



India WASH Forum

WASH News and Policy Update Bi-monthly e-Newsletter of India WASH Forum Issue # 36, July 2014

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India WASH Forum News

India WASH Forum stands for an independent credible voice in the water, sanitation and hygiene sector. We bring out one WASH News and Policy Update in two months. It is an open platform for engagement on contemporary issues in WASH sector in India and elsewhere. We are pleased to share the 36th Issue of our WASH Policy Newsletter that is produced once in two months consistently from 2009.

The WASH Policy Newsletter promotes information and knowledge sharing, research and analysis for advocacy on critical issues. We try to highlight critical WASH issues that are often ignored by specific WASH sector agencies who are sometimes engaged with promoting a specific approach or a WASH theme only. We are also conscious that WASH sector is increasingly being dominated by market based approaches, often drowning the voices of the people and real issues experienced on the ground. There is no dearth of funding in WASH sector because this is a politically sensitive sector. Yet we are witnessing a shift of funding focus away from real issues and investments in creating adequately staffed service provisioning to more and more infrastructure creation that may not be required. Increasing dependence on NGOs and privatization (often in the PPP mode).

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.

The last couple of months following the national general elections in India, there is interest of the new government to set new goals for sanitation and water. The Ministry of Drinking Water and Sanitation (MDWS) has been provided a target of 100% sanitation coverage in India by 2019. The Ministry is making new proposals to achieve the same although funding for the year 2014-15 for sanitation remains the same as was budgeted for by the previous government.

In this issue of WASH Policy Newsletter of India WASH Forum, we share analysis of two important topics. The linkage of WASH and malnutrition and critique of the Community Lead Total Sanitation (CLTS) approach. Both the issues are linked in the sense that CLTS promotion banks on 100% Open Defecation Free (ODF) communities as a pre requisite for reduction in diarrheal incidence leading to improved health outcomes and the research being



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conducted on WASH and malnutrition claims that benefits of WASH go beyond diarrhea reduction to actually addressing the chronic problem of malnutrition in India.

We analyse and explore these arguments of nutrition and sanitation, based on logical analysis of the hypothesis and findings of WHO and experience from the ground relating to other contributory factors of malnutrition in India that seem to have been ignored.

The case of rape and murder of young girls in UP recently, has been in news and has been picked up by some WASH sector agencies to highlight the correlation of lack of toilets and violence against women. Can we jump to this conclusion? An interesting blog on the IRC website has this to say.

A recent [article](#) on The Guardian news website struck a discordant note for some of us. We are concerned by the tone of the article which seems to subsume the pervasive societal ailment of violence against women, and specifically rape in this case, under the urgent need to promote public attention to the global sanitation crisis. As with the dire situation with regards to access to sanitation facilities, it is an undeniable truth that vulnerable and marginalised people – due to their socio-economic status, sex, age, physical ability, or other contextually specific factors such as caste or ethnicity – are exposed to circumstances that render them even more vulnerable when they must venture from the relative safety of their homes (provided they are not being violated by someone within their homes) to practice open defecation. As the World Health Organization notes, 'one in three women will experience physical and/or sexual violence by an intimate partner at some point in her life' (WHO, 2013).

However, the lack of access to safe sanitation and water facilities is only one facet of the endemic problem of violence against women. It is one factor that makes women vulnerable to violence, but it is neither a cause, nor a form, of violence.

Linkage of under nutrition and WASH has been highlighted as a critical missing link recently by several research studies. It is interesting to note that WHO estimates 50% malnutrition is associated with repeated diarrheal or intestinal worm infections. Another study has said that a quarter of stunting can be attributed to the occurrence of five or more episodes of diarrhea before two years of age.

Experience of western Europe in addressing safe sanitation and improvement in health indicators in their cities, is often quoted as an illustration for the same in rural areas in poor countries.

Nobody can deny the importance of sanitation, hygiene and safe drinking water in addressing improvement in health outcomes. However to prove a direct linkage of improved sanitation and reduction in malnutrition simply from correlation showing rural areas having high rates of open defecation are also suffer from malnutrition and stunting – will be too stretched. Without simultaneously looking at other factors that contribute to malnutrition and stunting, in different countries and local contexts, to attribute a range less 25% weightage of poor sanitation and stunting correlation, looks implausible.

Even WHO does not draw a direct linkage of malnutrition with lack of sanitation. All it says is that repeated diarrhea and intestinal worms is estimated to contribute to 50% of malnutrition. A weak immune system of a child, that could be a result of poor nutrition and food intake, of repeated diseases of respiratory tract and other infections including malaria and other tropical diseases – could also contribute to lower food absorption and malnutrition in children and adults alike. Is the remaining 50% of malnutrition explained by the WHO, arising from these factors? In which case, how much of stunting and malnutrition be attributed to lack of sanitation and safe drinking water, separately and combined?

Again this is not to state that improved sanitation and safe drinking water should not be a priority, only that making such a call should not take away attention from other pressing problems the poor face – inadequate food intake and food security specially in lean months of a year when infections are also high, lack of public funded basic health care, lack of basic health treatment



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in schools including de worming, lack of treatment for malaria and infections.

