

Making sense on sanitation

Rethinking the role of Information, Education and Communication (IEC) as a tool for participatory rural sanitation in Uttar Pradesh -Assessing possible policy lessons from Bangladesh.



Hari Om

Student No.SB 1749

Emails- 378138ho@student.eur.nl
sanvihari@yahoo.com

Supervisor: Prof. Des Gasper

Second readers: Dr Venkat Raman/ Dr Rachel Kurian

Acknowledgement:

This work is the result of the part requirement for the Master's degree in Governance, Policy and Political Economy (GPPE) with the International Institute of Social Studies (ISS), The Hague, Netherlands. I owe to many persons for the successful completion of this study. The foremost of them has been my research supervisor Professor Des Gasper- the eminent scholar, a true teacher and a friend. He has been deeply associated with this project right from the conception of the topic till its logical conclusion. No word of thanks could express my gratitude to him. My readers Dr Venkat Raman, professor with the Faculty of Management Studies (FMS), Delhi University, Dr Rachel Kurian, Dr Sunil Tankha and Prof. Arjun Bedi (all professors with the ISS) have helped me reset my focus on relevant questions during this study. I thank all of them. Joep Verhagen- an expert of rural sanitation in India and Bangladesh with the IRC, The Hague, Netherlands- has been the key resource person for my investigation regarding Bangladesh. I interviewed him twice and immensely used his views in case of Bangladesh. I am deeply grateful to him. I also thank Dr Kurian Baby- an Indian Administrative Service officer of Kerala cadre with scholarly excellence in the water sector, currently on deputation with the IRC- for some very useful realistic suggestions on my research design which added quality to my work. I received some very valuable inputs from Dr Robert Chambers and Dr Kamal Kar- the leading international proponents of CLTS- via email. I express my gratitude to them. I am also thankful to my friends and colleagues Andres Hueso Gonzalez, Gopal Suryanarayan, Shankar Jha, Netrapal Singh Yadav, Prabhir Vishnu, Candavelu Vinaygam, Shadhan Kumar Das and Saurabh Babu for their help, advice and comments. Last but not the least I would like to mention the love and care of my wife Dr Malvika and smiles of my daughters Shalmali and Sanvi as sources of my strength. Their company kept me stress-free throughout this arduous task. I am short of suitable words to convey my obligation towards them.

Abbreviations:

APL-Above Poverty Line
ASHA - Accredited Social Health Activist
BPL- Below Poverty Line
BRAC-Bangladesh Rural Advancement Committee/Building Resources Across Communities.
CATS- Community Approaches to Total Sanitation
CLTS- Community Led Total Sanitation.
CSC-Community Sanitary Complexes
CSO- Civil Society Organisation
CBO- Community Based Organisation
CRSPC-Central Rural Sanitation Programme
GOB-Government Of Bangladesh.
GOI-Government Of India
GP-Gram Panchayat/elected village self-governing unit
HLP- Horizontal Learning Programme.
IEC-Information, Education and Communication
IHHL-Individual Household Latrine
IRC-International Water and Sanitation Centre
JMP-Joint Monitoring Programme (by WHO and UNICEF)
MDGs-Millennium Development Goals
MDWS-Ministry of Drinking Water and Sanitation
NGO-Non-Government Organizations
NGP-Nirmal Gram Puraskar /clean village award
NBA-Nirmal Bharat Abhiyan/Clean India Campaign
OD-Open Defecation
ODF-Open Defecation Free
PEO-Programme Evaluation Organization
PCI- Planning Commission of India
PRI-Panchayati Raj Institutions
QIS-Qualitative Information System
SC/ST- Scheduled Castes/Scheduled Tribes
SLWM- Solid and Liquid Waste Management
TSC- Total Sanitation Campaign
SSA- Sarva Shiksha Abhiyan/Education for All Campaign
TFR-Total Fertility Rate
UN-United Nations
UNICEF-United Nations International Children Emergency Fund
UP- Uttar Pradesh (a state in India).
VWSC-Village Water and Sanitation Committee
VDO- Village Development Officer
WB- World Bank
WHO- World Health Organization
WASH- Water Sanitation and Hygiene
WSP- Water and Sanitation Programme

List of Tables and Graphs:

Table1. Overall sanitation scenario in India.....	09
Table2. Comparison of Kerala and UP.....	14
Table3. Sanitation profile of vulnerable areas of UP.....	15
Table4. Methodology of research.....	24
Table5. India and Bangladesh on select social indicators.....	27
Graph1. Equity in the Indian rural sanitation services.....	28
Graph2. Equity in the Bangladeshi rural sanitation services...	29
Table6. Item-wise physical progress of TSC in UP.....	35
Table7. IEC framework of UP.....	37
Table8. IEC activities in the sample districts.....	38-40
Table9. Application of methodology to sample villages.....	41

The Table of Contents:	Pages:
Acknowledgements.....	02
Abbreviations.....	03
List of Tables and Graphs.....	04
Table of Contents.....	05
Chapter 1: Introduction: Talking Sense on Sanitation	06-17
<p>Aim: Studying the Minds and Hearts of People History: Learning from the past, not looking back Problem statement: Treating the Disease, not Symptoms Justification: Why Compare UP and Bangladesh? Hypothesis and the Research Questions Research Structure</p>	
Chapter 2: Framework, Methodology and Data Sources	18-25
<p>Concepts and the Analytical frame: Adding Value Research Methodology: Testing the Tools Sources for Data: From Figures to Facts Scope and Limitations: The ‘Wide’ ‘Deep’ and ‘Narrow’ of Sanitation.</p>	
Chapter 3: Case of Bangladesh: Knowing the Neighbour	26-34
<p>What did they do? How did they do it? Whether they did it differently? Lessons on Information, Education and Communication</p>	
Chapter 4: Case of Uttar Pradesh: the Bad and the Worst	35-44
<p>Story of Rural Sanitation in Uttar Pradesh Software and the Hardware Reaching the Poor and the Vulnerable Looking, Listening and Learning</p>	
Chapter 5: Conclusions: Making Sense on Sanitation	45-47
<p>Bridging the Gap and Informing the Policy Knowing my limits Need for Further Research</p>	
References:	48-52

Abstract:

United Nations' Millennium Development Goals (MDGs) placed the issue of sanitation on the top of global agenda. This study rethinks the role of Information, Education and Communication (IEC) to ensure participatory rural sanitation in Uttar Pradesh -a state in India, after empirically assessing the grass-root realities, especially, in the most backward areas –including tribal areas. Bangladesh has achieved phenomenal successes, - using IEC, as a community mobilisation tool in many fields, including rural sanitation. This study tries to draw on possible policy lessons from Bangladesh to strengthen the system of IEC in Uttar Pradesh, in order to succeed in the rural sanitation campaign. This study shows substantial correlations between the effective IEC interventions and increased sanitary behaviour change in the context of most backward areas of Uttar Pradesh, -having vulnerable rural population, and also highlights the dimension of equity in the provision of sanitation services. This study suggests that the failure of rural sanitation campaign in Uttar Pradesh is largely due to the absence of a local mechanism to understand, activate and sustain the techniques of interpersonal/intercommunity communication (IPC/ICC) in order to actively engage children, women and other agents to bring about lasting change in social norms and practices related to sanitation.

Key Words: IEC, participatory sanitation, community mobilisation, vulnerability, equity.

