.

In the Dhaka 2011 Hygiene Workshop by IRC, we were faced with the results of one of the largest DFID supported Bangladesh WASH Hygiene promotion project results(SHEWA-B) showing no significant impact on heath outcomes(vis a vis control areas), despite an improved hygiene behaviours in the project areas. This was an integrated WASH project(that addressed all WASH interventions of handwashing, safe water and toilets use). Hence the results were really baffling. Was this a failed project or a failed project design or a something else? The same question can be posed to the Vietnam hand washing project that received so much publicity as a model.

The IRC workshop then drew the conclusion that measuring health outcomes from project results may be difficult if not impossible. That even large multi million dollar WASH projects may not be amenable to validate theory(unless perhaps they have a research component within it?). Hence instead of trying to measure health impacts from sample end line evaluation studies, the WASH projects should only try to measure adoption of hygiene behaviours. Leaving the health outcomes assessment to more pucca research work.

Will the donors, national governments and taxpayers be happy with this recommendation that you cannot measure health outcomes after spending millions of dollars in a project? As mentors, we who have worked in WASH sector for years, what advise and mentoring do we give to younger colleagues regarding simplistic assumptions for BCC in WASH?

- We identified three major reasons for WASH project failures - Faulty Project Design and/or Implementation failure include - Projects are subcontracted to agencies or consulting firms because milestones are to be achieved which are set ambitiously and not realistically and project outcomes are measured by spending rather than rigorous health indicators. There are more than dozen goals to be achieved during limited time and this include in this issues relating to gender, excluded community, capacity development at various levels, HR issues, private sector participation, Nutrition, WASH and sub-component in WASH. In these complex project the central theme is lost. You end up with dozens of national and international consultant working on bits and pieces and working in silos with no uniform goal. You end up with report with no conclusive evidence and community are left high and dry.....
- Impossibility of monitoring Health Outcomes in WASH projects
- Other Factors that could inhibit even successful health impacts of WASH projects and not lead to any perceptible health outcomes - hard labour inducing debilities, unsanitary working and living conditions, food, etc. Jan Bremen while studying migration and work in the sugarcane fields In Maharashtra had reported that the hard labour done cutting the sugarcane was worse than unemployment - something that economists will find difficult to accept. The toll that this hard labour took on their physical state was he said, worse than not working.

Recently WSSCC had roped in Shah Rukh Khan as a WASH Brand ambassador and then Govt of India had roped in Vidya Balan an actress of hindi cinema as sanitation ambassador. India is of a sub continental proportion with many nationalities and languages, each one has their own celebrities and filmstars. Hindi cinema is no longer a mass entertainment media that it was say 20 years ago and their heros now cater to non resident Indians and middle class and elite sections of India. Our hindi filmstars are not recognised as celebrities in the non hindi speaking hinterlands where sanitation status is the poorest. Infact hindi cinema heros plead for an opportunity to act in the sub national cinema ins states like Bihar where Bhojpuri cinema rules. Hence it is better to promote WASH using these sub national cinema heros and heroines as brand ambassadors, and to target the media campaign at state level and not national level. This is a suggestion to all agencies promoting BCC in WASH in India.

Giving up on throwing plastic waste on the road side, spitting, stopping smoking and using condoms, vegetarian food - was not promoted by celebrity and as a fashion statement.

Who is gaining from the advertising based WASH campaigns on television - the people or the media and television agencies? Has there been any assessment of impact of this media and celebrities on behaviour change in WASH? Then it is purely an assumption that people can

be fooled into buying coke and cigarettes, so they can also be fooled into changing WASH behaviours. Its a pity that we see people we work with as mindless consumers - to use short cuts to influence their minds. Lets have faith in people that they can change the world not just their behaviours, and faith in ourselves to be able to reach them to communicate through means that they want. For this we will first need to understand why they behave the way they do and then try any intervention. Usually we are in a hurry to make them use toilets or hand wash, without first understanding why this is not done.

WesNet had an interesting discussion on Menstrual Hygiene management in India. Summary of three main highlights of the discussion is presented below.

1. There is tendency to ignore and learn from existing and past practices and jump to solutions that are very much in terms of converting a traditional practice into a commercial service, that comes with a cost and a service provider. We see this so often in WASH sector. Hand washing with soap is promoted and not ash or any other non commercial product. Boiling of water that is the most widely practiced improved behaviour change for household water treatment and SODIS, find less favour as compared to all other treatment options. Creating a market for pit latrine cleaning using septic systems promoted as a PPP solution for rural areas. There is a tendency in WASH Behaviour Change communication - to preach simple hygiene messages in WASH without trying to know why people do what they do and assuming that awareness is not there.
2. Not all traditional practices may result in healthy and convenient solutions or be socially and individually acceptable today. If traditional practices are leading to serious impacts on womens health as is sometimes reported of young girls getting serious infections, then alternative solutions are needed. However if there is a potential for improving them with some changes(changing attitudes by removing stigma of drying the menstrual cloth in the open), and other prejudice – then its a better option than adopting a commercial service option(sanitary pad).
3. If womens hygiene requires privacy for bathing and cleaning, and that is not available, then that is perhaps a more critical priority to address menstrual hygiene.

Development Alternatives has come out with a Programme and Policy Paper on Household Water Treatment Systems, Safe Handling and Storage. The Paper is based on the action research work undertaken in slums of Delhi and provides useful pointers to what needs to be prioritised for policy and programme work in India. The findings guiding the recommendations are;

- **Awareness of need for safe drinking water and the correlation of contaminated drinking water and diarrhoea** is there among most residents. Behaviour change and practice does not match this awareness level. However, **knowledge and awareness** of the most appropriate and effective HWTS options is limited. **Convenience and affordability** determine the choice of HWTS option by a household.

- **Drinking water from DJB tanker supply is considered safe**. **Boiling of water, one of the oldest HWTS behavioural practice, is not a regular feature**. People mention boiling in times of emergency disease outbreaks only. The increasing cost of LNG/LPG cooking gas, free DJB water availability for some and affordable RO water for others, is restricting Boiling Water as a HWTS option in most settlements. The quality of RO water supplied, its conveyance, safe storage and hygienic usage is an issue.

- **Sanitation and drainage remain major health risks. Many residents are making large investments in toilets that do not deliver hygienic sanitation.** Absence of well maintained and clean public toilets, lack of open spaces for defecation, as well as convenience and security issues for women and children – are driving many residents who can afford the money, to build individual toilets.

Food Security Bill Passed by parliament on 26 August 2013, after months of wasted sessions, the Lok Sabha finally passed a historic legislation: the Food Security Bill. Many Indians woke two days later to headlines that the rupee had nosedived and the Indian markets had been “food poisoned”. It was a smart phrase. It captured the horror industry and what investors feel about the Bill. But it also epitomised the damaging hysteria and misinformation around it. It captured one of India’s most harsh dividing lines.

Pratap Bhanu Mehta, Director of the Centre for Policy Research, put it in an excellent *Indian Express* column: “Has any modern society evolved without robust welfare protection?” He goes on to add, “It’s no accident that even so-called right-wing politicians from Bismarck to Churchill and Nixon have supported an efficient and humane basic income guaranteed by the State.”

Who Will Dare to be Perween Rehman: Rina Saeed

That is the question that the NGO world, still reeling from the shock of Parveen's target killing in Orangi Township in Karachi, is now asking itself. At a memorial meeting held in Islamabad this week, NGO workers spoke of the "growing hostile environment for community service in Pakistan". Parents are now telling their children not to enter into this field, because clearly, "community service is becoming dangerous". The NGO officials from established organisations like Plan International, Aurat Foundation, the Akhter Hameed Khan Resource Center and the Imran Khan Foundation called for increased accountability and a minimum standard of protection for social workers. A call was given out to "respect, promote and support community service in Pakistan".

"Parveen Rehman knew of the risks and yet, **she willingly continued with her work**. She chose to do this", pointed out Dr Rakshinda Parveen of the Society for Advancement of Community, Health Education and Training (SACHET). There is no doubt that Parween Rehman was an extraordinarily brave woman. A trained architect who could have lived a comfortable life in Karachi's up-market Defense or Clifton areas, she instead chose to dedicate her life to the poor of the squatter settlements of Orangi Town. She was the dearly departed Dr Akhter Hameed Khan's (a development guru) brightest and as it turned out, bravest, student and with good reason he chose her to continue with his pioneering work in Orangi.

Parveen had been working at a private architecture firm before being recruited by Dr Akhter Hameed Khan to become Joint Director of the Orangi Pilot Project back in the early 1980s. She was put in charge of managing the housing and sanitation programmes. In 1988, OPP was split into four organisations, and Parveen Rahman became director of the OPP-RTI (Orangi Pilot Project – Research and Training Institute), managing programmes in education, youth training, water supply and secure housing. In 1999, Dr Akhter Hameed Khan passed away and Parveen remained steadfast in carrying the torch.

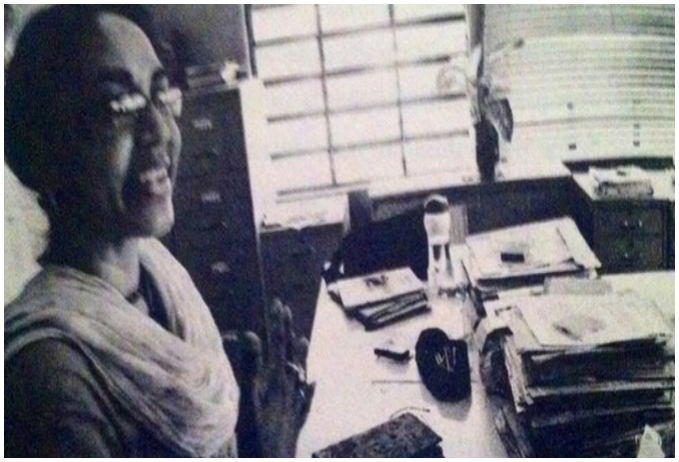
She would often describe Orangi's population of 1.5 million people as "a great example of self-help initiatives". The people of Orangi on a self-help basis (and with technical guidance from the OPP) established modern underground sewer lines and built latrines in their homes. The government only contributed by building the main sewers or nallahs. In Orangi, the people and the government became partners in development. The people of Orangi set up 650 private schools and opened 700 medical clinics, while establishing 40,000 small enterprises in various homes. Around 60 per cent became self-employed. Orangi consists of 113 settlements inhabited by various ethnic groups: Pathans, Balochis, Muhajirs, Biharis, Punjabis etc. It was set up in the 1960s by the government but it expanded very fast in 1981-82 when refugees from former East Pakistan began to settle there.