In India, we have high malnutrition rates in some of the developed states and urban areas with relatively high toilet coverage. Gujarat is a classical example of high malnutrition and relatively better sanitation coverage. Simply using data of some of the poorest states of India where open defecation is high and drawing correlation between the two variables to show a causal relationship, can be misleading. Where public health services are better and the government spends on health care, we find improved health outcomes and reduced IMR and MMR. Himachal Pradesh, Tamil Nadu and Kerala are examples of health outcomes improving significantly before open defecation was eliminated significantly.

Community Led Total Sanitation (CLTS) has been at the centre of attention for being a very successful sanitation promotion approach in the last decade. The CLTS approach is also criticized for not being sensitive to socially marginalized and excluded communities and facing resistance for its aggressive negative emphasis on ensuring sustainability and social control over those who do open defecation.

CLTS is propagated for two reasons. One that financial incentives for constructing and using latrines by individuals has not worked in achieving desired outcomes (usage of toilets). Secondly, promoting individual toilets is not the aim of a sanitation that is a public health improvement goal. CLTS is hailed by World Bank and some other agencies because it hits at the rationale for welfare subsidies for sanitation. While rural sanitation subsidies have indeed not produced the desired results in India, it is also true that in some states sanitation/toilet subsidies have been successful in promoting sanitation behavior change. Perhaps the World Bank logic in promoting CLTS is that more could be achieved with less money, sustainability and health outcomes. However as of today, there is little evidence that CLTS can be hailed for achieving 100% open defecation free communities at scale in India.

There are others who see CLTS as just another sanitation promotion approach, using the tools of triggering of disgust that motivates sanitation behavior change. And combining components of CLTS with human rights approach to make governments

accountable for providing subsidies for sanitation promotion in countries like India where the government provides sanitation subsidies. There is no contradiction in this if we are concerned about welfare of the people and not the success of a purist CLTS model, only the die hard CLTS promoters find this problematic. The Global Sanitation Fund in India is using CLTS triggering approach to promoting improved sanitation subsidies uptake.

The problem in presenting CLTS as a magic bullet is that it sees rural community as a homogenous entity that can be "triggered" to a social behavior change. Examples from India show that CLTS ends up forcing the most marginal communities – Nepali wage labor in Himachal who do not own lands, to somehow use toilets. Caste and class divisions are ignored. Forcing behavior change on lower caste and class by upper caste and class households – amounts to reinforcing the status quo and further marginalization.

The study by Susan and Anggun is perhaps one of the rare studies that have looked at the coercive CLTS approaches in a historical analysis - how similar tools were applied by the Dutch colonial masters and development agencies like Rockefeller Foundation in Indonesia and Java in the 1930s. The study draws interesting parallels with the morality and priorities of Dutch colonial rulers on the one hand and rivalry from a USA Foundation, to highlight how despite a seemingly change from coercive Dutch policies of making toilets compulsory to using education for sanitation promotion by Rockefeller Foundation, both the approaches failed to deliver desired results.

Despite the thrust on "triggering social change" for toilet construction of the entire community, there is hardly any rural community that achieves 100% open defecation status. Secondly, promotion of CLTS was supposed to happen as a community initiative, has actually succeeded only when it is done as an NGO initiative. This is true for Bangladesh where CLTS was piloted under a well funded WaterAid-VERC project and later in other countries including India where CLTS was actually piloted by expensive private consulting companies in a few villages.

CLTS as a sanitation and hygiene promotion approach started with promotion of fixed point defecation, as opposed to open defecation. Any toilet that people can



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build using their existing available resources, as an outcome of social triggering of shame and disgust, without external support and government subsidy. The VERC CLTS project boasted of promoting a toilet costing as low as \$1 to any amount, depending on peoples ability and willingness to pay. The whole idea was to promote improved sanitation behaviour of using toilets and hand washing with soap that should not cost much money. The idea of “sanitation ladder” was promoted as an integral component of CLTS, let people first start using a basic toilet and then they will invest in upgrading it later on their own. When criticism came from international WASH agencies that CLTS was promoting kuchha toilets that do not provide hygienic safe disposal of human faeces, CLTS approach shifted gear to promoting hygienic safe toilets at the lowest sanitation ladder. Hence one core pillar of CLTS approach got diluted in the process.

Scaling up of CLTS in India has happened with a mix of coercion and financial incentives. Often described by some WASH professionals, as “the most perverted form of the original no subsidy CLTS promotion approach”. In Indian version of CLTS, individual toilet subsidies under NBA are withheld for individuals and several other welfare schemes are also held back as a threat. Rural communities are told to first complete 100% toilet coverage and only then van they get any welfare benefits flowing in their village. A carrot and stick approach, using triggering and then a sustained follow up to prevent open defecation using fines and punishment – is sanctioned and supervised by the district officials, in most instances if not all. This is possible under firm supervision of high ranking district officials who make NBA their priority and use CLTS promotion with the active support of some professional private consultants and force different departments at the district level of prioritise sanitation. The moment these District Collectors leave their offices, the new officials often dump the sanitation priority and there is slippage at a large scale.

Problems of affordability and Right to Water and Sanitation now affect the poor of the developed countries. The 2010 UN Resolution on Right to Water and Sanitation therefore holds hope for the poor of the developed countries as well.