Chapter 1

Introduction: Talking Sense on Sanitation

“Sanitation is more important than independence.”
Mahatma Gandhi

What Mahatma Gandhi learnt and tried hard to make us learn, more than a century ago, is yet to be learnt and practised in India. Gandhi wrote in Navajivan on 24-5-1925-

*"I learnt 35 years ago that a lavatory must be as clean as a drawing-room.....The cause of many of our diseases is the condition of our lavatories and our bad habit of disposing of excreta anywhere and everywhere. I, therefore, believe in the absolute necessity of a clean place for answering the call of nature and clean articles for use at the time, have accustomed myself to them and wish that all others should do the same."*¹

Gandhi went on saying that *“our lavatories bring our civilization into discredit.”* In his speeches and writings Gandhi commented not only on *‘our dirty ways’* i.e. open defecation, public spitting, poor personal hygiene, irresponsible solid-liquid waste management, but also included in it the greed for unnecessary decorative-material objects in life which contribute to unhealthy living. The Gandhian message on sanitation and environmental cleanliness has not percolated down to the millions of the masses in India, even after 65years of political independence. In his sense of the term, India has yet to achieve the real independence.

Aim: *Studying the Minds and Hearts of People*

The aim of this research is, broadly, to study the minds and the hearts of rural people regarding sanitation- knowing why many of them don't subscribe to the government policy prescriptions on sanitary behaviour change and adhere to the traditional practice of open defecation(OD)-in Uttar Pradesh(UP).² At the same time this study tries to assess, update and eventually strengthen the system of Information, Education

¹Gandhi was a passionate pioneer of personal hygiene, social sanitary practices and environmental cleanliness in India. He spoke many times on it and wrote a series of articles in Navajivan (a weekly newspaper published by Gandhi, in Gujarati, from 1919 (September 7) to 1931, from Ahmedabad) highlighting the relationship of poor hygiene, unhealthy living and diseases. He linked sanitation to mental peace and spiritual wellbeing and not merely to physical health. His ideas on sanitation are available online as accessed 17 July 2013.

http://www.gandhimanibhavan.org/gandhiphilosophy/philosophy_environment_sanitation.htm

² Uttar Pradesh is a state (province) in India. It is the most populated and, one of the poorest and worst performing states of India in rural sanitation.

and Communication (IEC)³ to make the rural sanitation campaign in UP more participatory, community owned and thus more effective by drawing on possible policy lessons from our neighbour Bangladesh.

Bangladesh is a low income country and scored poorer (Dreze and Sen;2013) on the indexes related to poverty;-per capita income, infant mortality⁴ including under five years mortality, total fertility rate(TFR) share of rural population, population-density, etc. in comparison to India but on the issue of rural sanitation, it may, perhaps show India the way. The situation must have been even worse when Bangladesh started its rural sanitation programme around fifteen years ago in 1997. The then Bangladesh must have been worse than the present UP. India started its 'people centric' and 'demand driven' TSC in 1999 while Bangladesh did it in 2003(with the support of VERC and Water Aid).⁵ Now, according to the JMP survey (update 2012) 56% of the total population in Bangladesh (using the data up to the year 2010) has access to improved sanitation facilities. JMP projects that Bangladesh will achieve 100% sanitation target as set under the Millennium Development Goals (MDGs)⁶ by 2013. In this light this research attempts to evaluate the success of rural sanitation in Bangladesh, due to the effective IEC, and to suggest possible policy lessons for UP/ India.

India has recently revamped the TSC with an objective to have a clean India by 2022. It commits itself to completely stop OD by 2017. Policy makers, administrators, professionals and researchers are all trying to devise policy solutions and discover means to involve the rural community (or communities) in a sustained manner to succeed on this front. The main objective of this research is to rethink the role of the IEC as an effective policy tool for listening, understanding and empowering people with an objective to achieve community participation, by instilling a sense of belongingness, ownership and the need for urgent and sustained action on their part to end the problem of OD in rural areas of UP. To summarize, the proposed research has the following twin objectives:-

- To assess the role of the IEC in the success of rural sanitation programme in Bangladesh and suggest possible policy lessons for UP/ India.

³ Some think that BCC (Behaviour Change Communication) is a better substitute for the IEC as it tests the IEC techniques against the expected positive changes in the behaviour of the people. BCC evaluates the effectiveness of the intervention tools while IEC offers only prescriptions but in this research I have preferred the term IEC to BCC as it's the former which finds place in the TSC and the NBA guidelines and by using it I ascribe the same meaning as given to the BCC. I believe that the IEC, as an intervention tool, succeeds only when it is able to bring required change in behaviour.

⁴ The Economist: The Path through the fields (3rd Nov2012, print edition) compares Bangladesh and India on many social indicators. As accessed at <http://www.economist.com/news/briefing/21565617> on 12th Nov 2013.

⁵ Village Education Resource Centre is an NGO based in Bangladesh which works in the field of education, sanitation, peoples' empowerment and participatory development while WaterAid is an UK based international agency which works for ensuring safe drinking water, improved sanitation and hygiene in almost 27countries of the world mainly in Africa and South Asia.

⁶ The United Nations (UN) declaration (in the year 2000) on the Millennium Development Goals (MDGs)-to be achieved by 2015- has put the issue of sanitation again on the top of the Global agenda along with extreme poverty, primary education, women empowerment, fatal diseases, child mortality and maternal health.

- To rethink the role of the IEC as an effective tool for listening, understanding and empowering people with an objective to achieve active community participation in sanitation campaign in UP and a lasting behaviour change.

History: *Learning from the past, not looking back*

India started the first structured rural sanitation programme in 1986. The Central Rural Sanitation Programme (CRSP) was launched as a centrally planned and financed ‘target driven’ rural sanitation programme with minimal popular involvement. After a decade, a comprehensive “Baseline Survey on Knowledge, Attitudes and Practices in rural water supply and sanitation was conducted during 1996-97 under the aegis of the Indian Institute of Mass Communication, which showed that 55% of those with private latrines were self-motivated. Only 2% of the respondents claimed the existence of subsidy as the major motivating factor, while 54% claimed to have gone in for sanitary latrines due to convenience and privacy. The study also showed that 51% of the respondents were willing to spend up to Rs.1000/- to acquire sanitary toilets” (Guidelines on CRSP (TSC), GOI; 2004, 2010). The study offered various policy lessons to learn. One, the decade long government-run programme had little motivating impact on the minds and hearts of the people to go for improved sanitary practices. In other words one can say that there was least participation of people and communities. Two, subsidy played a trivial role in motivation. Three, safety, convenience and privacy are instrumental in adopting improved sanitation and hygiene and lastly people may be willing to spend money for acquiring toilets as it contributes to human development and a dignified life. However, this may not be possible in case of the poor and vulnerable having little income and being ignorant of the idea, impacts and relevance of safe sanitary practices to health, education, poverty and overall dignity in life. This makes the role of the IEC, capacity building, participatory approaches, facilitation and various incentives (more in case of the poor and vulnerable) pivotal in universalising the improved sanitation behaviour- both at the level of individuals and communities.