"Parveen's community work with the OPP was lessening the differences between the various ethnic groups. The people of the area don't really have issues with each other – the land and water mafias affiliated to various political groups like the PPP, ANP and MQM are the ones causing all the problems," explained Aurangzeb from the Al Falah Development Foundation based in Rawalpindi. Although much older than her in years, Aurangzeb considered Parveen to be his teacher and worked closely with her in the last few years. He attended her funeral in Karachi and said that thousands of people in Orangi are mourning her death. "She was very compassionate and it is a personal loss to all of us who work with the poor. For the people of Orangi, she was like a mother who cared for everyone and brought people together in the township".

Parween was **murdered by masked men who shot at her car** on Banaras Pul in Orangi (near the ANP controlled area). She was on her way home from work in the afternoon. Recently, she had had been documenting land-use around Karachi, and this may have upset the city's powerful land-grabbing criminals. She was also opposed to the "tanker mafia" who were stealing tube-well/piped water from low-income communities and then selling it back to them in water tankers. Parveen investigated the water shortage in the area and actually discovered that a crucial piece of pipe was missing and had it replaced.

According to Aurangzeb, these mafias have the patronage of politicians and have become even more powerful in recent years. "The situation has deteriorated since the PPP government came to power. These mafias have actually occupied various areas of Karachi and forcibly take bhatta (extortion money) from the local residents who live in fear of them. They are gangsters who are looting the public and really if the local people were given protection by the police or Rangers they would evict these criminals themselves. They are so fed up of them".

Although the police is now attempting to shift the blame for Parveen's murder onto the Taliban (who have not claimed responsibility for the attack) and other religious groups, the NGO world is convinced that it was these powerful land and water mafias who are responsible for her death.



"Parveen meticulously documented 500 goths (settlements) in Orangi, teaching young people to do the mapping and data collection. She regularised these settlements and the land mafia didn't like it one bit," explained Fayyaz Baqir, another close acquaintance of Parveen who heads the Dr Akhter Hameed Khan Resource Center. "In fact, at one stage the land mafia even tried unsuccessfully to take over the OPP office building itself. Parween would receive threats all the time". The OPP staff had actually been forced to stop work for a month while the land mafia occupied their office in the hope of forcing them off the plot (once peripheral but now well-located). They had to negotiate with other power brokers who recognised their contribution to improving people's lives and were willing to intercede to enable them to continue with their work.

The day after Parveen was killed, the OPP decided to open up its office and hundreds of NGO workers from all over Karachi came to Orangi to show their solidarity. "We must continue with her work, we cannot be deterred by her murderers", vowed Fayyaz Baqir at the meeting in Islamabad. Along with the heads of other NGOs in the capital, he is organising an open house at the Islamabad Hotel on Thursday at 4pm to "express solidarity with Parveen Rehman". Civil society members, the media, university students and trade unions are all invited to come and learn about this amazing woman and to ensure that others, especially amongst the younger generation, will indeed dare to be like her.

The writer is an award-winning environmental journalist based in Islamabad, who also covers climate change and health issues. She can be reached at rinasaeed@gmail.com

Promoting Household Water Treatment Systems, Safe Storage and Safe Handling Among Urban Poor: Programme & Policy Note

Executive Summary

THE POLICY NOTE IS PREPARED WITH THE OBJECTIVE OF ADDRESSING THE RISK OF WATERBORNE DISEASES FROM UNSAFE DRINKING WATER IN URBAN INFORMAL SETTLEMENTS. THE NOTE RECOMMENDS SETTING UP OF A NATIONAL MISSION ON HOUSEHOLD WATER TREATMENT, SAFE HANDLING AND STORAGE, AS A MAJOR POLICY AND PROGRAMME THRUST OF GOVERNMENT OF INDIA AND STATE GOVERNMENTS. IT IS BASED ON THE WORK DONE BY DEVELOPMENT ALTERNATIVES AND ITS PARTNER NGOS IN DELHI.

Introduction

Health is universally recognised as a Public Good. Access to water and sanitation is recognised as a Human Right as per the UN Declaration of 2010, and a state responsibility. Providing safe, reliable, piped-in water to every household is an essential goal of all countries and civic bodies incharge of water and sanitation. The Policy note **reaffirms the commitment of the government for provision of safe drinking water and sanitation for all. It makes a case for promotion of Household Water Treatment as an interim solution by all civic agencies and government departments,** that is urgently needed but is not a substitute for safe drinking water for all.

Point of Use drinking water safety in complex water supply regimes, varying social and economic contexts or urban settlement, is a key priority for all stakeholders.**Linkage of water and sanitation to health** outcomes has been a major determinant of policy and financial assistance to WASH sector.

Prevailing Practice

Global evidence shows that boiling of water is the most prevalent means of treating water in the home in most parts of the world. It is practised by hundreds of millions of people, perhaps because the necessary hardware are already available in most cases resulting in becoming part of the culture and practice.

Other measures of HWTS besides boiling water, include;

- Chlorination
- Solar disinfection(SODIS)
- Filtration – ceramic filters and bio-sand filters
- RO and UV systems

- Sachets combining flocculent and disinfectant

Emergencies and disasters see the most use of low cost water treatment options. Unlike in Europe and US, assured 24x7 piped water supply in India is a distant reality, bacterial contamination exists even in piped water supply. Hence the need for and a market that is flooded with Filtration, UV and RO based household water treatment systems on the one hand and a growing informal and formal sector treated water supply business.

The Development Alternatives(DA) project in Delhi highlighted the diversity of Household Water Treatment options and their prioritisation by slum communities that is dependent on a range of factors including location of the slum settlement within a city, the quality of ground water it can access, political patronage that allows them to secure water from the Water Utility(Delhi Jal Board), the economic status of the majority population of the settlement.

Water quality issues vary from one slum to another, within a city and across cities. **Peoples priorities determines their behaviours and influences success of any behaviour change intervention**. What is often missing is an understanding of the specific type of water quality issues in each slum area, what options they can exercise that are required to treat the water quality problems and actions to promote adoption and practice of low cost methods. Understanding why people prefer to continue with their behaviours is therefore important, instead of pushing an improved behaviour change intervention without first trying to understand what makes them do what they do.

Water Quality-Health Linkage

The health status of an inhabitant of a poor urban settlement, cannot be statistically correlated to one specific WASH attribute. The health of the urban poor is related to the living conditions(sanitary) that includes clean air and water and free from disease spreading agents, safe hygienic food and personal hygiene. WASH research and advocacy initiatives often draw attention to hand washing hygiene as the most significant contributor to reducing incidence of diarrhoea. Drinking water quality is also an important factor. It is a combination of all the critical WASH factors and not one aspect alone, that needs to be addressed. A recent World Bank Study has shown that hygiene education and water quality improvements are more effective(42% and 39%) respectively at reducing diarrhoeal incidence than simply providing toilets/sanitation and drinking water supply.

Lack of sanitation/toilets and sewerage leads to open defecation and high private investments to build septic tanks as base tanks on 12 square meter housing plots in the resettlement colonies of Delhi. Open defecation, poor disposal of solid waste and overflowing septic tanks in streets without adequate drainage poses the greatest health risk.

Status of Drinking Water Access of the Urban Poor

It is observed that **awareness of need for safe drinking water and the correlation of contaminated drinking water and diarrhoea** is there among most residents of slums settlements. Behaviour change and practice however does not match this awareness level. **Knowledge and awareness** of the most appropriate and effective Household Water Treatment Systems(HWTS) options is limited. **Convenience and affordability** determine the choice of HWTS option by a household. **Drinking water from Delhi Jal Board(DJB) tanker supply is considered safe**. Risk of contamination of water on the way(transit from tankers to home) and in the containers used, is not recognised as a problem. **Boiling of water, one of the oldest HWTS behavioural practice, is not a regular feature**. People mention boiling in times of emergency disease outbreaks only.

Existing Programme and Policy Frameworks for Safe Drinking Water in India

MoUD, through its technical wing CPHEEO, suggests indicators benchmarks for quality and quality of water supply including 100% piped supply, 24X7 supply, 135 litres per capita day and quality of water supplied is 100% to allocate performance based grants to ULBs(MoUD website, 2012). The central JNNURM scheme, started in 2005, promotes reforms at state and city levels by making the funding for its projects conditional to bring a shift in focus from infrastructure creation to delivery of service outcomes. Several other initiatives followed to incentivise cities to upgrade their water and sanitation infrastructure : the City Development Plans, the City and State Sanitation Plans, Service Level Benchmarking for Urban Bodies.

Despite massive investments in expanding urban water supply and sewerage, slums and unauthorised colonies are still denied piped water and sewerage connectivity. Cities depend on water from rivers and external sources. Large metro cities like Bangalore have run out of their entitlement of water from Cauvery river. Delhi too is running out of water, despite securing its water requirements from three rivers(Yamuna, Ganga, Beas). Cities and towns in the semi arid and arid regions of India suffer from chronic water shortages. 24x7 water supply projects being implemented in some cities are facing the challenge of securing enough water from limited sources. Lack of water availability and not lack of finance, is

emerging as a major problem in ensuring drinking water security in urban India.