The average monthly water bill in Detroit is

\$75 for a family of four — nearly twice the United States average — and the department is increasing rates this month by 8.7 percent. Over the past decade, sales have decreased by 0 to 30 percent, while the water department’s fixed costs and debt have remained high. Nonpayment of bills is also common. The increasing strain on the department’s resources is then passed on to customers.”

“I’ve seen water problems in poor countries and the third world,” said Maude Barlow, the board chairwoman of the nonprofit Food and Water Watch. “But I’ve never seen this in the United States, never.”

The news report of 30 districts of UP affected by Arsenic contamination should not come as a surprise. Given the presence of Arsenic in the Indo-Gangetic basin and its possibility established for the upper reaches of Ganga river basin long ago by Dr. Dipankar Chakravorti and Saurabh of Innervoice Foundation of Balia. Yet it seems to have taken a very long time for the government of UP to wake up to the problem.

Expensive engineering solutions to Arsenic water treatment, large water treatment plants and piped water supply in some of the poorest rural areas, have long been the preferred options and have seldom worked. What are the most effective solutions available, how can they reach the poor who are suffering from Arsenic induced cancer and ulcers, is nowhere being discussed. Compared to India, Bangladesh has done a much better job in not only providing alternative safe drinking water but also in setting up hospital and medical services for poor people affected by Arsenic contamination.



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What are the links between under-nutrition and WASH?

<http://www.wateraid.org/~media/Publications/Undernutrition-and-WASH.pdf>

Direct links: The World Health Organisation (WHO) estimates that 50% of malnutrition is associated with repeated diarrhea or intestinal worm infections as a result of unsafe water, inadequate sanitation or insufficient hygiene.

- Diarrhea, largely caused by a lack of water, sanitation and hygiene, is a leading cause of death in children under-five globally, and its constant presence in low income settings may contribute significantly to under nutrition.
- Parasitic infections, such as soil-transmitted helminths (worms), caused by a lack of sanitation and hygiene, infect around 2 billion people globally, while an estimated 4.5 billion people are at risk of infection. Such infections can lead to anemia and reduced physical and cognitive development.

Indirect links: A lack of safe water close to home has many indirect effects on nutrition. People are often left with no choice but to drink unsafe water from unprotected sources. Where safe water is available to purchase from vendors, limited quantities leave little for good hygiene practices. The time wasted collecting water or suffering from water-related illnesses prevents young people from getting an education, which has a significant impact on their health, wellbeing and economic status.

A growing evidence base

To date, there have been very few rigorous trials to determine the magnitude of the effect of WASH on under-nutrition, due to the relatively low priority given to WASH in medical research. However, in recent years, there has been increasing recognition of the need for better evidence in this area in light of a suggestive causal link.

The first ever systematic review of the available evidence of the effects of WASH on childhood under-nutrition, conducted by the London School of Hygiene and Tropical Medicine through the Cochrane

Collaboration, found 'a small benefit of WASH interventions (specifically solar disinfection of water, provision of soap, and improvement of water quality) on length growth in children under five years of age.

- A hypothesis published in The Lancet in 2009 argued that 'prevention of tropical enteropathy, which may afflict almost all children in the developing world, will be crucial to normalise child growth, and that this will not be possible without provision of toilets.
- Recent analysis in The Lancet stated that a quarter of stunting can be attributed to the occurrence of five or more episodes of diarrhea before two years of age.
- A number of large trials are currently being conducted to address the evidence gap (Clasen et al, Orissa, India; Luby et al, Bangladesh; and Humphrey et al, Zimbabwe).

What role for WASH in global nutrition frameworks and post-2015 goals?

- Clear outcome goals are essential for generating the political will, accountability and resources needed to tackle global development issues. An outcome goal that clearly sets out the vision for reducing global under-nutrition should therefore form part of the post-2015 development framework. However, outcome goals alone will not be enough to ensure effective development, or address inequalities within and between countries.
- A goal for nutrition should be accompanied by time-bound targets to address the challenges that contribute to under-nutrition, including those linked to sanitation and hygiene behaviour change. Given the considerable impact of

WASH on nutritional outcomes, it is crucial that such targets include WASH. The 'results frameworks' advocated by the Scaling Up Nutrition Movement offer a useful example of setting goals on universal access to affordable, nutritious food, clean water, sanitation, healthcare and social protection at the national level.

- Although the current MDG framework includes a standalone target on drinking water and sanitation, its separation from the outcome goals on health, nutrition and education contributed to a fragmented approach. This discouraged integrated, cross-sectoral



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approaches that could deliver a greater and more sustainable impact. It is essential that the current discussions on the post-2015 development framework address these challenges by building in integrated planning approaches into the indicators for outcome-based goals. A framework is needed that results in long-lasting improvements in nutrition and health, and ultimately, in the elimination of poverty and attainment of overall wellbeing.

- The successful implementation of such a framework for achievement of improved nutritional outcomes will require a commitment from aid agencies to support programmes that respond to the national context and causes of under-nutrition, as well as commitment by national governments to prioritise, demonstrate and evaluate an integrated package of WASH interventions alongside direct interventions such as feeding and micronutrient supplementation.