Based on this appraisal, the programme was revamped as the CRSP,- Total Sanitation Campaign (TSC) in 1999 as a ‘community led’ ‘demand driven’ ‘incentive based’ and ‘people centric’ campaign with a resolve to end Open Defecation(OD) in rural India by 2012. The revised approach emphasized more on the role of IEC to increase community participation and generate demand for individual household latrines (IHHL). Financial incentives were provided to Below Poverty Line (BPL) households for construction and usage of the toilets and to deter from OD. The other main components of TSC were the construction of school toilet units, Anganwadi (a child care centre in a village) toilets and Community Sanitary Complexes (CSC), apart from undertaking activities under Solid and Liquid Waste Management (SLWM) (TSC Guide Lines, 1999). In 2003 the Government of India (GOI) launched an incentive scheme i.e. Nirmal Gram Puraskar (NGP/clean village award) to recognize and motivate the efforts in the field of rural sanitation by Gram Panchayats (GP/ the elected village self-governing unit), Block Development Committees, Districts and NGOs etc. This helped in giving the TSC a momentum with invigorated community participation. The GOI has recently come up with a revitalized rural sanitation

campaign i.e. Nirmal Bharat Abhiyan (NBA/ clean India campaign) with broadened objectives as underlined in the NBA Guidelines released in July 2012;-

- Bring about an improvement in the general quality of life in the rural areas.
- Accelerate sanitation coverage in rural areas to achieve the vision of Nirmal Bharat by 2022 with all GPs in the country attaining Nirmal status.
- Motivate communities and Panchayati Raj Institutions (PRI) promoting sustainable sanitation facilities through awareness creation and health education.
- To cover with proper sanitation facilities the remaining schools not covered under Sarva Shiksha Abhiyan (SSA/education for all campaign) and Anganwadi Centres in the rural areas and undertake proactive promotion of hygiene education and sanitary habits among students.
- Encourage cost effective and appropriate technologies for ecologically safe and sustainable sanitation.
- Develop community managed environmental sanitation systems focusing on solid & liquid waste management for overall cleanliness in the rural areas.

The NBA objectives clearly highlight the role of awareness generation, health education, community participation and community managed environmental sanitation systems to achieve overall cleanliness in rural India. In this context let us have a look at the current sanitation status in rural India.

The overall sanitation scenario in India⁷

Baseline Survey 2012 - All India Abstract Report		
Sl.No	Category	%
1	% of Household not having Toilet	54.15
2	% of Household having Toilet	45.85
3	% of Household having functional Toilet out of the total HH having Toilet	86.35
4	% of Household having dysfunctional Toilet out of the total HH having Toilet	13.65
5	% of Government Anganwadi (child care centre in a village)having Latrine	78.29
6	% of Government Anganwadi having adequate Water Facility	67.42
7	% of GPs (Gram Panchayat i.e. the elected village self-governing unit) where VWSC(village water and sanitation committee) is formed	74.94
8	% of GPs where VWSC is Functional	68.44
9	% of GPs where Swachchhata Doot (the employee, appointed by and from the local village community, who keeps the village clean) is Posted	64.02
10	% of Govt. School Without Toilet	5.05

⁷ Source: official website Ministry of Drinking Water and Sanitation (MDWS) GOI. The data is provisional and liable to be changed due to continuous data entries.

11	% of Govt. School Without Water Facility	12.72
12	% of Private School Without Toilet	9.90
13	% of Private School Without water Facility	10.21
14	% of GPs Where other Organisations (NGOs) are Involved	71.74

Table1.

World Health Organization (WHO) defines sanitation as *‘the provision of facilities and services for the safe disposal of human urine and faeces. It also refers to the maintenance of hygienic conditions, through services such as garbage collection and wastewater disposal.’*⁸The UN declaration on the MDGs has put the issue of sanitation again on the top of the Global agenda. The access to safe drinking water and sanitation is a basic human right.⁹ The right to life is protected as a fundamental right which also means a life with dignity and reputation.¹⁰ Sanitation is part of human dignity. It’s, therefore, not only the duty of the governments but a claim of the people which must be fulfilled.

The problems of OD, personal hygiene and waste disposal have linkage to issues such as child malnutrition, infant mortality, maternal health, safe drinking water and many fatal diseases such as diarrhoea, dysentery, cholera. Polio-a crippling disease-also owes its origin to poor sanitation. Recent studies have also shown direct relations among OD, undernutrition and stunting (low height for age) in India (Spears, Dean : 2012b, Chambers et al: 2013).The poor health and hygiene of the population and the environmental degradation indirectly affect the physical and mental capabilities of a society which in turn hampers the productivity, creativity and prosperity prospects of India. In *Economic Impacts of Inadequate Sanitation in India*, the Water and Sanitation Program of the World Bank estimated that the total annual economic impact of inadequate sanitation in India in 2006 was \$48 per person or about 6.4% of the GDP, while most African countries were in the range of only 1% to 2% of the GDP (WSP, 2011). Going further, the absence of safe, adequate and private sanitary facilities brings shame and indignity to women (and men also) which further leads to strengthening the foundation of caste and gender discriminations in a feudal and patriarchal society like India. I have experienced many such instances during my tenure as field administrator, where women are assaulted, molested, kidnapped and raped while they were out for defecation at odd hours i.e. early morning or late evenings. The related incidents of snake biting, road accident, drowning, physical fight, violence and even killing are not rare, affecting both -men and women. This is now an established fact that the convenient access to water and sanitation facilities increases privacy and reduce risk to women and girls of sexual

⁸ For the purposes of this research, sanitation means round the year access of the rural population to safe and hygienic toilets and the absence of OD. It covers the state of institutional sanitation, i.e. the toilets and their usages in the schools, child care (Anganwadi) centres, community buildings and premises such as Panchayat Ghar, village marriage houses, guest houses, meeting places, cultural and religious congregation centres, etc. However, this study does not cover the wider spectrum of personal hygiene, safe storage and handling of drinking water, safe disposal or productive uses of faecal sludge and overall cleanliness or environmental sanitation.

⁹ On 28 July 2010, through Resolution 64/292, the United Nations General Assembly explicitly recognized the human right to water and sanitation, and acknowledged that clean drinking water and sanitation are essential to the realization of all human rights.

¹⁰ The Constitution of India, chapter 3 Article 21. Supreme Court of India explains it to include dignity (1978, Maneka Gandhi case) and reputation (2008, Deepak Bajaj case).

harassment/assault.¹¹ The access to sanitation reduces the school dropout rates of girls and increases their attendance (Mahon and Fernandez, 2010). Thus, the UN resolve to promote gender equality and empower women (MDG3), and to have effective and sustainable projects, is linked in many ways to the availability of safe water and sanitation facilities for women. Increased participation of women in the management of water and sanitation facilities gives them the opportunity for networking, builds solidarity among them and generates immense social capital by mobilizing and giving them leadership roles in community development activities.

The learning from the history of sanitation policies and practices goes wider and deeper in India as the fact of rampant OD does not only pose sanitation, health, hygiene, productivity and environment problems and strengthens the bases of caste and gender discriminations but also forces a section of the Indian society (mainly women and children of low castes) to earn its livelihood traditionally from a dehumanized occupation -manual scavenging- and to live a disgusting life.¹²

Problem statement: *Treating the Disease, not Symptoms*

India ranked 160th out of 193 countries in the coverage with improved sanitation as per the JMP report 2010. The current data shows that India has 59.4% (626 million) of the people doing OD in the world.¹³ In other words, 53% of India's total population practices OD. Out of this, 91% (574 million) are rural dwellers (India Census, 2011). This is starkly in contrast with what was reported officially before the start of the Census (that only 32% of rural population practice OD (TSC data based on the budget spent on building toilets till 2010). The Census reported 35million toilets 'missing' among the households.¹⁴ Given the figures, India has so far failed to achieve rural sanitation, despite spending substantial money, reiterated political resolves and continued policy interventions.