The exhaustive drinking water quality standards that exist in the country are merely recommendatory in nature, except for the bottled drinking water industry, and not mandated or implemented through a statutory framework (Report on UIWSS, 2011). The water supplied in urban areas should meet the BIS 10500: 2012 drinking water specifications. However, the water supplied doesn't meet acceptable limits (refer MoUD manual, 1999) of drinking water quality standards and urban population has to content with the permissible limits of water quality in absence of an alternate source. In the slums the per capita supply is around 40 LPCD as per CPHEEO norms.

HWTS Options and Safe Storage Practices

HWTS systems were developed to provide a first or extra barrier of protection to ensure safe drinking water quality. They have gained increasing recognition and are implemented in the developing world as a means of safe drinking water at the point-of-use. The idea is simple – to treat water at the point of use, preferably using effective but low-cost treatment technologies that could be developed using locally available raw materials.

The market for HWTS products is very competitive. There is aggressive marketing and promotional work done by the private sector and a large number of economically better off residents of Delhi and many other Indian cities have been effectively reached through this advertising. It is not uncommon to see middle class families installing expensive RO based water treatment systems on DJB supplied water in Delhi. The uptake of Filtration and RO systems remains low in the poorest urban settlements, among people who perhaps need safe drinking water the most. Increasing cost of LPG and electricity makes boiling as a treatment option expensive.

Better off households preference for RO treated water supplied from a private vendor and not adoption of household water treatment systems could be correlated to;

- Status of available ground water - polluted with chemical contaminants, high Iron content[1] - that cannot be treated by Filtration
- Hardness in ground water(high TDS content), that cannot be remedied with Filtration[2]
- Cheaper availability of RO treated water(perhaps costs lower than Filtration based HWTS at home[3], requires no investments and recurring costs, and does not inconvenience the consumer).

Barriers and Motivation of Urban Poor in Adopting of HWTS

Middle and high income residents of slum settlements have better affordability and are willing to purchase treated water that they store in their refrigerators. Most of low income households in the slums authorised and unauthorised settlement of Delhi use the water supplied in homes or accessed from tankers and other sources for drinking and cooking purpose without using any HWTS technology.

In the DA project in 26 settlements of Delhi provides important lessons to the prevailing HWTS options and preferences in urban settlement. The project has worked towards increasing awareness of water quality problems and advocating low cost solutions. Most people are aware of the water quality issues yet in terms of practice, adopting measures of water treatment and willingness to pay the following is witnessed;

- Few people undertake chlorination of water as a treatment option.
- SODIS treatment works well in poorest jhugi jhompri colonies where it is easy to place and retrieve plastic bottles from the roofs.
- Filter based treatment systems are not very popular and are being purchased by those who are willing to pay for purchase and replacement of filters.
- Availability of RO and UV treated water (not verifiable if it actually is treated and is safe) and the aggressive advertising that this is the safest treated drinking water sources, has created a demand for RO treated water. Where RO treated water is available at cheaper rates owning to competitive pricing and bottling within the slums, it

[1] Iron content is visible in Madanpur Khaddar resettlement colony ground water.

[2] TDS is high in Savda Ghevra. In Rangpuri pahari settlement no water testing is being done on ground water

[3] Cost of Pureit Filter treatment of Unilever is cited as Rs.0.33/Litre that is higher than the Rs.0.25/liter for RO water in the resettlement colony of Madanpur Khaddar.

is competing with household water treatment filter systems.
- Boling of water is not a preferred water treatment option in most slums of Delhi, it is practiced only in winters and when there is a scare of an outbreak of a water problem.

Factors inhibiting HWTS scaling up

- Low cost Filters, Chlorine and Flocculants not available locally and on a regular basis
- Perceived poor taste of water, temperature and additional effort required
- SODIS and Chlorination require regular follow up and face to face communication and persuasion to encourage people to use these HWTS methods.
- Low cost HWTS and safe storage is not promoted as an aspirational social and individual behaviour change ideal in a creative way
- Water stored in homes is never tested for quality/contamination.
- Absence of any programme or campaign that promotes HWTS and safe storage. Where this is promoted by ASHA workers who also supply chlorine tablets, it leads to positive behaviour change.

Behaviour Change Priorities for HWTS Promotion

Awareness of need for safe drinking water and the correlation of contaminated drinking water and diarrhoea is there among most residents. Behaviour change and practice does not match this awareness level. However, **knowledge and awareness** of the most appropriate and effective HWTS options is limited. **Convenience and affordability** determine the choice of HWTS option by a household.

Drinking water from DJB tanker supply is considered safe. **Boiling of water, one of the oldest HWTS behavioural practice, is not a regular feature**. People mention boiling in times of emergency disease outbreaks only. The increasing cost of LNG/LPG cooking gas, free DJB water availability for some and affordable RO water for others, is restricting Boiling Water as a HWTS option in most settlements. The quality of RO water supplied, its conveyance, safe storage and hygienic usage is an issue.

Sanitation and drainage remain major health risks. Many residents are making large investments in toilets that do not deliver hygienic sanitation. Absence of well maintained and clean public toilets, lack of open spaces for defecation, as well as convenience and security issues for women and children – are driving many residents who can afford the money, to build individual toilets.

Recommendations

Low cost simple household water treatment can work and people will adopt SODIS and Chlorination. This requires awareness generation about low cost solutions and understanding that low cost treatments are as effective as high cost HWTS solutions, consistent follow up on behaviour change, explaining how SODIS bottles should be used and placed, dosage of chlorination and safe water storage at home, and provision of regular supply of low cost items like Chlorine.

Lack of demand for low cost HWTS is a behavioural issue resulting from low social and individual priority for water safety. Aggressive commercial advertising and promotion of high cost HWTS as aspirational symbols, makes low cost solutions look unsafe and inferior and suppress their demand. Marketing of commercial products requires subsidising the cost through attractive sales promotion pricing and rebates for consumers. Promoting low cost or no cost behaviours and practices that do not have product selling as its aim(SODIS and Boiling of Water), is not possible by employing commercial marketing approaches.

No NGO can compete with the big advertising and promotional budgets of the commercial sector for promoting HWTS. It is therefore imperative that the state supports the promotion of low cost household water treatment options and behaviour change promotion on a regular and sustained basis. Not as one off posters and advertising campaigns on TV and Radio. **Promoting Household Water Treatment Systems(HWTS) could be seen as a Public Health Good and a responsibility of the state**(till everyone gets adequate and safe piped drinking water). The principles of using public funding will dictate that the **options promoted should be such that the government can promote them for all the people and not just a few.** Promoting low cost HWTS options(Flocculent, SODIS, Chlorination and Boiling) and awareness for Behavior Change in place of product promotion, may be the best strategy for national and state governments. In addition to household based water treatment systems, public funding can also be used for promoting low cost community(slums and unauthorized colonies) based water treatment systems where the water utility is not providing piped treated water to residents.

People's perceptions of low self worth(arising out of their poverty and social status in slums) generates resistance to pay for treated water or to even make an effort to promote low cost and costless HWTS. It propels them to believe that nothing will happen to them if they

consume untreated water. Awareness generation for the need of HWTS must consider specific problems and constraints related to ground water and other sources of water supply, as well as deep seated self perceptions and psychological barriers.

The Policy Note makes the following recommendations;

1. **Reaffirm the commitment of the government for provision of safe drinking water.** Recognise HWTS as interim solutions that are urgently needed but are not substitutes for safe drinking water for all. Declare HWTS as a public good and a health priority
2. **Set up a HWTS Mission** as **a high priority National Initiative** within a Govt of India Ministry(preferably under the MoUD/MoHUPA or Health Ministry) for a 10 year time period. Designate a central Ministry as the Nodal Agency for **promoting HWTS and Community level water treatment systems.**
    - The primary Role of the HWTS Mission could be **Recommendatory, Promotional and Coordination**
    - The Mission could work as an **Inter Ministerial Convergence Mission at the Central level**. Having representatives from different Ministries, the Mission acts as a clearing house for prioritising HWTS across all Ministries
    - The Mission develops **frameworks for promoting and certification of best technical solutions** for drinking water treatment at the household level and at decentralised community level initiatives
    - **Convergence with other ministries and government departments**

3. **Set up State level Nodal Agency/Unit.** Under a state government agency to implement BCC interventions, water quality testing and monitoring and HWTS promotional activities.

4. **Programming priorities for HWTS**
    - **Prioritise awareness** of the need for Treatment of Water and safe Storage, as a Campaign on regular basis.
    - **Promote simple HWTS solutions** of Boiling water, Chlorination and SODIS. Boiling water is among the most microbiologically effective HWTS methods and it is the only approach that has achieved scale. Potential for boiling water should not be ignored in favour of more commercial approaches to HWTS.
    - **Promote community level Water Treatment solutions.** Where possible and where public infrastructure including community parks and toilets exist, efforts should be made to promote community level water treatment systems. Promoting solar heated/boiled water supply and chlorination can done from such facilities.
    - **Create awareness/literacy of the types of water pollution**(bacteriological and chemical) and the awareness for an appropriate HWTS response. Backed by regular water quality checks at point of use of households. Give choice to the citizens to adopt a water treatment solution based on sufficient information of the problem.
    - **Develop collaborative approach with Private sector- NGOs-Government** for longer term HWTS awareness and promotional work.

WATSAN is Reduced to Simplistic Science like Handwashing.

The statement saying handwashing reduces diarrhea. This sends wrong signal that neither safe water or adequate sanitation is necessary.

R Srikanth, Community of Practice Group:

http://www.linkedin.com/groupItem?view=&gid=1238187&type=member&item=263466741&qid=4031b6a5-fdef-4c3b-981a-7a04e76e429d&trk=group_most_popular-0-b-ttl&goback=%2Egmp_1238187

How much does hand washing contribute to reduction in diarrhoea and other benefits - needs to be studied at country and district levels. Srikanth is right that it is simplistic to say one hygiene behaviour contributes more to health outcomes than others. International research findings need to be verified in country/local context instead of taking them as given.