Yael Velleman (WaterAid), Isabelle Pugh (SHARE)

Going Without Water in Detroit

JULY 3, 2014 By ANNA CLARK

DETROIT — A FAMILY of five with no water for two weeks who were embarrassed to ask friends if they could bathe at their house. A woman excited about purchasing a home who learned she would be held responsible for the previous owner's delinquent water bill: all \$8,000 of it. A 90-year-old woman with bedsores and no water available to clean them. These are the stories that keep Mia Cupp up at night.

Ms. Cupp is the director of development and communication for the Wayne Metropolitan Community Action Agency, a nonprofit contracted by the state of Michigan to work as a human-services agency for Detroit. In August 2013, with a \$1 million allocation, Wayne Metro became the only program to assist residents with water bills. Ms. Cupp quickly learned that this was "by far the greatest need."

In January alone, Wayne Metro received 10,000 calls for water assistance, many of them referred directly by the Detroit Department of Water and Sewerage. It supported 904 water customers over 10 months before exhausting its funding in June.

Ms. Cupp said Wayne Metro still gets hundreds of calls a day from residents. But it has no way to help them, and nowhere to refer them.

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Detroit borders the Great Lakes system, containing 21 percent of the world's surface freshwater. The lakes are the source of the city's water supply, but a growing number of residents can't turn on the tap. Over the past three months, the water department has conducted an aggressive shut-off campaign to get more than 90,000 customers to pay \$90.3 million in past-due bills. Between March 25 and June 14, 12,500 Detroit customers had their water shut off.

The average monthly water bill in Detroit is \$75 for a family of four — [nearly twice the United States average](#) — and the department is increasing rates this month by 8.7 percent. Over the past decade, sales have decreased by 20 to 30 percent, while the water department's fixed costs and debt have remained high. Nonpayment of bills is also common. The increasing strain on the department's resources is then passed on to customers.

But residents aren't the only ones with delinquent accounts. Darryl Latimer, the department's deputy director, told me that the State of Michigan holds its biggest bill: \$5 million for water at state fairgrounds. (The state disputes the bill, arguing that it's not responsible for the costs of infrastructure leaks.)

A [local news investigation](#) revealed that Joe Louis Arena, home of the Detroit Red Wings, owed \$82,255 as of April. Ford Field, where the Detroit Lions play, owed more than \$55,000. City-owned golf courses owed more than \$400,000. As of July 2, none had paid. Mr. Latimer said the Department of Water and Sewerage would post notice, giving these commercial customers 10 days to pay before cutting service. But he did not say when.

And in the meantime the city is going after any customers who are more than 60 days late and owe at least \$150.



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The department reports that 60 percent of its customers pay in full or begin a payment plan within 24 hours of a shut-off, and water service is reinstated. Mr. Latimer said that this proved that many could afford their bills, and simply weren't paying them.

The city of Detroit, which filed for bankruptcy protection a year ago, certainly has not just the right but the obligation to demand payment of outstanding bills.

But cutting water to homes risks a public health crisis. Instead, the water department should more aggressively target delinquent commercial customers who carry a large share of the unpaid bills. It should enact a comprehensive plan to fix leaking pipes; flooded streets are common here, and water customers — whether the state or ordinary residents — must pay for sewerage, not just running water, and often are billed erroneously for these leaks.

The department must also ensure that water is shut off to abandoned buildings, and eliminate errors in address transfers. Mr. Latimer explained that the department used addresses rather than names as the collectible agent on an account — a problematic practice in a city of 80,000 vacancies, rife with foreclosures.

Ms. Cupp said that the average bill for the residents Wayne Metro has helped was \$1,600; she saw one as high as \$10,000. The water department's standard payment plan requires at least a 30 percent down payment. This is out of reach for many. To increase participation, the department should eliminate the down payment, as well as the \$30 reconnection fee it charges.

The department [went on the record with local news organizations](#) last week, saying that it would introduce a financial-assistance program on July 1 in partnership with a nonprofit, the Heat and Warmth Fund, and would use more than \$800,000 in funds collected through 50-cent donations on monthly bills.

This was good news, but the announcement was

premature. On July 1, a representative for the nonprofit said the program might not be operational until August. Meanwhile, Ms. Cupp said Wayne Metro had asked the water department to stop giving out its number to needy customers until it could get additional funding.

Mr. Latimer said that mass shut-offs were the only way to find the shirkers: Those who can pay will do so quickly. But their neighbors are left to fill jugs of water at the homes of friends or at fire hydrants to meet basic needs. Even for a city that has grown accustomed to limited city services, like streetlights and police response times, this is a new low.

"I've seen water problems in poor countries and the third world," said Maude Barlow, the board chairwoman of the nonprofit Food and Water Watch. "But I've never seen this in the United States, never."

Anna Clark is a freelance journalist and the editor of "A Detroit Anthology."

30 Districts of UP in grip of Arsenic Poisoning

<http://timesofindia.indiatimes.com/city/lucknow/30-UP-districts-in-grip-of-arsenic-poisoning/articleshow/38375610.cms>

LUCKNOW: Arsenic contamination, considered so far endemic to eastern part of Uttar Pradesh bordering Bihar, has now taken into its fold a large part of the state. With nearly 30 districts of the state in the grip of arsenic contamination, the situation has only worsened for masses exposed to this slow and consistent toxin.