The issue of sanitation is deeply linked to many aspects of development and more so to the dignified human life. The main problem is to convince and involve people (in different senses of the term) in a sustained campaign which could bring lasting behavioural changes in their sanitary practices by empowering them to take initiatives towards leading a dignified life. The Programme Evaluation Organization (PEO) of Planning Commission of India (PCI) holds that "*lack of awareness*" is one of the predominant reasons for OD in India (Evaluation Study on Total Sanitation Campaign, 2013). The NBA Guidelines also clearly highlight this issue - "*Intensive IEC Campaign is the corner stone of the programme involving Panchayati Raj Institutions, Co-operatives, ASHA (Accredited Social Health Activist-the local lady*

¹¹a) Millennium Project Task Force on Water and Sanitation, Health, Dignity and Development: What will it take? Stockholm, Stockholm International Water Institute, 2005.

b) Also, see Lennon; 2011.

¹² Manual scavenging is the removal of human excreta manually from the dry latrine/ toilets without modern flush system. Scavengers are called by different names such as Bhangi (in Gujarat and UP), Phaki (in Andhra Pradesh) and Sikkaliar (in Tamil Nadu) A random survey conducted by Action Aid in 2002 in six states of India- Madhya Pradesh, Andhra Pradesh. Orissa, UP, Rajasthan and Bihar- claimed that 30,000 manual scavengers were found working on the dry latrines. Also see Rajiv Kumar Singh and Ziyuddin; Manual Scavenging as Social Exclusion: A Case Study; 2009.

¹³ Joint Monitoring Programme (JMP) of UNICEF and WHO report 2010.

¹⁴ Uttar Pradesh topped the list of the states where data on new toilets was allegedly inflated-it had 11.6 million 'missing' toilets; India Census 2011.

village health worker), *Anganwadi workers*, *Women Groups*, *Self Help Groups*, *NGOs etc.*” as part of an effective strategy (p.6, NBA Guidelines:2012). The question, however, is why does India fail despite reemphasizing the role of intensive IEC in participatory rural sanitation? Does there exist a vast information asymmetry, emanating from the deep rooted inequalities, injustices and discriminations in Indian society? Has this to do something with the kind of values, morals, beliefs, religious faiths, socio-cultural norms, gender relations and the interpersonal or intercommunity behavioural practices in the society? Does all this affect the interest and the involvement of the poor, vulnerable and women in the government run sanitation campaign? Does the IEC tool, when implemented as policy prescriptions, result in social stratification, marginalization and exclusion of the poor, vulnerable and the ignorant from the development processes? The problem in this research is, thus partly, to find out ways to dismantle this huge information asymmetry, to break down the barriers of apathy, disinterest and disillusionment for achieving greater community participation and possibly, to diagnose the inherent processes of social exclusion in the rural sanitation campaign. Moreover, the concern for sanitation may also have to be extended to the sizeable population which does not have a permanent settlement- the nomadic communities, the homeless, the travelling workers and their families, and so on.

The experiences in the developed countries and some of the developing countries like *Bangladesh* show that prioritization of sanitation by the National Government, the historic interventions by NGOs like CLTS (Community Led Total Sanitation) foundation¹⁵ and BRAC(Bangladesh Rural Advancement Committee now Building Resources Across Communities)¹⁶, the assistance from international organisations such as UN, WB and UNICEF, donors’ concerns, the sustained dialogue with the communities, building partnerships among stakeholders and the use of IEC as an effective tool for community mobilization could, -perhaps- bring the required results. Based on my several years of relevant experience in the UP administration, I perceive the problem in India mainly as a failure on the part of the government and other agencies to initiate and sustain a convincing dialogue with the communities¹⁷ to mobilize their participation in the rural sanitation campaign with a sense of ownership and commitment.

The problem is thus, not of preaching to, patronising, protecting and promoting poor and vulnerable people in order to make them understand what is to be done but to

¹⁵ CLTS refers to an integrated approach to achieve and sustain open defecation free (ODF) status. This approach was invented by Dr Kamal Kar in Bangladesh in 1999-2000. CLTS facilitates the community’s analysis of their sanitation profile, their practices of defecation and the consequences, leading to collective action to become ODF. Presently CLTS is being experimented with in 51 countries across the globe. More than 85 thousand villages have attained ODF status and more than 25 million people have benefited directly or indirectly from the CLTS (www.cltsfoundation.org). Dr Kar set up the CLTS foundation in 2010 with its headquarters at Kolkata, India.

¹⁶ BRAC, established in 1972 in Bangladesh, largely self-funded, is the largest NGO in the world. It started its massive WASH programme in partnership with the government in 2006 which covers half of the Bangladesh and provides sustainable and integrated WASH services to over 37 million people in the rural areas of Bangladesh (<http://www.irc.nl/page/69649> accessed on July 8, 2013).

¹⁷ ‘The Penguin Dictionary cites three meanings of community beyond merely ‘inhabitants’, the people living in the same territory,- 1) a group having shared system of social structure. 2) a self-contained operational unit and 3) a group with a feeling of belonging or community spirit. One can add 4) a group in which all the inhabitants at least form part of a network of interaction, even if it is not self-contained.’ The Ethics of Development, Des Gasper, 2004, p.206.

enable them come forward and lead themselves to the tasks of development, including sanitation. We have to cure the disease, not symptoms.

Justification: *Why compare UP and Bangladesh?*

UP is one of the largest geographically (approx 0.24 million square km), and one of the poorest (approx \$600 per capita income as against India's average of approx \$1200)¹⁸ of all the provinces in India and is the most populated (almost 200 million of which 131 million is rural)¹⁹. It is also socially (prevalent caste-feudal system, communal problems, religious bigotry and gender discrimination etc.) and politically turbulent (the history of unstable governments, criminalization of politics, allegations of corruption and bad-governance) which presents serious challenges to make the rural sanitation campaign a success, something which eludes policy makers, the executive, activists and researchers alike.

Bangladesh makes a comparable case with UP on the criteria of rural population (107 million, 2010) and per capita income (US\$640, 2009) apart from the other indicators such as poor rural infrastructure and remote, inaccessible rural areas (such as the Chittagong Hill Tracts).

The socio-economic problems mentioned above have deep impacts on the state and scope of peoples' empowerment and community participation in rural sanitation in UP. UP has a complex structure and large variation in development across the state. Western UP, the area adjoining the capital city of Delhi, witnesses industrialization, a fast pace of urbanization and development while some other parts, namely Bundelkhand (with 10 million population) and the tribal areas -Sonbhadra, Mirzapur and Chandauli districts (with approx 5.5 million population)- lag far behind on socio-economic indicators. The tribal areas are the poorest and the most backward in the state. In order to reflect upon the effectiveness of the rural sanitation campaign so far in a meaningful way it would be pertinent to test the theories of awareness, gender empowerment, equity and equality, sanitation communication and community participation in the most vulnerable areas of the already relatively very backward state of UP.

Rural sanitation is facing a tough time in gaining ground in most parts of UP. Thus the data collected from the field, the studies conducted on the experiences in rural sanitation in UP and the conclusions drawn, will be representative of the backward areas/regions/provinces of India, for it deals with the complex set of socio-economic and political problems, a large proportion of the population of the country and a vast geographical area. India's failure to succeed in the states like UP would eventually undermine her efforts to respond to the sanitation targets set under the MDGs.

The study in the most backward areas of UP when compared with other areas (developed regions/districts or the states) of India on the rural sanitation index, finds utmost relevance. It is interesting to see that the areas-like Kerala and Himachal Pradesh having better infrastructure, education, per capita income, gender

¹⁸ For the year 2011-12, as per the Central Statistical Organization, GOI data released in 2012.

¹⁹ India census 2011, GOI

empowerment, and an enabling environment with a tradition of good governance, have shown remarkable achievements on rural sanitation.