I should have posted this research finding on hand washing Impact Evaluation on this discussion and am doing it now. In case you did not see the results of the Vietnam Handwashing Scaling Up Project that was in news as being one of the best hygiene programme.

Vietnam Handwashing Impact Evaluation, 2012, https://www.wsp.org/sites/wsp.org/files/publications/WSP-Vietnam-HWWS-Impact-Evaluation-Research-Brief.pdf

"Improvements in handwashing behavior reported by caregivers do not appear sufficient to lead to impacts on child health or caregiver time savings. Diarrhea

prevalence is 16.6% lower in the treatment group relative to the control (4.5% in treatment vs. 5.4% in control); however the difference is not statistically significant. Given the lack of observed impact on handwashing behavior we cannot attribute this difference to the handwashing campaign. Likewise, the evaluation found no reductions in time spent caring for sick children, which could in turn be used for money generating activities leading to increased household welfare. Even under enabling conditions of high baseline knowledge and access to soap and water, changing handwashing behavior is difficult. The handwashing campaign did not provide soap and water to intervention households and did not seek to only improve knowledge of handwashing in the target audience. Formative research and baseline survey findings found these conditions were already in place. Despite this, handwashing with soap behavior in the target population has not changed substantially as a result of the intervention, which sought to influence the motivating factors and barriers to handwashing such as beliefs about the need for handwashing and placement of soap in an accessible location."

Kevin Tayler • Thanks to Depinder for posting the information on the Vietnam study and the link to the research brief. One important point is that the limited reduction in diarrhea prevalence was not necessarily because handwashing itself was found to be ineffective but rather that the impact of interventions on behavior were limited. Stephen Luby and his co-authors report similar findings from two studies in Karachi, carried out about 10 years ago - see http://www.ajtmh.org/content/81/1/140.full . The finding in Karachi was that there was an initial improvement in handwashing practice but a follow-up study showed that this had not been sustained. It seems that people were still buying soap but using less of it, suggesting that they were using less soap and not washing their hands properly. The researchers attributed this, at least partly, on a desire to save money.

They also refer to an earlier study in Mirpur, Bangladesh, which showed that improvements in behavior following a handwashing campaign were largely sustained. The important point about this campaign seems to be that it was integrated, including action to improve both water supply and sanitation. So, people were encouraged to improve their hygiene behavior and given the means to do so.

Depinder Kapur • Thanks Kevin for responding. I agree with you that integrated messaging for all WASH interventions is important and required. This is usually missing as Katie has shown when donors take up one issue at a time to propagate one hygiene message, resulting in what this discussion by Srikanth highlighted as a major problem of BCC and Handwashing - that this is indeed reduced to a simplistic science.

The larger question regarding measuring success/failure of BCC in WASH - when we look at evidence from project outputs in WASH - is whether the project has failed to deliver health outcomes or is there a problem in taking projects as proxies for verifying health outcomes and theory of WASH benefits?

In the Dhaka 2011 Hygiene Workshop by IRC, we were faced with the results of one of the largest DFID supported Bangladesh WASH Hygiene promotion project results(SHEWA-B) showing no significant impact on heath outcomes(vis a vis control areas), despite an improved hygiene behaviours in the project areas. This was an integrated WASH project(that addressed all WASH interventions of handwashing, safe water and toilets use). Hence the results were really baffling. Was this a failed project or a failed project design or a something else? The same question can be posed to the Vietnam hand washing project that received so much publicity as a model.

The IRC workshop then drew the conclusion that measuring health outcomes from project results may be difficult if not impossible. That even large multi million dollar WASH projects may not be amenable to validate theory(unless perhaps they have a research component within it?). Hence instead of trying to measure health impacts from sample end line evaluation studies, the WASH projects should only try to measure adoption of hygiene behaviours. Leaving the health outcomes assessment to more pucca research work.

Will the donors, national governments and taxpayers be happy with this recommendation that you cannot measure health outcomes after spending millions of dollars in a project? As mentors, we who have worked in WASH sector for years, what advise and mentoring do we give to younger colleagues regarding simplistic assumptions for BCC in WASH?

Kevin Tayler • Following up on Depinder's comments on the SHEWA-B project in Bangladesh, I suspect that the problem probably relates to the results achieved by the project and these, in turn, may well relate to project design. I have been working on World Bank urban projects in Bangladesh and my impression is that the social and physical environment in low income communities is not always the same as that assumed by NGOs and others who try to intervene in those communities. Project designs often fail to take account of existing power structures and

the ways in which these may affect access to services and the viability of proposals to manage those services. There is a very interesting paper Kirsten Hackenbroch, and Shahadat Hossain (2012): The organised encroachment of the powerful. Everyday practices of public space and water supply in Dhaka, Bangladesh, Planning Theory and Practice 13(3): 397-420. Shahadat Hossain has another paper covering similar ground in the latest edition of Environment and Urbanization. My impression after reading these papers is that the community management models promoted by international agencies and local and international NGOs tend to be simplistic and take insufficient account of the way in which power is distributed within 'slums'. The result is that the physical aspect of many projects fails prematurely - toilet pits and tanks fill and are not emptied, tubewells break down and are not repaired etc. There is some anecdotal evidence that this is happening in the larger cities. If this is indeed the case, and bearing in mind Luby et al's findings on the limited impact of hygiene education messages, it is not surprising that there are no obvious changes in health indicators. Its relatively easy to see what the problem is but much more difficult to find solutions. However, I think the first step in finding a solution is to admit that there is a problem, which the IRC workshop described by Depinder clearly showed.

I think I agree that it is best to focus on what can be measure behavior rather than health impacts. DFID, for one, are very keen to try to measure health impacts but I would focus resources on trying to get better systems and worry about the health impacts later. We know that water, sanitation and hygiene education together bring about big improvements in health from the long-term experience in industrialized countries from the 19th Century onwards

Katie Carroll • I think if you look at donor and NGO programs going forward you won't see a lot of the stand-alone handwashing programs that were implemented in the last 5-10 years. I believe donors did learn from these experiences. The future of handwashing behavior change is in an integrated approach. Integration into WASH programs, school programs, healthcare facility programs, HIV/AIDS programs, nutrition programs, etc. We, at the PPPHW, support this integrated approach. Handwashing is not done once a day on it's own. The occasions for handwashing are all very different and so the behavior, at a program level, must be promoted in context.

Depinder Kapur • Hi Kevin for sharing the Papers/Authors. Urban WASH in India poses similar challenges as you mention in Bangladesh.

There is more data from another discussion happening in India that shows less or no correlation of WASH infrastructure(water and toilets access) with Maternal Mortality Rates(MMR) in India and I quote Johnson who shared this; "Uttrakhand has lowest MMR. Odisha having the lowest drinking water access inside premises and latrine within premises but has less MMR when compared to others is a point to be analysed."

Hence in addition to the two possibilities we discussed;

1. Bad project design and project failure in meeting health outcomes
2. Inability to monitor health outcomes in a project mode
3. We could have this third possibility as well - Weak or no correlation of health outcomes to WASH in specific project areas, where other problems may perhaps have an equally strong health impact as WASH, hence WASH positive impacts are cancelled out. What there other factors can be will need to be researched in each project area.

I think it will remain problematic if we confine our analysis of WASH(and BCC in WASH) project failures in the first two domains and not explore other compounding factors.

Depinder Kapur • Hi Kevin. The recent novel by Mohsin Hamid - "How to Get Filthy Rich in Rising Asia", is in the context of urban drinking water market business and complex informal markets context that you were referring to. Sometimes god literature can show the reality better than lengthy reports. Mohsin Hamid is also the author of the novel - The Reluctant Fundamentalist, that was recently made into a Hollywood film.
It is not just NGO projects that fail in this contextual setting but also large World Bank and ADB projects, that by design often exclude the slum settlements. This is what we had found in our research on ADB Urban projects in India.
The work of Perween Rehman at the OPP project and her murder, also exposes the nexus of urban land market and the mafia that springs from there, affects water and other services.

Kevin Tayler • HI Depinder. You are right about the World Bank and ADB projects failing to come to grips with the problems of low income areas. (This is a bit off topic - perhaps time to start a new thread on this). My experience is that the problem lies at least partly in the way in which internationally funded projects are structured. They typically have to be completed in around 5 years and there is often little flexibility once the project has been appraised. It is also sometimes difficult to work out how to integrate activities like hygiene promotion into contracts which use fairly complex standardized formats. The other problem is that the international agencies usually work

with government departments, which may have limited interest in the needs of low income areas.

You are right about the probable land mafia involvement in Parveen Rehman's death. She had been doing work on mapping the peri-urban areas and I imagine that this threatened vested interests. There are some interesting questions about the OPP approach, its strengths and weaknesses but they definitely need a new topic - I will look at starting one later today

Sujoy Chaudhury • Hi everyone, I have been reading the posts with a lot of interest- mostly because I get to learn so much more from the experiences of peers. Depinder , brought the question "If water, sanitation and hygiene are integrated - then do we need separate messages to promote one of them at a time? Why cannot messages also be integrated, either simultaneously or sequentially, in an integrated WASH campaign? " and the general argument was in favour of a bunched communication rather than separate messages for water, sanitation and hygiene. I accept that Water ,sanitation and hygiene are integral to positive health outcomes- however I do not think that bunched communications are the solution. In my experience of working with poor communities in Sundarbans, I have come to realize that what works best is sanitation messages with hand washing messages in the beginning and then when the community has attained a reasonable success in their sanitation and hand washing status, provide messages on water safety and messages on food hygiene along with hand washing and then after the community has achieved a reasonable status in respect to the quality of drinking water and food hygiene status , promote individual, family and community hygiene including environmental sanitation. This is in a context where access to drinking water is fair , while the status of household sanitation was terrible and so were the hygiene indicators. I am of the opinion that while bunched messages integrating water,sanitation and hygiene could be developed and transmitted, the quantity and quality of what is received and assimilated will be low and not enough to have the desired change. It is like suddenly being told one day that I have to change the way I live , change my habits, begin owning /using a latrine and drinking safe water - all these when I am mostly broke and so much of my life is dependent on external factors beyond my control.