According to a technical report, 'arsenic toxicity in ground water of Uttar Pradesh', harmful concentration of arsenic in ground water, exceeding the Bureau of Indian Standards permissible limit (of 0.01 mg/litre), is spread across 31 districts of the state. The BIS standards are also in sync with the guidelines laid down by the World Health Organisation vis-a-vis arsenic contamination. Testing of water samples from all over UP was done at the Indian Institute of Toxicology Research.

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The 20 districts which figure in the severely toxic zones (above 0.05mg/litre), where arsenic presence has been found to be more than five times of allowed limit, are Ballia, Lakhimpur-Kheri, Bahraich, Ghazipur, Gorakhpur, Bareilly, Siddharthanagar, Basti, Chandauli, Unnao, Moradabad, Sant Kabir Nagar, Sant Ravidas Nagar, Gonda, Bijnor, Mirzapur, Shahjahanpur, Balrampur, Meerut, and Rae Bareli.

Three districts which fall in highly toxic (arsenic presence from 0.04mg/litre to 0.05mg/litre) category are Faizabad, Kanpur Nagar and Sitapur.

The five districts, which make the dangerously toxic (from 0.01mg/litre to 0.04mg/litre) list, are Ambedkarnagar, Baghpat, Budaun, Lucknow and Pilibhit. Three districts where arsenic level was detected around 0.01mg/litre are Kaushambi, Saharanpur and Sultanpur.

The report adds "Ballia and Lakhimpur-Kheri are the worst affected districts with arsenic in groundwater. Reoti, Belhari & Dubhand blocks in Ballia district and Nighasan, Isanagar, Palia & Ramia Behar blocks in Lakhimpur are the 'most critically contaminated areas'." Among the river basins, the Ghaghra basin is most severely arsenic affected region of the state.

As far as occurrence of arsenic is concerned, it is a general belief that rocks with arsenic eroded from the Himalayas, got deposited as sediments in the alluvial deposits of the Gangetic plain over thousands of years. Sedimentary rocks are supposed to contain higher concentrations of arsenic as compared to igneous & volcanic.

Expressing concern over the current state of affairs, Magasaysay awardee and 'waterman of India', Rajendra Singh said "problem of arsenic contamination is prevalent in areas where extraction of groundwater has been rampant and where there is no provision for recharge." He added that due to no recharging of groundwater, concentration of arsenic (which is existing naturally) goes up and causes a number of diseases and ailments.

Finding of UNICEF supported study by UP Jal Nigam:

After the initial study reports of the Jadhavpur University on the occurrence of Arsenic in groundwater

of Ballia came into light, the UP government took the matter seriously. Accordingly, the UP Jal Nigam, in 2005, with the support of UNICEF initiated the Arsenic screening of public water sources (i.e hand pumps) in all the 17 blocks of Ballia and also in 15 blocks of Lakhimpur Kheri under the Phase-I.

It was found that 475 habitations in both these districts were having Arsenic concentration 5 times greater than the permissible limit of 0.01 mg/l (i.e. 0.05 mg/l or more). The number of such affected handpumps stood at 1631.

Based on the results of Arsenic testing of groundwater in district Ballia & Lakhimpur Kheri, situated in Ghaghra & Ganga basins and also taking into consideration the various previous researches and their observations & findings, it was inferred that the other areas falling in Ganga river basin might also possess Arsenic in groundwater. Hence, on the basis of this inference, 49 districts along the Ganga flood plains were selected as priority areas for the UNICEF support study undertaken by UPJN under the Arsenic Phase-II project.

Total of 74,896 groundwater samples from public handpumps (India Mark-II), located in 273 blocks of these 49 districts were tested for finding the Arsenic.

21% (15739) sources were found affected with Arsenic.

In 136 blocks of 29 districts, Arsenic was detected in groundwater with varying concentrations (in the range upto permissible limit of 0.01 mg/l and beyond that).

10,084 sources were found having Arsenic concentration in the range upto 0.01 mg/litre. In 26 districts, Arsenic in high concentration beyond BIS limit of 0.01 mg/l was detected in 5655 sources from 112 blocks.

In 24 blocks, Arsenic detected within the BIS limit (upto 0.01 mg/litre)

In 1517 hand pumps located in Kaushambi, Saharanpur & Sultanpur, though Arsenic was detected, but the concentration levels were below the permissible limit.



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CLTS Programme - IDS

<https://www.ids.ac.uk/idsresearch/community-led-total-sanitation-programme>

At the heart of CLTS lies the recognition that merely providing toilets does not guarantee their use, nor result in improved sanitation and hygiene. Earlier approaches to sanitation prescribed high initial standards and offered subsidies as an incentive. But this often led to uneven adoption, problems with long-term sustainability and only partial use. It also created a culture of dependence on subsidies. Open defecation and the cycle of fecal–oral contamination continued to spread disease. In contrast, CLTS focuses on the behavioural change needed to ensure real and sustainable improvements – investing in community mobilisation instead of hardware, and shifting the focus from toilet construction for individual households to the creation of 'open defecation-free' villages. By raising awareness that as long as even a minority continues to defecate in the open everyone is at risk of disease, CLTS triggers the community's desire for change, propels them into action and encourages innovation, mutual support and appropriate local solutions, thus leading to greater ownership and sustainability.