The basic data related to Kerala and UP are presented just to have a comparative look at the rural sanitation scenario.²⁰

Baseline Survey 2012 - State Abstract Report			
		Kerala	UP
SL No.	Category	%	%
1	% of Households not having Toilet	4.32	65.54
2	% of Households having Toilet	95.68	34.46
3	% of Household having functional toilets from HH having toilets	95.91	71.31
4	% of Household having dysfunctional Toilet from HH having Toilet	4.09	28.69
5	% of Government Anganwadi having Latrine	94.12	73.60
6	% of Government Anganwadi having adequate Water Facility	87.49	63.01
7	% of GPs where VWSC formed	79.03	56.14
8	% of GPs where VWSC Functional	79.42	52.06
9	% of GPs where Swachchhata Doot is Posted	0.00	44.48
10	% of Govt School Without Toilet	11.50	3.38
11	% of Govt School Without Water Facility	4.83	10.68
12	% of Private School Without Toilet	1.51	10.01
13	% of Private School Without water Facility	0.17	6.29
14	% of GPs Where other Organisations (NGO/CBO) Involved	65.63	37.05
Note:-1) The report of Kerala is based on the entries done by 515 out of 999(51.55 %) GPs as reported by 11 district(s).		Note:-1)The report of UP is based on entries done by 21238 out of 52841(40.19 %)GPs as reported by 68 district(s).	
2) Report may get changed because of continuous data entries are being done.		2) Report may get changed because of continuous data entries are being done	

Table2.

UP, as mentioned above, has stark variation in development from area to area which is more explicit in the context of rural sanitation. Various factors contribute to this variance, including little community participation at the GP level, poor water availability or water abundance, lack of involvement of agencies,-other than the government, lack of functional transparency at all levels, lack of awareness, motivation and commitment and general apathy/disillusionment/ mistrust on government-led campaigns. One can also sense the invisible hand of poverty, deep social divisions, strong gender hierarchy, corrupt patron-client local power structures, huge information asymmetry, social norms, cultures backing traditional sanitary practices, and geo-climatic settings, behind these visible failures.

²⁰ The data is provisional and drawn from the official website of the MDWS, GOI.

The table below, contains the sanitation data from the most backward/vulnerable areas- Chandauli and Sonbhadra (tribal) and Chitrakoot (Bundelkhand-the water-starved region of UP) districts. The sanitation profile in these areas are compared to Ghaziabad (a district in relatively developed Western UP) and to the average situation in UP.²¹

Baseline Survey 2012 - District Abstract Report						
SL.No.	Category	Chandauli %	Sonbhadra %	Chitrakoot %	Ghaziabad %	UP %
1	% of Households not having toilet	73.51	66.70	79.58	9.96	65.54
2	% of Households having toilet	26.49	33.30	20.42	90.04	34.46
3	% of Households having functional toilet from HH having Toilet	62.41	40.32	52.83	94.18	71.31
4	% of Households having dysfunctional toilet from HH having toilets	37.59	59.68	47.17	5.82	28.69
5	% of AWCs having latrine	50.38	59.46	82.22	100	73.60
6	% of AWCs having adequate water facility	38.93	32.43	62.22	28.57	63.01
7	% of GPs where the VWSC is formed	90.68	30.10	92.52	100	56.14
8	% of GPs where VWSC is functional	86.82	27.47	70.09	100	52.06
9	% of GPs where Swachchhata Doot is Posted	85.21	7.27	88.79	96.30	44.48
10	% of Government schools without toilet	17.07	4.28	1.02	1.43	3.38
11	% of Government schools without water facility	52.23	12.08	4.36	11.59	10.68
12	% of Private schools without toilet	31	26.92	22.45	0.00	10.01
13	% of Private schools without water facility	56.52	8.42	2.63	0.00	6.29
14	% of GPs where other organisations(NGOs) are involved in the campaign	63.02	22.02	77.57	96.30	37.05

Table3.

Chandauli, Sonbhadra and Chitrakoot are among the worst performing districts on the rural sanitation standards as only 2, 7 and 0 GPs have received NGP respectively since its inception, while Ghaziabad is the best in UP as 71GPs have received this

²¹ Ibid. The highlighted figures are enough to underline the gravity of the problem in these districts and have logical inter-linkages.

honour.²²This research is aimed at finding and showing, in the above context, how do the dynamics of change work at one place and fail at the other, even though the policy framework and the implementation agencies remain the same. It would be further interesting to know why and how some of the GPs in the worst performing districts have managed to achieve the total sanitation status despite all the adversities.

Hypothesis and the Research Questions

One can argue that a hypothesis may restrict, lead or tailor the research but still we need one to explore new areas of inquiry and expand the horizon of intellectual investigations. The present study will try to test the following hypothesis in the light of some research questions-

A well-conceived, implemented and sustained IEC system, perhaps, holds the key to the success of the rural sanitation campaign in UP.

1. How and to what extent can the IEC, as a tool, contribute to achieve participatory rural sanitation in UP? This implies-
 - What are the basic ingredients of an effective IEC system according to the successful/best practices in rural sanitation in UP/India?
 - To what extent the policy prescriptions on the IEC (in the TSC guidelines) got translated into practice in UP and what are the lessons?
 - To what extent the IEC, as an intervention tool, is effective in creating and sustaining demand for sanitation services and the much needed behaviour change in the rural communities?

2. How is IEC being addressed in Bangladesh?
 - Whether it differs from what we do in UP/India?
 - To what extent,-can the success of the rural sanitation campaign in Bangladesh,- be credited to an effective IEC system?
 - What are the policy lessons from Bangladesh in order to bridge the existing information asymmetry in the vulnerable areas of UP/India?

Research Structure

This study is organised into five chapters.

The second chapter reviews the main concepts and related theories relevant to the topic of research. The broad area of inquiry, i.e. the role of IEC in participatory rural sanitation, is tested against the value loaded and contested concepts/theories of

²² As per the data available on MDWS, GOI website. Despite good performance by some districts, e.g. Ghaziabad, no Block or the District received NGP so far in UP while 117 Blocks and 8 Districts received this honour in Kerala.

sanitation communication, equity, equality, vulnerability, community, gender empowerment and participation. These concepts are summarily discussed in order to make the intervention tool of the IEC more effective and inform the policy formulation and implementation processes in the area of rural sanitation. This chapter also discusses the methodology adopted for the research, the sources of data, prospective strengths and the potential weaknesses of the researcher and the research.

The third chapter deals with the case of Bangladesh. An attempt is made to know the neighbouring country and its successes in the field of rural sanitation with specific focus on its experiments with the systems of IEC. This chapter tries to find out the answers for the 'what' and 'how' of rural sanitation in Bangladesh and its relevance for upgrading the IEC regime in UP/India.

The fourth chapter is the outcome of work on, including the field work in UP. It throws light on the history and the present status of rural sanitation in UP, the experiments-general and local- with the tools of IEC and the evaluation of the form and content of the IEC strategy followed to achieve community participation in sanitation campaign. Finally the chapter reflects on the whole processes of reaching the far-flung areas, looking at the realities on the grass-root level, listening to the poor, vulnerable and 'voiceless' and learning from them.

The fifth and the last chapter summarises the findings and lessons learnt after the whole exercise. It tries to make sense on rural sanitation and bridge the gaps in intervention strategies at the levels of policy formulation and implementation. The chapter indicates the limitations of this study and suggests some areas of further research and intellectual inquiry.

Chapter 2

Framework, Methodology and Data Sources

Concepts and the Analytical Frame: *Adding Value*

This chapter tries to clarify the main concepts to make the discussion on participatory rural sanitation more concrete, logical and meaningful.