I do not like the predominance of the acronym WASH whose interpretation is often water first followed by sanitation and then hygiene at the end. Considering that communities today have better access to drinking water , but access to safe sanitation is poor and so is their hygiene practices, I would think that a re-arrangement of the letters are due. Maybe we should something like SHW with an underline to indicate the integration. Responses solicited.

Depinder Kapur • Hi Sujoy. Thanks for sharing your experience of BCC in SHW in rural areas with reasonable drinking water access. Sounds logical in that setting - to focus first on sanitation and hand washing. you agree that this would change in other contexts and in urban settings. I don't think anyone on this discussion, certainly not me, has recommended bunched up BCC in WASH messages. The critique here is of simplistic one message focussed large campaigns and projects. Secondly, considering one behaviour change like Hand washing with soap as the most significant contributor to health outcome and translating this into simplistic BCC messages. I was saying what you are saying - identify what to start from and why, in specific contexts - instead of one message focussed BCC campaigns. Its good to hear from Katie that this is indeed being done now in most WASH projects. Secondly, deeper barriers to behaviour change and its understanding may lead to BCC work that is different from the current advertising campaign mode to address one behaviour change at a time. You could undertake a BCC campaign addressing underlying behaviours without immediately linking it with one WASH behaviour change. For example if hand washing with soap is not a practiced behaviour because low caste farming males because they feel that keeping neat and clean and washing hands with soap is a prerogative of the rich, then a BCC campaign may need to address pride in hard work and dirty hands before gently suggesting that hand washing with soap is a pride of the hard working people.
Its a real pity that the large corporate campaigns of BCC in Hand washing with soap - have so little understanding of these deeper barriers, their advertising is limited to urban consumerist behaviours and aspirations. Hence it is not surprising that they so often fail. This is the serious discussion we were having on the other discussion group - Why BCC in WASH has been a terrible failure and what needs to be done?"

Sujoy Chaudhury • Hi Depinder. Thank you for your response and yes, I have been following the discussions on BCC in WASH. In my opinion we need to create another word for campaign, particularly beacuse the current interpretation of the word is top- down and everyone understands it that way as knowing what to tell people to do. The "campaign " for the NBA for example is a salutory example of what everyone understands a campaign to be. All campign activities are conducted under the IEC component and targeted people are expected to change their sanitation and environmental sanitation behaviour. The barriers to improved behaviour assumed is generic and in some cases very ill informed. For those concerned with facilitating behaviour change in

communities, we realize that our role is not to tell people what we think they should be doing, but to encourage people to talk about their personal barriers and facilitating self action against those barriers. We realize that change associated through this process yields a life long habit. This is what an ideal campaign should be- a process of programme design that is based on comprehensive barrier analysis conducted and expressed by the targets themselves. This is much difefrent from a base line or a needs assessment as clearly the process will seek the involvement of most if not all targets. Advertising and the media strageies should only be designed after the barrier analysis phase is over. As people have already started talking and thinking about issues, well designed and appropriate messages at the areas of concern will be most effectivel to induce desired bahaviour change.

Fidelis Folifac, PhD • Dear All, I find this discussion interesting and will like to share some ideas from my work in Cameroon. First we all seem to agree that WASH is an integrated vision than WATSAN, literally. In my view, an integrated vision does not necessary call for integrated messages. There is the contemporary concern on appropriate entry points to trigger behavior change. Different communities, even within the same region, will have different WASH priorities. Some will be in great need of all three, here an integrated message can be more helpful but simple actions can trigger complex changes. Some communities may have relatively fair access to 'safe' water and sanitation in which case hygiene becomes an issue of primary concern. In summary, as practitioners, the challenge is on us to adequately engage communities in addressing WASH issues. There is no one size fit all. My work in rural and urban Cameroon

Srikanth Raghavachari • Depinder , the most probable reason why health outcomes are not been significant is majority of the donor project lacks clarity on what it is going to achieve . For example there is ambitious health project of DFID in Bihar currently running is classic example where it is aimed to achieve positive health outcomes . It is perhaps first time that health, nutrition and WASH are included together in a health project with millions of British pound being spent. But to my knowledge there is little or no integration among these component in that project. The problem is you choose the target villages for intervention after the project gets underway sometime midway, staff gets changed or replaced as per convenience . The community are not involved nor consulted before the projects gets started .Many times projects are subcontracted to agencies or consulting firms because milestones are to be achieved which are set ambitiously and not realistically and project outcomes are measured by spending rather than rigorous health indicators. There are more than dozen goals to be achieved during limited time and this include in this issues relating to gender, excluded community, capacity development at various levels,HR issues, private sector participation, Nutrition, WASH and sub-component in WASH. In these complex project the central theme is lost. You end up with dozens of national and international consultant working on bits and pieces and working in silos with no uniform goal . You end up with report with no conclusive evidence and community are left high and dry and consulting company making good money at the expense of poor community. To be successful the project design should be rigorously tested , statisticians should be involved right from the design phase and goals should be simple .How do to you measure the impact role of hand-washing in such a complex project i have mentioned ?? It is like chasing wild goose.

How To Feed A Billion. And Why It Pays

*The Food Security Bill is not a spend; it is an investment, crucial for India's future and growth, says Shoma Chaudhury
http://www.tehelka.com/foodsecuritybill2013/?utm_source=wysija&utm_medium=email&utm_campaign=30_aug_2013#

On 26 August 2013, after months of wasted sessions, the Lok Sabha finally passed a historic legislation: the Food Security Bill. Many Indians woke two days later to headlines that the rupee had nosedived and the Indian markets had been "food poisoned". It was a smart phrase. It captured the horror industry and what investors feel about the Bill. But it also epitomised the damaging hysteria and misinformation around it. It captured one of India's most harsh dividing lines.

In the summer of 2012, I travelled with economists Jean Drèze and Reetika Khera through some of Uttar Pradesh's most impoverished districts. They were on a fact-finding mission, going door-to-door in the searing sun, asking people whether they had enough to eat and whether the government's Public Distribution System reached them. It was a deeply humbling experience. In hut after hut, one was confronted by the sheer absurdity of the Indian situation. In some of the country's most forsaken landscapes — dust and bare scrub for miles, not even the possibility of employment anywhere — destitute, bone-thin families produced their pink and white ration cards with utter bewilderment. The first, a BPL card — below poverty line — entitled them to rice, wheat, and some sugar. The second, an APL card — above poverty line — got them only some kerosene oil. (How can one satisfy one's hunger with kerosene, a woman asked in desperation?)

Often, they got neither. But what confused them the most was how one neighbour — living in exactly the same set

of debilitating circumstances — had been picked for the pink card; and how others had been cursed with the white. Then, of course, there were dozens of families who had no card at all. Someone, somewhere, in some faraway city — beyond the realm of their imagination — had determined how many poor people resided in their village, and no matter how much their stomach ached or their children cried, they could not get themselves on the map. They could not get work either. The helplessness of it all was staggering.

Potentially, the Food Security Bill could change all of that. It promises a minimum of 5 kg of cereal per person, per month, to 75 percent of India's rural households and 50 percent of its urban poor at a price ranging from Rs 3 – Rs 1 a kg. This is being billed as the largest welfare scheme in the history of the world. It is committed to ensuring 800 million people get at least a minimum level of food in their stomachs every day. Crucially, it also provides Rs 1,000 per month to pregnant and lactating mothers for a period of six months; and a nutritious meal to all children from age 0 to 3; and then, through the midday meal scheme, up to the age of 14.

Ordinarily, this should have been a moment to celebrate. Instead, bizarrely, a large section of India's elite feels it has been robbed in broad daylight. There is widespread fear that India absolutely cannot afford such a scheme; that it will cripple an already devastated fiscal deficit; that it will turn India into a lazy, unproductive society, disinterested in searching for jobs; that India does not produce enough foodgrain to meet such a commitment; that just one drought year would break the back of the country; and that, assured of getting their food from the government, small farmers will stop tilling their farms altogether and India will be pushed to import foodgrain, further skewing the current account deficit. Yashwant Sinha, a senior BJP leader and India's former finance minister, captured this zeitgeist when he said, "Why can't people work and put food in their own stomach?" One day in Uttar Pradesh's Sonbhadra district would answer that question.

The Bill is certainly not a perfect one. But the visceral hostility to it is highly self-damaging. Firstly, its root lies in an essential failure of vocabulary. Critics of the Bill see this as profligate government "spending". But to assess the merits and demerits of the Bill, one must first correct the lens: this is not a spend, it's an *investment*, crucial for India's future and growth.

Over the past two decades, economic planners and corporates alike have held up India's "demographic dividend" — its millions of young people, second only to China — as one of the major keys to its buoyant economy. But mystifyingly, against all economic logic, they refuse to invest in this dividend. What we have, therefore, is this: almost 50 percent of India's children — that is one out of every two children — suffer from severe malnutrition, at levels worse than sub-Saharan Africa. They also have almost no access to healthcare; clean water; quality schooling; toilets; or housing. What this means is that we are nurturing literally hundreds of millions of Indians who are bursting with aspiration but who have no tools to satisfy them. How can they possibly become productive members of the country's economy until they have access to a basic platform of human dignity? (From a corporate point of view too, how can the buying power of India's demographic dividend — its huge "market" — be unleashed, unless they are given basic rights and capacities?)