Evaluation of CLTS in Ghana, 2009

<http://www.ircwash.org/resources/evaluation-community-led-total-sanitation-clts-ghana-paper-prepared-west-africa-regional>

The Evaluation revealed that the projects had led to significant sanitation improvements in more than 200 communities in Ghana which was part of the . 60% of the communities visited had access to latrines; clean environments, well maintained refuse pits/ and some had hand washing facilities with soap in use next to the latrines. A total of 1857 household latrines were constructed over a period of two years which is very significant and if they are facilitated well with other PLA tools like the Sanitation Ladder they can move up and encourage others to construct their own household latrines and at least 5 communities had 100% coverage of improved sanitation facilities. 69 communities have been declared open defecation free.

Shaming and Sanitation in Indonesia: A Return to Colonial Public Health Practices?

Susan Engel and Anggun Susilo

<http://onlinelibrary.wiley.com/doi/10.1111/dech.12075/full>

WASH sector is severely handicapped for lack of serious research and history of human psychology when promoting behavior change models in sanitation and hygiene. The study by Susan and Anggun is perhaps one of the rare studies that has looked at the coercive CLTS approaches in a historical analysis of how similar tools were applied by the Dutch colonial masters and development agencies like Rockefeller Foundation in Indonesia and Java in the 1930s. The study draws interesting parallels with the morality and priorities of Dutch colonial rulers on the one hand and rivalry from a USA Foundation, to highlight how despite a seemingly change from coercive Dutch policies of making toilets compulsory to using education for sanitation promotion by Rockefeller Foundation, both the approaches failed to deliver desired results.

We highlights some key aspects of the research in this WASH Newsletter.

“The WSP has also produced its own social marketing material starring a figure called *Lik Telek*, which translates roughly as Uncle Faeces (World Bank, 2008). *Lik Telek* is poor, physically deformed, dirty and ‘disgusting’; he is quite similar to a character called *Kromo* in one of the films produced by the Rockefeller programme in Indonesia (Stein, 2006) although, interestingly, *Kromo* is not as much of a caricature as *Lik Telek*. *Kromo*'s name is a colonial Malay word for ‘common people’ and he is disfigured but not as dirty or perverted as *Lik Telek*, who in one image is presented as a peeping tom. Indeed, as Stein (ibid.: 24) points out, the film about *Kromo* is designed more to elicit ‘empathy and identification from the audience’ than to encourage moralizing, although other films produced by the unit did adopt a more moralizing tone, highlighting the underlying belief in the diseased Javanese body. One of our informants from the 2012 interviews in Rejowinangun shared that he had been identified as a *Lik Telek*. He said it was ‘very embarrassing’ to be *Lik Telek* and that the village head and other government staff had ‘encouraged’ him to construct a latrine by teasing him and his family

because of their use of the canal. He said the ‘Village Head and his staff teased me like this: “you have a gorgeous wife, if you are not making a proper toilet, we may see your wife”’. The ‘encouragement’ did not seem to consider his poor household circumstances at the time, although he was given a concrete pit liner by the village head for his latrine.

Peter Harvey, the Chief of Water, Sanitation and Hygiene Education (WASHE) for UNICEF, has claimed that while the shock factor is part of CLTS, the triggering process done by external facilitators should not ‘shame, insult or embarrass the community in anyway’ (Harvey, 2011: 100). Yet CLTS is clearly a very intrusive process involving facilitators from outside the village inspecting individual households and shaming predominantly poor individuals and households for their circumstances and local practices. The process has, since its inception in Bangladesh, involved a policing and punishment component.²⁴ In both WSP and the Rockefeller project, such interventions take place within a village realm that is seemingly free of differences — there are no class, ethnicity, gender or age distinctions. Thus, the possibility that the projects will adversely impact any particular group is not considered; indeed, with WSP the implicit assumption is that the participatory CLTS process will reconcile these sometimes antagonistic interests (Carroll, 2010: 4; Zérah, 2009). Our research indicates that it is primarily the poor who are the ‘targets’ of this intervention and that they are, in effect, punished for their poverty and local practices.

Sustained latrine use is meant to be a strength of WSP, as it was for the Rockefeller programme. However, evidence for this is slim. For WSP, despite claims of its efficacy, there are still very limited data available on outcomes for latrine use across the globe.²⁵ One study in Timor Leste found that regular latrine usage may have been only 50 per cent one year after the programme (Noy and Kelly, 2009), and a study of CLTS in Indonesia found only 12 per cent of 547 participating villages had achieved ODF status (Buhl-Nielsen et al., 2009). “

CLTS for people in vulnerable situations

<http://www.wateraid.org/~media/Publications/community-led-total-sanitation-people-vulnerable-bangladesh.pdf>

“CLTS involves facilitating a process to inspire and empower rural communities to stop open defecation and to build and use latrines” (Kar and Pasteur, 2005). It uses participatory methodologies to develop awareness of the risks of open defecation and facilitate community self-analysis of their health and sanitation status. Its aim is to „ignite” communities to cease open defecation and commence toilet construction using local materials. CLTS has been recognised by the United Nations as one of the most effective approaches to promoting sanitation and achieving the MDGs for sanitation (Ahmed, 2008).

Despite the significant impact CLTS has had in Bangladesh, as with all development initiatives, it is confronted with the social realities that characterise communities. One of these challenges concerns the inclusion within the CLTS process of what this study refers to as, people in vulnerable situations”, who face particular challenges.