IEC The IEC, as an intervention tool, aims at addressing the individual and social psyche to achieve intended results:-a sustained change in thinking and behaviour of sanitation and hygiene practices. As discussed in the first chapter, IEC finds special mention and has a pivotal role in all the policy documents on rural sanitation in India (TSC Guidelines; 1999 and NBA Guidelines; 2012). Countries like India and Bangladesh (National Sanitation Strategy; 2005, GOB, WSP; 2006), international agencies like WB (WSP Mission; 2007, WSP; 2008, 2012) WHO, UNICEF, IRC(1998, 1999, WHO-UNICEFJMP; 2008, UNICEF with MDWS, GOI; 2012), IDS(Dyalchand et al;2009) and NGOs such as CLTS, Plan UK (Kar with Chambers;2008,Kar; 2010),WaterAid, VERC(Ahmed; 2006) and BRAC(WASH programme and the use of communication tools such as QIS, SenseMaker and Sanitation Ladders for community mobilization and output monitoring), have all emphasised the need of developing a behaviour change framework in order to mobilize people, communities and the society as a whole to realize the goals of safe drinking water, improved sanitation, health and hygiene and finally, environmental sustainability.

For the last decade or so, IEC has taken the front seat with the creation of institutional arrangements to impart sanitation communication among various stakeholders in order to make sense on the ideas, impacts and the relevance of sanitation in development, gender empowerment, human dignity and overall wellbeing throughout the world. The experiences in South Asia(including India and Bangladesh) have shown that the conventional approaches to generate awareness about the benefit of

toilet usage were not very effective in changing the individual sanitation behaviour (WSP Mission;2007). The case of India suggests that arranging finance, spending substantial amount on subsidies and finally building toilets may not bring the required change in the sanitation behaviour of the individual and the communities. The latest census reported a huge gap between official claims and the field reality in toilet usage (India Census2011; GOI). Merely talking of the IEC and budgeting for the 'sanitation and hygiene advocacy and communication strategy framework' (as adopted by the GOI for the year2012-17 under NBA) is also not going to bring the expected outcome. The question is how and to what extent are these policy prescriptions converted into practice? To what extent are these standard prescriptions realised in local contexts? What should be the realistic form and the content of an effective IEC system? How to go about convincing the people? Can government do it alone? Who are the stakeholders? What are the factors which frustrate the official and non-official exercise of telling and selling²³ the sanitation stories to the people and the communities? Why and how do some people, communities and areas understand, learn and adopt improved sanitation practices much faster than the others even in the 'not so varied' local settings? All these questions don't let the talk on the IEC remain a simple talk on telling and selling the sanitation. It requires wider and deeper digging. All policy prescriptions, narrations of stories and campaigning with good health and hygiene practices fail when they are unable to ignite desire for a lasting change in sanitation behaviour, deep rooted in traditions, social norms, values and convictions (Craig Kullmann;WSP2008,Dyalchand, A. et al; 2001 and 2009). As aptly described here, "*pathways leading to health behaviours are mediated through social relations, micro-environments, structural barriers, community norms in addition to individual intent. Understanding variations in behavioural pathways can assist in planning locally relevant, culturally specific, and socially compatible behaviour change programmes*"(Kapadia-Kundu,Dyalchand;2008,pp.1). People and communities require physical and mental (moral may be added) capabilities, need, desire, conviction and motivation to be involved in a sustained manner with the sanitation programme. Economic wellbeing, education and health help in building individual and social capabilities (Dreze and Sen; 2002) in the long run. IEC, as a tool, if exercised scrupulously, may create, channelize and utilise these capabilities for making the rural sanitation campaign more effective and participatory. The idea of IEC in rural sanitation, however, needs to be discussed and understood in the light of other relevant concepts.

Vulnerability This research aims at testing the hypothesis in the most vulnerable areas/population of UP/India with a focus on the role of the IEC system in generating awareness and empowering the people and the communities. It has various connotations and dimensions. Oxford dictionary defines vulnerability as the state of being '*exposed to the possibility of being attacked or harmed, either physically or emotionally.*' Other sources refer it to be '*the inability to withstand the effects of a hostile environment*' (Wikipedia), '*susceptible to being wounded or hurt*, also '*open to moral attack, criticism, temptation, etc.* (Dictionary.com). W. Neil Adger (2006) has

²³ Some sanitation experts say that IEC is not telling, it's selling the sanitation- obviously they use the marketing term which treats sanitation as a social commodity. I think the better way to explain this is to build a sense on sanitation in the minds and hearts of people and the communities, to enter into a dialogue, to understand them, to listen and learn from them and finally to enable and empower them to own and manage the sanitation campaign themselves. Telling and selling-both presume an external presence in the personal and local domain of an individual and the community.

studied the research traditions of vulnerability to environmental change and the challenges in integrating it with the domains of resilience and adaptation. The author discussed the various approaches to understand and situate the concept of vulnerability in different socio-economic-political and ecological contexts such as vulnerability to famine and food insecurity (Sen;1981, Swift;1989,Watts and Bohle;1993),to hazards(Burton et al;1993,Smith;1996,Anderson and Woodrow;1998), in human ecology(Hewitt;1983,Mustafa;1998), to pressures and releases (Winchester;1992,Pelling;2003), of sustainable livelihoods and poverty (Ellis;2000,Dercon and Krishnan;2000, Dercon;2004) and finally in social-ecological systems (Turner et al;2003a and 2003b, O'Brien et al.;2004,Luers;2005). However, the purpose of reviewing the concept here is to understand various forms of vulnerability and socio-economic and ecological (which includes political, cultural, religious and moral systems) dynamics that explain, affect and represent the idea of vulnerability in the context of UP/India.

Vulnerability is more generally discussed in the context of poverty (deprivation in income, the fear of losing job, land and other resources) and related dimensions such as health, nutrition and sanitation (Rosa A. et al; 2008, Zaidi;1988, Mehta;2003). But in order to understand the failure of rural sanitation in UP, this concept must be understood in the context of caste(Meher;2007,Singh;2009;Kumar et al.;2009), gender (Gutierrez;1990,Kabeer;1994,1999,2010, Ahmed;2001,Grown,Caren et al.;2005,Rao;2010), religion(Robinson;2008), region (Meher;2007), disaster (Krishnan;2012), social norms (Dyalchand et al; 2009) and other behavioural patterns, different identities (caste, gender, community etc.), geographical locations (flood-drought prone, forested, hilly, endemic, barren, inaccessible/backward/tribal etc.), lack of education (access to IEC), age (children, old), language (Chambers; 2004), physical and mental susceptibility to various hazards, failure of entitlement (Sen;1984) and other socio-economic and political deprivations. All these play important role in deciding the degree of vulnerability of individuals, groups, communities and societies (in the global context). This multidimensionality of deprivation or/and state of being, constrains the involvement of people in the development processes and adversely affects the outcome of public actions, i.e. public policies and campaigns. Thus, policy formulations and public interventions also intend to (or they must) reduce these constraints of participation through incentives, capacity building and empowerment in order to achieve desired results.²⁴

Equity The concept of equity and its multidimensional manifestations are important in the context of sanitation campaign. If sanitation is essential for a dignified life, then it becomes a priority public good and everyone has a claim to it. It would be interesting to explore the criteria of listening and not listening, informing and not informing, selecting and not selecting, including and excluding individuals/communities/regions in the sanitation campaigns from the perspectives of the public policy and other public interventions. The problem of OD and its linkages to caste hierarchies, community identities, gender discriminations, social exclusion, economic deprivation, political-

²⁴ Dreze and Sen in their seminal work 'India: Development and Participation' (2002), have discussed this issue in the name of 'building human capabilities through education and health with an aim of expanding the real freedoms of the citizens to enable them pursue their objectives of life.' The authors see the expansion of human capability as 'the central feature of the processes of development.' See chapters 2 (Economic Development and Social Opportunity), 5(Basic Education as a Political Issue),7(Gender Inequality and Women Agency) and 10(The Practice of Democracy).

administrative neglect and regional marginalisation necessitates proper understanding of the norms and criteria of equity and its application in the development processes. The understanding of the concept of equity may, perhaps, answer the questions like why don't the poor still have toilets despite spending so much money in subsidy? Why are the toilets not being used? Why has the campaign, in effect, neglected certain regions (the most backward/tribal areas) or communities (SC/STs and Muslims) in UP? Why is there so little community participation in rural sanitation campaign? Why is there no mechanism to fix the political and administrative responsibility of ensuring the provision of sanitation services to all equally? Why do women, despite suffering more in the absence of sanitation facilities, have no or very little voice compared to men? In sum, why is the provision of fundamental right to dignified life (which includes sanitation) under the Constitution of India, not realized to the poor and the vulnerable?