For many privileged Indians — who are willing to buy bathtubs for a couple of lakh rupees but who are aghast at their taxes being used to feed the poor — the idea of malnutrition is a value-neutral word. Unless one has gone chronically and repeatedly hungry to bed, it is hard to imagine what that can do to one's body and mind. But this is not just bleeding-heart faff. Set aside the human and moral catastrophe of having hundreds of millions of people going hungry every day, but consider this: the impact of malnutrition poses a very real and imminent economic danger for the country. Malnutrition severely stunts intellectual, emotional and physical growth.

Studies also show that the effect of malnutrition is most acute in the age group from 0 to 3 and this cannot be mitigated in one's adult life. In effect then, it's not just that there is no employment to be had; the fact is we are complicit in systematically creating unemployable and under-par fellow-citizens. We are building a storm-bank of frustration. By guaranteeing food, by guaranteeing every pregnant mother at least a minimum level of nutrition, the Food Security Bill attempts to strike at the very heart of this fundamental economic problem.

As Pratap Bhanu Mehta, Director of the Centre for Policy Research, put it in an excellent *Indian Express* column: "Has any modern society evolved without robust welfare protection?" He goes on to add, "It's no accident that even so-called right-wing politicians from Bismarck to Churchill and Nixon have supported an efficient and humane basic income guaranteed by the State."

Or as UPA chairperson Sonia Gandhi put it, "It's not a question of whether we can afford to have this Bill, but rather can we afford not to?"

The question of what the Food Security Bill will cost though is indeed a highly aggravated one. Defenders of the Bill say the government is already spending Rs 90,000 crore on food subsidy: expanding the net of beneficiaries

will cost an additional Rs 30,000 crore. This, they argue, is not something India cannot afford. Rs 1.2 lakh crore on securing food for one's citizens amounts to only 1.2 percent of the country's GDP. How can one grudge that when one compares this with other subsidies?

Development economist Reetika Khera, for instance, points out that tax exemptions given to Indian industry in 2012-13 alone amounts to a whopping Rs 5 trillion. India's fuel subsidy — much of which is enjoyed by the rich — is approximately Rs 1.6 lakh crore. Tax breaks given to the gold and diamond industry in the last year is Rs. 60,000 crore, nearly 20 percent of the revenue forgone. (For perspective: this industry employs 1.8 million people, which is less than 1 percent of the Indian workforce. The Food Bill would benefit 67 percent of the population at merely an additional cost of Rs 30,000 crore.) The list could go on. The point is, shaving just a little from all this would help balance the books.

Or reverse the gaze. Examine the scams: just the irrigation scam in Maharashtra is worth Rs 70,000 crore. Tax evasions from private mining companies would cross many trillion. Why not urge government to fix this? Why is it that the market can withstand this waste with stoicism, but it panics at the prospect of providing food?

There are robust answers for many of the other fears the Bill triggers too. For instance, it is absurd to imagine that getting a mere fistful of rice in one's belly every night is going to kill India's aspiration and turn it into a lazy society. Can one really argue that India's poor will not work towards better clothes, shoes, schooling and living standards for their children, because they have allayed the basic gnawing in their stomach?

As for India's capacity to produce foodgrain: in good monsoon years, almost 700 lakh metric tonnes of foodgrain lie rotting in warehouses or in the open. If you laid these sacks out in a row, it would cover one million kilometres: a road to the moon and back. Often, rather than distribute this successfully to its poor, the government exports it at a loss to other countries to feed cattle and pigs.

There are many other well-grounded fears about the Bill, however, that deserve closer scrutiny. For instance, what indeed will the country do in a drought year? Are there hidden costs about infrastructure and delivery mechanisms that the government has not fixed before getting its Bill passed? Will these load the costs further in unplanned ways? Is it better to have direct cash transfers rather than undertake the unwieldy process of acquiring and distributing foodgrain to far-flung corners of the country? How will the Bill affect the farm sector? How will it fix the existing 40 percent inefficiency and leakages in the system? Is the design too centralised?

Many of these questions are posed and answered in the interviews and columns that follow.

The real significance of this Bill, however, is that in every democracy, the starting point must always be an articulation of rights and intention. A legislation itself can never be a magic wand: but the syllables of idealism rightfully belong to it. Enacting the Abolition of Untouchability did not mean the curse of caste disappeared overnight. Nor will the Right to Education ensure every child turns into a scholar in a day. Nor indeed can the Right to Information ensure governments will reveal all their dark truths. What legislations do is set forces into motion. They might take decades to mature but they create the correct moral framework. They give citizens the right to demand.

The outrage over the enactment of the Food Security Bill, therefore, should turn its glare not on the promise but the delivery: we should want our citizens fed, but we should demand it is done efficiently.

This is not an impossible task. On the same trip to Uttar Pradesh, we also travelled through the Sarguja district of Chhattisgarh. Here, miraculously, almost every citizen was getting their food entitlement. The state had taken some simple steps to make this happen. Most importantly, it had removed the unfeasible practice of giving targeted subsidies.

In the current PDS system, there are 13 parameters to determine who is poor: how many sets of clothes a person has, whether they live in a *kacha* or *pucca* house, whether they own a patch of land; possess a cow, and so on. This is then marked on a scale of 0-5 and a percentage of the poor who make it to that scale are computed as worthy to receive subsidies. It does not need a particularly fertile brain to imagine how boggling this sort of classification can be. Uttar Pradesh is proof of that.

In Chhattisgarh, however, rather than undertake the gargantuan task of looking for its poor, the state pretty much universalised its beneficiaries. This means whoever needs it, just asks for it; those who don't, don't bother. The state also took away fair-price shops from private operators and gave them to cooperatives, panchayats or women's self-help groups; it raised the commission earned by these mediators; it set up computerised ledgers in godowns and, among other things, sent out a diktat that all food-related grievances must be settled by district magistrates within 15 days. According to Chief Minister Raman Singh, their leakage is down from 40 percent to four.

There is no reason why other states cannot replicate this. The return on investment promises to be very high. As a woman in Sarguja told us: "For the first time in our life, we are sure we have enough to eat. So instead of spending 15 hours a day trying to find money to buy roti and salt, we have started a cooperative and are running a dairy."

The destitute have become the dividend.

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Superstitions wash out sanitation :M. K. Ananth

http://www.thehindu.com/news/national/tamil-nadu/superstitions-wash-out-sanitation/article4686886.ece?homepage=true

Superstitious beliefs, religious sentiments and *vasthu shastra* are making construction of toilets in rural areas of Namakkal district an uphill task.

P. Aruna (32) and her husband Periyasamy (45), a truck driver of Parali panchayat, stopped construction of toilet and filled up the newly-dug leach pit with debris. "An astrologer, who came to our house, told us that we should not dig any pit or else our five-year-old boy will have a bad time", the couple said.

Sivasakthi (30), a carpenter of Aniyapuram panchayat, demolished the toilet that he built at the cost of Rs. 6,000 and rebuilt one, spending Rs. 25,000 to match the specifications given by their *vasthu* consultant. Villagers also halt construction of toilets in times of temple festivals as it is considered inauspicious.

According to census 2011, in Namakkal district, 59.6 per cent of the rural population and 43.8 per cent of the total population defecate in the open. A technical officer of an NGO involved in sanitation projects, Paul Antony, says a leach pit should be 10 metres away from wells and borewells as it is designed to allow water from the pit to be absorbed by the soil. "But, there are many cases in which it is dug close to a well because a *vasthu* consultant has shown them the spot. It will affect people in the long run", he added.

The director of LEAF Society, an NGO involved in constructing toilets in the rural localities, S.L. Sathiya Nesan, says efforts made by the government and NGOs to motivate the rural people to build toilets will not yield results as long as people believe in superstitions. "Construction of toilets is a science. The advice of *Vasthu* experts would not serve the purpose of a toilet", he observed.

"A study conducted among many villagers showed that each family spends about Rs. 8,000 a year for religious festivals. But, they are not ready to invest the same amount for a toilet", he added.

On the other hand, toilets are yet to be considered an integral part of the house. In many cases, newly-built toilets in rural pockets are away from houses. "They fear that foul smell could come into their house. Building toilets attached to their houses can save on cost. It also makes it safer for women to use toilets even at night", says project coordinator Vanitha Deivamani.

Potable water kiosks to end drought woes: Sovi Vidyadharan

People facing acute shortage of drinking water in the wake of severe drought can now heave a sigh of relief.

The state's first set of 'drinking water kiosks' which will provide safe, potable water in areas facing water shortage, will start functioning from next week onwards in Kannur.

The proposal for setting up water kiosks in severely drought-hit areas of the state was mooted during a drought risk reduction meeting held recently by the Revenue Department. ''The District Collectors were asked to identify areas with maximum drinking water shortage in coordination with local bodies,'' Dr Sekhar Kuriakose, Head of the Hazard Vulnerability and Risk Assessment Cell of the Kerala State Disaster Management Authority, told 'Express'.

Setting up of 'water kiosks' was one among the 26-point proposals for drought mitigation, he said, adding that Kannur district took the lead in this direction. Other districts are also expected to set up water kiosks in water-scarce areas soon.

''Water kiosks are basically tanks with a capacity to store 5,000 to 10,000 litres of potable water. After consultations with village panchayat representatives, 55 locations in the district which face acute water shortage were identified,'' Kannur District Collector Ratan Kelkar said.

Terming the water scarcity in these 55 locations as ''acute'', Kelkar said that wells in the area, which was the only source of drinking water for people, had totally dried up. The Kerala Water Authority will provide water to these kiosks on a periodic basis and the cost will be borne from

the drought relief fund of the district administration. Grama panchayat members and secretaries will be entrusted with the task of maintaining these kiosks. They will decide the quantum of water needed for each family and inform the KWA of the requirements, Kelkar said.

Though the kiosks will run for the time being using the drought relief fund, panchayats will be asked to use their plan funds to maintain it in future, he said.