Several recent studies have suggested that people in particularly vulnerable situations are often neglected and/or have difficulties participating in CLTS for a variety of reasons (Bode and Haq, 2009; Chambers, 2008; Huda, 2008; Jones et al, 2009; Mahbub, 2008). This idea has been met with some criticism as it devalues the ability of CLTS as a method to assist the poorest people.

Another criticism leveled at CLTS in this area is its, “naming and shaming” component. For example, people who are caught openly defecating during the CLTS process are often publicly identified and may be ridiculed. This may inadvertently reinforce stigma and social exclusion of some groups.

CLTS certainly has the potential to improve the livelihoods of communities. Whether it has the ability to improve the livelihoods of every member of a community is less clear.

Toilet Tripod: Understanding successful sanitation in rural India

<http://www.sciencedirect.com/science/article/pii/S1353829214000768>

Unlike West Bengal (WB), toilet interventions in Himachal Pradesh (HP) were conducted only by local government institutions. NGOs were not involved. GPs implemented the first toilet drive between 1985 and 1990, based on directives from the state government with funding channeled through block development offices. Subsidies were available to everyone except government employees. Initially, subsidies included wheat (in exchange for labor), a pan/plate, pipe from pan to pit, building materials like cement. A second round of subsidies in the early 1990s involved cash, ranging from Rs 1200 to Rs 2000. Although the subsidy was insufficient to build a toilet, many respondents told us that it was substantial enough that they felt compelled to take advantage of it. One SC male interviewee explains that he could not forego the subsidy, “We were given about Rs. 1500 through the IRDP [Integrated Rural Development Program] scheme, which I did not think was sufficient to build the toilet. Nevertheless, we still got it built.” In 2000, the TSC was introduced by the HP state on the directive of the central government. The TSC campaign culminated in the NGP drive in 2005; both HP1 and HP2 won the award in 2007 and 2008, respectively. Recognizing that most households had built toilets but were not using them, the TSC in HP focused on education and sanctions to encourage usage (HP Rural Development Department senior official, personal communication, January 2013).

In both WB and HP, subsidies were combined with a massive education campaign on sanitation. One male SHG group leader from WB1 talked about the process of education: “There was a lot of resistance then to taking the plate paikhana. We had to explain that open defecation causes pollution, and that flies and mosquitoes that sit on feces will spread germs and diseases. Then, people became aware and built their own toilet or still are using panchayat’s plate paikhana.” A female Panchayat member HP1 shared how they educated people about sanitation: “I got the villagers aware of toilet usage and its benefits in door-to-door campaigns. We told them if you defecate anywhere,

the feces would contaminate our water sources especially when it rained.”

Material sanctions were employed as disincentives to open defecation. Sanctions included withholding of subsidized food benefits, agricultural assistance and other aid given to households. In WB2, the local NGO could withhold its own benefits, besides the panchayat’s subsidies and entitlements it was authorized to give. In WB1, the GP issued yellow cards to those who had toilets. With these cards people accessed their entitlements to subsidized grain, oil and kerosene, school admissions for children, and caste and death certificates. The yellow card was an effective motivator of toilet building since many households depended on these subsidies. One older SC interviewee talked about the importance of the yellow card: “If you don’t have a toilet, nothing will be provided to you.”

In HP, sanctions were used also, but to a lesser extent, as more people already had toilets. One woman ward member in HP explained that although many households had toilets for themselves, their laborers were practicing open defecation. The GP threatened these people with fines if they did not provide at least a basic pit toilet for their laborers. Material sanctions were an important aspect of political will because local government supported their deployment and withstood pressure against them. Sometimes stronger social sanctions were applied.

In 2010, when WB1 was still not open defecation free, an international NGO trained the panchayat and other local leaders in CLTS “shock and shame” methods. The panchayat health secretary explained that taking pictures shamed people into discontinuing open defecation: “Some people came, sat there, and started defecating. We took pictures of them. This is how we stopped people.” Shock and shame were used to force those who were not able or willing to use toilets—usually poorer households. One poor male interviewee commented that he was forced to build a toilet after being caught defecating in the open: “They used to check if we went for open defecation in the morning. The panchayat members and another man came and threatened us. We built this toilet the same day.”

“Shock and shame” methods were considered too extreme in HP; CLTS would make people build toilets but did not insure that they would be used, according to

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the Rural Development Department official. “Besides, geography mattered,” he said, “In HP, households were scattered and distant in rural places, so who would be around to pressure people?” Instead of CLTS, the Department chose a more humane and effective strategy it called “hand holding.” The “hand holding” approach centered on catering to the needs of individual households to insure that almost any obstacle they faced would be overcome with community support. For example, one ward member in HP2 explained that her women’s group volunteered their labor to help poor households dig pits and construct cabins from plastic sheeting. However, in HP1 some local leaders shared that they sometimes used more severe social sanctions such as encouraging people to throw rocks at those defecating near water bodies, usually Nepali laborers without access to toilets.