Equity is normally understood (in dictionaries) as natural justice, freedom from bias or favouritism (Webster's), impartiality or fairness in acts or outcomes (Collins), the state, quality or ideal of being just, impartial, and fair (Farlex). The concept is important not only in the context of sharing gains from and costs of development but also equality of treatment in social and political 'spheres of justice' (Walzer;1983). Gasper underlines many new aspects in the debate on equity (Gasper; 2004: 84-112). The urgent need for sanitation services for the women, children, old, crippled and those who are unable to contribute to the cost of creating and maintaining such services can be explained by understanding the concept of equity.

Community participation What forms a community (Gasper; 2004:p. 206)? What can be called active participation? Finally, how does community participation contribute to the success of a rural sanitation campaign? The failure of the TSC in mobilising communities and motivating them to lasting behaviour change in sanitary practices showed that only building the toilets is not sufficient. The local communities should also own the campaign and commit to the need of total sanitation. This has compelled the policy makers to revamp the programme with greater emphasis on community participation through IEC and increased 'incentives' (subsidy and awards like NGP). The target of having a clean India has now been postponed until 2022. One of the main objectives of NBA is to '*motivate communities and PRI to promote sustainable sanitation facilities through awareness creation and health education*' (NBA Guidelines; 2012: p.6). The stray successes of rural sanitation campaign in India (and the example of Bangladesh) indicate that poverty, illiteracy and financial incentives are not decisive in achieving ODF status. It is the community participation and leadership in planning and implementing the sanitation programme with considered conviction that is crucial. A temporary, sincere facilitation from outside,- may realize this.

The CLTS(Kar;2008)has been a paradigm shift in the field of rural sanitation after its debut success in Bangladesh and subsequent successes in many countries. Though,- the trigger caused by disgust and shame, generated after the community-led analysis of local sanitary practices, may not be the only factor behind such successes yet the CLTS approach has shown that 'subsidy' and regular external (government or non-government) interventions are not required for a sustained change of sanitary behaviour in the poor (Kar et al.;2005, Chambers;2007,2009). UNICEF in a study *Community Approaches to Total Sanitation* (CATS) highlights the role of

communities worldwide (including India) in achieving the the goal of eliminating open defecation. The study finds that the successes are ‘rooted in community demand and leadership, focused on behaviour and social change, and commitment to local innovation’ (UNICEF;2009). However, the villages in UP/India are not a community in the real sense of the term. The factors of caste, class, gender, religion, education, health and wealth etc. facilitate and undermine, at the same time, the cause of active community participation. People differ in values, pursuits, preferences, needs and abilities, thus making the task of active community participation even more difficult in the rural areas. Social norms, beliefs, customary behaviours and cultural practices etc. also affect communities’ involvement in sanitation campaigns.

Public Policy When we talk of IEC in rural sanitation, we talk of some policy instruments to carry the issue of sanitation to the domains of community and individual households in such a way that it convinces, motivates and finally involves various actors, agencies, communities and individuals in the sanitation activity. The importance of research to policy making, the role of different actors in updating policy initiatives and the centrality of advocacy, persuasion and lobbying for good change have been aptly highlighted in the context of rural sanitation in India (Saxena, N.C; 2005). Geof Wood presents an Institutional Responsibility Matrix which explains the presence and practice of social policy as an outcome of the interactions amongst the state, market, community and the household. These interactions, conditioned by various universal and local factors, take place in domestic and global settings. Wood mentions MDGs as one of the wellbeing outcomes of this interplay (Wood;2009). We have already noted that sanitation is a priority public good and the MDGs have placed it on the top of the global policy agenda. There are several agencies and structures which decide, direct, condition and affect the policy formulation, implementation, outcome and appraisal both in the domestic and international areas. If we take the case of sanitation, we find that UN, WB, UNICEF, WaterAid, Plan UK, IDS, IRC and other international agencies have a role to play in the policy on sanitation. There are numerous donor countries also. In the domestic arena the state interacts with a great number of NGOs, CSOs, CBOs, caste groups, women organisations, researchers, academicians, media, religions, cultures and moral regimes when faced with the task of devising a policy solution for the problem of rural sanitation. Business has a role in providing finance, technique, material and expertise and innovations for sustainable sanitary services. Moreover, there are certain areas which are beyond control or cannot be fully influenced by an actor, including the State such as human social behaviour, her personal preferences, traditions, norms, values, morals etc. These can only be anticipated and/or appreciated within a particular context. All this makes the task of public policy very complex and requires greater insight, coordination and cohesion of efforts and appreciations. The test of a good policy is in its practice and public policy cannot be effective in all the socio-economic and cultural settings. The sanitary behaviour of people varies from place to place. In Wood’s parlance, the task of public policy on sanitation would be to engage various actors and agencies in such a way as to maximise demand for sanitary services, sustain its usage and finally bring a positive change in people’s sanitary behaviour (wellbeing outcomes). But as his matrix shows, the success of such a policy falls well beyond the influence and control of the state. The change in individual and community behaviours cannot be ensured through legislation and directives. Much is left for the anticipation, apprehension and appreciation in a local setting. Behaviours, choices, preference and practices are customary, emanating from age-old

convenience, conditioning and conviction. This increases the role of IEC, persistence, persuasion, facilitation and mobilization for a broad based and active participatory approach towards rural sanitation with an eye on local needs, initiatives and actions.

Research Methodology: *Testing the Tools*

There can be several ways of knowing and assessing the social reality. No method can boast to be perfect when confronted with human beings, their behaviours, values, ethics and the customs shaping human agencies and structures. The choice of methodology depends on many things, i.e. the preference of the researcher, feasibility and utility for the given area and subject of inquiry: here, human sanitation behaviour in rural UP (with a focus on the most backward areas) and the role of the agencies and structures that influence it in a positive way in the light of the Bangladesh experiences. This requires a field visit to collect data, an interaction with the resource persons with field experience and the related agencies working in the field and first a review of the secondary (official and non-official) data available.