Metro water blasts private agency's skewed survey:

C Shivakumar

http://newindianexpress.com/cities/chennai/Metro-water-blasts-private-agencys-skewed-survey/2013/08/27/article1753918.ece?service=print

Chennai Metro Water has expressed concerns over private agencies trying to spook residents over the quality of water by using flawed surveys to promote their products. Hitting out at one such allegedly flawed survey by Eureka Forbes and GFK Mode, Metro Water officials say the study is more of a marketing gimmick than an indepth analysis of the city's water issues. The survey in question claims that 80 per cent diseases in the city are caused by unhealthy drinking water.

The study titled 'Kya Aapka Pani Beemar Hai' (Is Your Water Unhealthy?) alleges that Chennai is reeling under "severe water contamination", affecting the health of its residents. It also claims that of the 80 per cent diseases in the city are water borne with cough, cold and fever constituting 68 per cent.

Metro Water officials said the study fails to differentiate between water-borne and air-borne diseases. "It is total nonsense. They say cold and cough are water-borne. These diseases are air-borne and spread through what is called droplet infection. If they cannot distinguish between water-borne and air-borne diseases, how are they competent to talk about city water," fumed a Metro Water official.

"Water-borne diseases do not mean that the supply is bad. It only means that diseases are being transmitted through water. Source of the contamination can range from unclean practices like not washing hands, not storing water properly to unhygienic cooking," the official added. There are doubts even over the sample size of the survey. "The sample size is a mere 193 households and the study claims to have come out with hard-hitting facts that are nothing but observations without scientific basis," said official

According to joint UNICEF and WHO (2012) estimates for 2010, 15 percent of people in the world openly defecate without any toilet or latrine; 60 percent of these live in India. The global impact of poor sanitation on infant and child death and health is profound. Black et al. (2003) estimated that 10 million children under 5 die every year { 2.4 million of them in India { and that a fifth to a quarter of these deaths are due to diarrhea. Disease early in life also has lasting effects on the health and human capital of children who survive (Almond and Currie, 2011). Evidence from the history of now-rich countries has demonstrated that complete sanitation infrastructure { sewage pipes and septic tanks { importantly improves health outcomes. However, it is not plausible that these public investments will soon be implemented by the limited capacity states that govern many poor people. Therefore, it would be important to learn the effects of low-cost sanitation programs that could be implemented by poor country bureaucracies.

Well-identified evidence on the effectiveness of sanitation policy tools available in poor countries remains absent from the literature. Much of the policy focus within rural \water and sanitation" programs, and much of the econometric evidence, has been on water supply (Black and Fawcett, 2008). Yet, evidence on the health effects of programs to improve rural water supply is of mixed quality and results (Zwane and Kremer, 2007). The econometric \water and sanitation" literature has largely ignored low-cost strategies for excreta disposal { that is, adequately constructed and used household pit latrines { about which the literature lacks well-identified estimates of causal effects. If people living in poor countries are unlikely to receive sewage pipes, and if improving water supply alone does not eliminate the hazards sanitation: over the approximately ten-year period studied, it reports building one latrine per 10 rural people in India; it spent $1.5 billion. The TSC was designed to improve upon perceived shortcomings of earlier programs: instead of emphasizing subsidies for building infrastructure, it included an ex post monetary incentive for local political leaders to eliminate open defecation and made use of village social structures. As Ravallion (2012) and others have observed, much of the causally credible evidence of program effectiveness in the literature may concern small programs or ideal policy conditions that may not generalize.

The TSC was implemented by the Indian government at central and local levels; many of the estimates presented will be representative of rural India. Thus, this paper studies a full-scale program, and its benefits and costs reject real implementation. The TSC caused a decline in infant mortality: at the mean observed program intensity, IMR decreased by about 4 infants per 1,000. Additionally, children who lived their first year of life in years and districts with better sanitation grew taller by about 0.2

standard deviations, on average. This magnitude is comparable to the cross-sectional difference in height associated with doubling household consumption per capita. This adds further evidence of an effect of the disease environment after birth on subsequent height (Bozzoli et al., 2009) to the growing literature on the importance of early life health. The result suggests that poor sanitation could account for part of the widespread and extreme stunting among Indian children.

Estimating causal effects of infrastructure is always challenging, given possibly endogenous construction (Dinkelman, 2011); this paper combines converging evidence of causality from three identification strategies. The first and main results use individual-level data with year and district fixed effects. I match data on infants' survival of their first year of life to district-level administrative data on latrine construction each year. Relative to other children born in the same districts or in the same years, rural children exposed to better sanitation in their first year of life were more likely to survive infancy.

Several falsification tests of this first strategy are consistent with a causal effect. Because and negative externalities of open defecation, could a rural sanitation program that is feasible to a poor country government improve human capital accumulation and health production?

This paper estimates effects of India's Total Sanitation Campaign (TSC) on infant mortality and on children's height. This campaign represents a large effort to improve rural the TSC is a rural program, urban children were not exposed to it: I find no \effect" of the TSC on urban children. Similarly, tests inspired by Granger causality rule out spurious effects of district trends: later latrines have no temporally backwards \effect" on the health of children born before they were constructed. As an additional credibility check, I show that the effect of the TSC is concentrated on post-neonatal mortality, which is sensitive to disease environments, not neonatal mortality in the first month of life, which is less so. Further, the effect is greater for children who ate food other than breast milk earlier in their lives, consistent with sanitation reducing feacal contamination of food and water, to which these children would be more exposed. Similarly, the effect of TSC latrines is greater in districts with higher population density, where contamination from open defecation is otherwise more likely. Applying this same identification strategy to another individual-level dataset, I find that children who lived their first year of life in district-years with more TSC latrines grew taller than other children born in different years or different districts.

The second set of estimates use a difference-in-differences identification scheme, applied to district-level census and related aggregate infant mortality data. These long-difference, between-district results replicate the within-district estimates. No \effect" of the TSC trend is seen in the decades before the program, nor is there an \effect" of other government programs happening at the same time.

The third strategy exploits a monetary prize offered by the Indian government to village officials for successfully implementing the program. The prize is discontinuously increasing in village size; the discontinuous incentive was devised solely for this program. I expect that political chairmen of villages with populations just above prize discontinuities have greater incentives to implement the program than chairmen of slightly smaller villages. Empirically, I find that districts with more villages just above the prize discontinuities experienced less infant mortality in data from after the program; conversely, districts with more villages just below the discontinuities experienced more infant mortality. Because these prizes can be captured by a small number of informed and socially powerful political actors within.

Innovative Urban Solid Waste Management in Tripura

Abhishek Chandra, IAS, Tripura

WASTE MANAGEMENT IN KAILASHAHAR AND KUMARGHAT NAGAR PANCHAYAT AREAS

The city of Kailashahar has no worthwhile sewage as developed by civic system and is largely overgrown village wherein there has been little emphasis made on sanitation and inculcating hygiene practice amongst the people. The District has a population of 2,98,574 and has two Nagar Panchayat areas where the urban civic bodies namely Kailashahar and Kumarghat have a population of 38,456. The elected representative namely Chairperson of Nagar Panchayat and Sabhadhipati, Zilla Parishad have tried for making some efforts in bringing in a Solid Waste Management in these areas. However, to the utter dismay, it has not yielded result, as earlier practices were peace meal, non targeted and were never planned to the last mile. It has been observed that people do not move out of their residence to take an extra efforts to throw the wastes in the neighbourhood areas at a common point and they prefer that the waste is collected from the residences. Additionally, the adjoining areas namely rural areas objected that the dumping of the waste that was taking place was not from their areas and as such should be stopped forthwith. It also violated the rule that polluter must pay principle and that rather punished those who were managing their own wastes effectively.

NEW INITIATIVE :

Keeping this background in view, the District Magistrate and Collector had decided to take stock of the situation and brought in a new methodology towards Solid Waste Management and Biomedical Waste Management through an effective leadership of the office of the DM & Collector with the help of the Line Departments as well as elected representatives on the ground.

Each Ward would have local level people who would be paid remuneration through Nagar Panchayat the wages would be paid through TEUP. They would collect the wastes from individual household as per pre-designated time in morning 7 to 8 am. and evening 7 to 8 pm. However, a secondary system of Auto Rickshaws, Hand Carts and small Vans would be used to collect common wastes from the ground as well as from the primary agents and the same would then be congregated at a common point of a secondary station. At the secondary station the undersigned delineated a clear cut responsibility of the Sanitation Inspectors, Member Secretary, Drinking Water & Sanitation Committee to ensure that the agency which congregates the wastes also segregates the wastes into bio-degradable, non-degradable and plastics for effective disposition of the same. Further for making sure that the wastes was disposed in the river with minimal damage to ecosystem. Treatment of wastes was undertaken as part of the project.

FINANCIAL PLAN

The undersigned demarcated Rs.66.00 lakhs from the Total Sanitation Campaign, Rs.20.00 lakhs from TUEP, Rs.19.00 lakhs from MGNREGA fund and funds from 13th Finance Commission as well as Panchayat Development Fund (PDF) for this project. Additional funds from NRHM and SGSY were utilized. To give a shape for the programme a consultant was called for and asked to submit a Detailed Project Report (DPR) for placement of fund to the designated agency to operate and to maintain this programme. A unique system was developed where Auto Rickhsaw drivers would be given Autos through DRDA SGSY programme and will be asked to operate auto by paying them mandays / wages through Nagar Panchayat fund and TUEP. Thus, over a period of time the asset, which was taken in form of loan would be owned by poor unemployed youth and at the same time effective mandays would be generated to keep the city clean and hygienic in the long run. The consultant would be asked to look into the Liquid Waste Management on a subsequent date.

In view of above facts, the city will improve its sanitation programme and will be looked upon as a model for others to emulate.