Inequity a shared cause of low access to sanitation services and violence against women

A blog by [Deirdre C. Casella](#), [Giacomo Galli](#) and [Alana Potter](#)

<http://www.ircwash.org/blog/inequity-root-cause-low-sanitation-access-rates-and-violence-against-women>

In Development as Freedom, Amartya Sen proposes the notion that we view development ‘...as a process that expands the freedoms that people enjoy’ (Sen, 1999, p. 3). Sen further proposes that [d]evelopment requires the removal of major sources of unfreedom: poverty as well as tyranny, poor economic opportunities as well as systematic social deprivation [and] neglect of public facilities...’ (Sen, 1999, p.3). In keeping with this take on development as an expansion of people’s freedoms and capabilities, IRC wholeheartedly supports the global effort to increase people’s access to the fundamental human right to safe, hygienic sanitation facilities and services.

It is an undeniable truth that things are not as they should be in terms of levels of access to sanitation facilities, much less services, for much of the world’s population. By one estimate, 2.5 billion people do not

use an ‘improved sanitation facility’, and approximately 1 billion people still practice open defecation ([UNICEF, 2011](#)). These figures are unacceptable by any measure. However, a recent [article](#) on The Guardian news website struck a discordant note for some of us.

We are concerned by the tone of the article which seems to subsume the pervasive societal ailment of violence against women, and specifically rape in this case, under the urgent need to promote public attention to the global sanitation crisis. As with the dire situation with regards to access to sanitation facilities, it is an undeniable truth that vulnerable and marginalised people – due to their socio-economic status, sex, age, physical ability, or other contextually specific factors such as caste or ethnicity – are exposed to circumstances that render them even more vulnerable when they must venture from the relative safety of their homes (provided they are not being violated by someone within their homes) to practice open defecation. As the World Health Organization notes, ‘one in three women will experience physical and/or sexual violence by an intimate partner at some point in her life’ (WHO, 2013).

However, the lack of access to safe sanitation and water facilities is only one facet of the endemic problem of violence against women. It is one factor that makes women vulnerable to violence, but it is neither a cause, nor a form, of violence.

While lack of access to sanitation facilities of any status (safe, improved, private, publically-managed block facilities) certainly contributes to increased vulnerability of women already experiencing disadvantaged circumstances – or what Sen calls *unfreedoms* - there is great danger in presenting a linear, dare we say simplistic, line of thinking about the solutions to this problem. It is but a small step from saying that girls and women shouldn’t “take the risk” of leaving the house in order to defecate, to saying that girls and women shouldn’t leave the house at all. Conversely, many women with toilets in their homes do not necessarily enjoy their human right to a life of freedom from violence and rape.

Violence against women, including rape, is a social problem and a crime. Violence and rape are crimes

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perpetrated by humans against other humans. Not by toilets or the lack thereof, not because women wear one type of clothing or another, not because of the lack of a lock on one's front door in a low-income peri-urban area, or due to having to travel long distances alone for whatever reason.

Violence and rape happen because a perpetrator takes the decision to violate another person's right to a life free from violent assault. Additionally, there exist multiple other inter-linked phenomena that enable this choice, or freedom, of the perpetrator of violence, to dominate over the freedom of another person to enjoy a safe and dignified life. Such a complex matter cannot be addressed by focusing on single facets, or circumstances, alone that render us more vulnerable.

If we revisit *Development as Freedom*, Sen asks that we understand "development as freedom" as a perspective in which '*...freedoms link with each other and with the ends of enhancement of human freedom in general*' (Sen, 1999, p. 10).

Along this line of thinking, lack of access to sanitation is not a form of violence against women, and this is where things get delicate - the lack of access to services by women, the poor and other vulnerable/marginalised groups is a result of inequity. Violence against women is also a result of inequity (expressed in and fostered by patriarchy), so in that sense they have a similar root cause, but the one does not cause the other.

Personal safety is one of multiple imperatives for improving people's access to safe and hygiene sanitation facilities and expanding their freedoms. In other words, merely tackling the vulnerability of the victims without recognising the urgency of eradicating the patterns of violent behaviours of perpetrators, and the need to change institutions such as legal and social norms that grant perpetrators a certain clemency, means that we accept the impossibility of changing these practices and the mindset that promulgates them.

If we want to give attention to violence against women, let us do so. Let us address the persistent underlying issues such as misogyny, patriarchal institutions and

legal systems, and at individual level the misplaced sense of entitlement to exercise one's desire (for control or for sex) over another person's right to a life free from the threat of violation. These are all aspects of what has sadly come to be termed 'rape culture' – one element of which entails 'teaching women to avoid getting raped instead of teaching men not to rape'.

Let us also collectively draw public attention to the urgency around promoting the full complement of human rights, freedoms and capabilities – including the fundamental human right of access to safe and hygienic water and sanitation services. But let us do so in a manner that is meaningful, locating the discussion in the wider context of eradicating inequity in all its forms and sources - expressing what Sen implores us to understand as '*...the remarkable empirical connection that links freedoms of different kinds with one another*' (p. 11). This understanding is valuable for enabling us to view, and engage with, the whole system currently preventing people from enjoying their freedoms.

While remaining committed to the mission of everyone, forever, we shall seek to avoid conflating, or subsuming, violence against women, or other expressions of inequity, under topics or issues that potentially distract from the deep and intractable nature of inequity in its various forms and expressions.



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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.

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.

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
 - 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



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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

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.

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 organisations 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.

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