AREA OPERATION

The Nagar Panchayat areas of Kumarghat and Kailashahar along with rural areas of Noorpur, Tilabazar, Goldherpur under Kailashahar Sub-Division and Sukanta Nagar, Fatikroy under Kumarghat Sub-Division will be the areas of execution where the said project works will be undertaken. The sub component of NBA (Nirmal Bharat Abhijan) also called Total Sanitation Campaign (TSC) will be largely converged with Nagar Panchayat funds to make Solid Waste programme a grand success. Further, funds under TUEP and Zilla Parishad shall be used to gap fill any additional requirement that will arise to execute the programme.

The total cost of the project for the Plant, Collection and Transportation was One Crore thirty lakhs. Additionally a provision for RDF plant is also mandated.

A Project Group was constituted to visit the successful areas where SLWM projects were in operation,the project group has studied various models of SLWM. The cost benefit analysis of the project done by the group suggests that with a small corpus of fund using existing schemes and programmes of the Government one can undertake SLWM project in each District of our Country. The Economic Analysis confirms that over a period of time the economic benefits accrue much more than Financial gains.

The power point presentation is attached with the report also highlights various case studies both within our country and across the world on solid waste management.

Petition for Right to Sanitation for All

To: The Heads of States, SACOSAN V, Kathmandu, Nepal AND President, 61 Session of United Nations General Assembly, United Nations, New York

The region of South Asia has seen considerable changes in different development indicators although they are still way below from where the region should be. Particularly, the situation of the marginalized and excluded communities in the South Asian countries has been in an all time difficult status as they struggle to sustain their lives. Among others, one of the most important challenges in South Asia still remains to be the crisis of Sanitation as it poses an emergency like situation across the region. In contrast to the considerable progress in the region, over a billion people still don't have access to basic sanitation and around 700 million practice open defecation. Diarrhoea caused by unsafe water, poor sanitation and

hygiene is the second biggest killer of children under five. A huge percentage of people are denied access to improved sanitation (69% in Nepal, 66% in India, 63% in Afghanistan, 56% in Bhutan, 52 % in Pakistan, 44 % in Bangladesh).[4]

There is enough evidence that improved & adequate sanitation is strongly linked to economic growth, dignified lives, better health, reduce preventable deaths especially among under five children and improve their nutritional status. It is also widely recognized that improved sanitation and hygiene contributes significantly to gender equality, school attendance, livelihood and safeguard the environment.

Equity and inclusion is the core challenge: richest vs poorest income quintile

The overall sanitation use and urban/rural disparity figures reflect huge inequalities. The JMP report examined sanitation use according to wealth quintiles in India, Bangladesh and Nepal, and states that the poorest 40% of the population have barely benefitted from gains in sanitation use in the last decade. This indicates towards a structural problem in South Asia. The continued neglect leaves stark inequalities unchecked: poor people in South Asia are over 13 times less likely to have access to sanitation than rich people.

National investments are not responding to needs

The rural/urban disparity suggests that investments are highly biased, and resources are not reaching where the need is greatest. National budget analysis carried out by different civil society organizations provides strong evidence that most sector investments in the last four years have been channelled to major urban centres.

Inadequate & inappropriate financing for sanitation and hygiene

Sanitation and hygiene still suffer from a lack of public sector finance for achieving the Millennium Development Goals (MDGs) and universal coverage in comparison with other social sectors. This is clear from country statements made at the second high-level meeting of the Sanitation and Water for All partnership in Washington DC in April 2012. The available financial resources are also not reaching where they are needed most, as indicated above. The GLAAS 2012 report finds that funding levels for WASH are insufficient, especially for sanitation, and although most of the countries did not report hygiene expenditure, for those that did, it was only 2% of total WASH expenditure.

Government expenditure on health, education and WASH (% of GDP)

(Source: WHO, GLAAS, 2012)

Country	Expenditure on Health	Expenditure on Education	Expenditure on Sanitation & Drinking Water
Bangladesh	1.1	2.4	0.4
India	1.3	3.0	0.2
Nepal	1.7	4.7	0.8
Pakistan			0.4

Political Commitments of the Governments

There have been several high-level political commitment to provide sanitation and hygiene services to the poorest people in the region. At the Millennium Summit in 2000, all countries from South Asia committed to reverse unacceptable conditions. Since 2003, the countries have met four times at the South Asian Conference on Sanitation (SACOSAN), pledging to improve sanitation in the region. During the 17th South Asian Association for Regional Cooperation (SAARC) summit, leaders from the region agreed to work collectively to address the water and sanitation challenges.

All countries from the region supported and signed the UN resolution on the rights to water and sanitation – thereby committing to take steps towards progressive realisation of these rights by upholding human rights principles and standards of non-discrimination and universality. Five out of eight SAARC countries (Pakistan, Afghanistan, Bangladesh, Nepal and Sri Lanka) have joined the Sanitation and Water for All partnership. Particularly the SACOSAN IV held in Sri Lanka in 2011, specific commitments related to recognise sanitation as a human right, increasing finance, ensuring an equitable and inclusive sanitation and hygiene programs and so on were made by the South Asian governments.

Despite political commitments at all levels, current progress on addressing equity and overall use is far from satisfactory. There is a need to address this as an emergency like situation and bring sustainable change.

It is in this context, we, the citizens of Bangladesh, Bhutan, India, Nepal, Pakistan and Sri Lanka appeal to

[4] UNICEF/WHO JMP report 2012

you to ensure the following in the whole of South Asia.:

1. Recognise sanitation as a legally enforceable right fundamental for human health, dignity, empowerment and development as committed in SACOSAN III & IV and resolved to be fulfilled by the United Nations General Assembly
2. Fulfil existing national and international commitments for ensuring universal access to sanitation including all households, schools, health centres, work places, public buildings and public spaces/places at all times and in all situations including disasters, emergencies, conflicts and migration
3. Spend at least 1% of GDP to achieve universal access to sanitation and an adequate proportion of this on operation and maintenance of existing infrastructure. To enable monitoring of this budget allocation and utilization, include a separate budget line for sanitation within national budgets
4. Ensure inclusive and participatory planning and governance and improved standards of sanitation programs for the entire population with a special emphasis on women, persons with disabilities, children & older people in both rural and urban areas, including slums
5. Establish a participatory & transparent multi-stakeholder monitoring mechanism for annual reporting against clear indicators for poor, marginalised and excluded groups, including people with disabilities, women, children and older people
6. Institutionalize concrete steps to uphold human rights and dignity by eliminating the stigma of impurity and pollution ascribed to sanitation, especially to menstruation and to those providing sanitation services, and ensure that services are provided in the most unbiased and non-discriminatory manner
7. Eliminate all forms of manual scavenging and ensure dignity and equality for the sanitation workforce. Ensure that disposal and management of human waste is carried out in strict conformity to the principles of protecting human rights, health and environmental sustainability.
8. Position right to sanitation & hygiene for all at all times in the development of the post-2015 framework and SAARC agenda and advocate for a separate target for '**universal access to Sanitation'**

South Asia Campaign on Right to Sanitation and several other groups and people

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About India WASH Forum

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.

In order to undertake credible independent WASH advocacy work in India, the national coalition got registered as an Indian charity in 2008 and has undertaken a number of significant research and advocacy work that includes:

Knowledge Networking and Advocacy initiatives undertaken by India WASH Forum;

- Gender and Sanitation South Asia Workshop with National Foundation of India in Delhi; 2005
- Review of Swajaldhara and TSC Programme Guidelines; 2007
- Input to the Technical Expert Group set up to review the National Drinking Water Mission(RGNDWM); 2007
- Civil Society Input, Urban Sanitation Policy 2009
- Review of TSC in 4 states of India 2009
- Organisation of SACOSAN 3 in Delhi. CSO session and a CSO Statement of Action, 2009
- National Right to Water and Sanitation Workshop 2009 with participation from the Ministry and CSOs
- Start up of the GSF programme in India
    - Launch workshop 2009 with stakeholders in Delhi, 2009
    - Developing and finalising the Country Programme Proposal, 2010

India WASH Forum

  - Leading the PCM of GSF, as an institutional host and Chair and Convener.
  - Providing oversight for programme review.
- Member Govt of India 12th Five Year Plan Working Group on Drinking Water and Sanitation 2010. Recommendations on behaviour change priorities and staffing for national sanitation programme.
- Recommendations for Urban and Rural Water and Sanitation inputs: national consultations on drinking water and sanitation by Planning Commission Govt of India and Arghyam 2010
- National Pro poor Urban Water and Sanitation Consultation, 2010
- National report and a South Asia Report for SACOSAN 3 : Peoples Voices – a National Study project, Reports for India and South Asia, 2011
- Formal Input to the National Water Policy 2012, with a focus on drinking water and sanitation
- Report to the Ministry of Drinking Water and Sanitation: UNDP international consultation – Greening of Rural Water Supply Programme and Guidelines, 2012
- FANSA-IWF Review of national commitments and progress since Sacosan 4, and preparation for World Water Forum 2012
- School Sanitation Baseline Research by GIZ for Tirupati and Mysore, 2012

A unique feature of IWF is its non-hierarchical set up. Most of the Trustees of India WASH Forum are represented in their individual capacity and do not represent the organsiations they are associated with. The agenda and activities that India WASH Forum are determined at the initiative of the Trustees and support from organisations and individuals.

Since 2010, India WASH Forum is actively engaged in the Global Sanitation Fund(GSF) and currently hosts Programme Coordination Mechanism(PCM), of 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 makes NGO sub grants in the two states of Jharkhand and Assam. The Programme is managed directly from WSSCC Geneva and with the support of the PCM and an Auditor(called the Country Programme Monitor) that is KPMG for India.

The mandate/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 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 influence** work through
  - Monitoring and evaluations
  - Media advocacy and campaigns, and
  - Fact finding missions
- **Undertaking lobbying and networking to promote common objectives** in the sector.

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