In the above context I have chosen to test the hypothesis and apply the analytical frame to the most backward, including tribal, areas of UP in order to find out empirical and logical correlations among the factors that are responsible for the success or the failure of the sanitation campaign. These areas, being very poor, located far away from the state or district headquarters, having poor infrastructure, facing scarcity of physical, financial and human resources and lacking proper access to information networks, are the toughest ones to achieve a breakthrough in the rural sanitation campaign. *I selected ten contrasting GPs from the districts of the most backward areas of UP, with largely vulnerable population (SC/ST) and also some GPs from the average or better off districts and try to show how and why they perform and differ on the performance index of rural sanitation and how the successes or failures are credited to the mentioned variables. I draw on my 15 years experience as a field officer in the UP government.*

For the UP part, apart from collecting and reviewing the secondary data, I visited the selected villages and collected primary data but for Bangladesh, I rely on the secondary data i.e. the literature available in print and electronic forms, the evaluation reports, surveys, official data, successful case studies from the field, experiences of the resource persons etc. I use the case of Bangladesh for general guiding benchmarks to evaluate, testify and derive policy lessons in the light of the empirical data collected from the above areas of UP. The following table presents the idea behind the methodology-

Criterion of selection of Villages	Successful Villages	Unsuccessful Villages
Unfavourable conditions		
Favourable conditions		

Table4. Methodology of research

By favourable conditions, I mean the conditions opposite to ones which I mentioned in the context of the most backward areas in the above paragraph. These are the conditions which make them perform better on sanitation index in comparison to the problematic areas.

Sources for Data: *From Figures to Facts*

The literature review The literature on the concepts of the IEC, vulnerability, equity, community participation and public policy has been reviewed in the beginning of this chapter. The relevant literature will be used further in understanding and representing the realities in the field of rural sanitation in UP/India and Bangladesh.

Secondary data Published evaluation reports, surveys, studies and observations regarding the rural sanitation campaign in Bangladesh, UP/ India have been used. The GOI, the GOB, World Bank (WB), WHO, UNICEF, donor agencies, NGOs (Water Aid, Plan UK, BRAC etc.), activists and independent researchers like Dr Robert Chambers, Dr Kamal Kar etc. have published and/or made available online,- a series of reports on rural sanitation. Apart from Robert Chambers' and Kamal Kar's individual contributions, the Institute of Development Studies (IDS) at,- University of Sussex, IRC²⁵ and CLTS Foundation conduct research programmes on the issues of water and sanitation, participatory development and governance etc. This study has benefitted from these agencies and the resource persons working there. The research has also used the relevant materials published in the journals of water, sanitation and hygiene for development and online updates available from time to time on the websites of IDS, IRC, CLTS foundation, portals such as India Sanitation Portal, Water Aid, WSP, World Bank etc., blogs and other forums dedicated to the issues of water and sanitation. The policy documents, guidelines and survey data available on the official websites of the National and state Governments and other trusted sources along with the IEC materials, used to achieve community participation in rural sanitation in UP have been assessed and used.

Primary data: There have been some unstructured or semi-structured qualitative interviews of resource persons i.e., government officials working at the village, block and district levels, elected representatives- Gram Pradhan (elected village chief), activists or community leaders working or having field experiences of rural sanitation in UP, either personally or through email. I have worked in the area of rural sanitation as an administrator and could have access to such resource persons and community leaders through my own network. For the Bangladesh part, I could reach such resource persons personally- like JoepVerhagen²⁶ and others on email via Robert Chambers, Dr Kamal Kar and Dr. V. Kurian Baby (water expert at the IRC). In addition, the primary data was collected from the selected GPs of UP. For this I visited the selected GPs in October and assessed the field situation by a series of interviews, informal interactions with resource persons and perusal of the available

²⁵ IRC (International Water and Sanitation Centre) is a knowledge-focused NGO. It works with a worldwide network of partner organisations in order to achieve equitable and sustainable water, sanitation and hygiene (WASH) services. The organisation was founded in 1968. It has its headquarters in The Hague, Netherlands.

²⁶ JoepVerhagen is a senior manager South Asia and Latin America Team of IRC. He has worked in the WASH sector for the last 20 years, both in India and Bangladesh and is an expert in rural sanitation.

official and non-official data. The direct interaction with the villagers, community leaders, women, children, teachers, village functionaries, GP office-bearers etc. proved to be central for this study. The approach has been to look at the grass-root realities, listen to the common people, understand them and learn in order to inform the policy on the issue of rural sanitation.

Personal experiences I have been supervising the TSC in UP for the last ten years in different capacities (also as the District Programme Coordinator) and so have also built up and drawn on my personal experiences during the research.

Scope and Limitations: *The 'Wide' 'Deep' and 'Narrow' of Sanitation*

This research widens the spectrum of policy debate on rural sanitation by learning not merely from the best practices (WSP; 2012) in India but also from enormous successes in Bangladesh. It compares the bad and the worst GPs in the light of the IEC interventions to enhance community participation. It also adds one more dimension to the field inquiry by digging deep into the realities in the most vulnerable- including tribal- areas of UP where the sanitation index lies much below the state average. This study widens the arena of debate to cover all these factors affecting individual and community behaviour and the resultant policy outcomes.

Sanitation is narrowly treated as a health and hygiene issue but actually it has wider and deeper implications as part of human dignity and one of the basic ingredients to the right to life -a fundamental right. The talk on sanitation, therefore, will have to extend to the larger issues of environmental sustainability and the common man's claim for dignified life. The class campaign has to convert into mass campaigns.



Chapter 3

Case of Bangladesh: Knowing the Neighbour

What did they do?

In the first chapter I underlined certain grounds of comparability between Bangladesh and UP, and the successes of Bangladesh on many social indicators, including rural sanitation. Jean Dreze and Amartya Sen, in their latest book on India, have shown how well Bangladesh has excelled over India on most of the social indicators, despite having around half of India's per capita income (Dreze and Sen; 2013, chapter3) during the last two decades. This proves that financial resources (Bangladesh has much less income and more poverty than India), political stability and the pace of democratisation at various levels (Bangladesh has a history of civil strife and more recently it faced military interference into popular regimes while India is said to be the largest functioning democracy in the world) and good governance (Bangladesh is ranked much worse(144) than India (94) on public corruption index in the world as assessed by Transparency International in 2012)do not have decisive impacts on social mobilization and community participation in well planned social campaigns such as sanitation, basic education and health, "*once the people are informed and an enabling atmosphere is created for their participation in the decision making processes at different levels*", as JoepVerhagen, the sanitation expert for both-Bangladesh and India, remarked.

In the book *An Uncertain Glory: India and its Contradiction*, Dreze and Sen compare the achievements of India in terms of the selected social indicators to the 16poorest

countries, outside Sub-Saharan Africa in general and to Bangladesh in particular. The successes of Bangladesh are by no means, - less than a miracle. To quote from the book-

“The comparison between Bangladesh and India is a good place to start. During the last twenty years or so, India has grown much richer than Bangladesh: India’s per capita income, already 60 per cent higher than Bangladesh’s in 1990, was estimated to be about double that of Bangladesh by 2011. However, during the same period, Bangladesh has overtaken India in terms of a wide range of basic social indicators, including life expectancy, child survival, enhanced immunization rates, reduced fertility rates...” (p.54)

The following table presents a comparative picture of India and Bangladesh on access to sanitation and related social indicators in 1990 and the latest.

No.	Indicators	Year	India	Bangladesh
1.	GDP per capita, PPP: (constant 2005 in \$)	1990 2011	1,193 3,203	741 1,569
2.	Access to improved sanitation (%)	1990 2011	18 34	39 56
3.	Rural population practising OD	1990 2011	90 66	38 5
4.	Infant mortality rate: (per 1000 live births)	1990 2011	81 47	97 37
5.	Under-5 mortality rate: (per 1000 live births)	1990 2011	114 61	139 46
6.	Female literacy rate Age 15-24(%)	1991 2010	49 74	38 78
7.	Total fertility rate: (children per woman)	1990 2011	3.9 2.6	4.5 2.2

Table5.²⁷

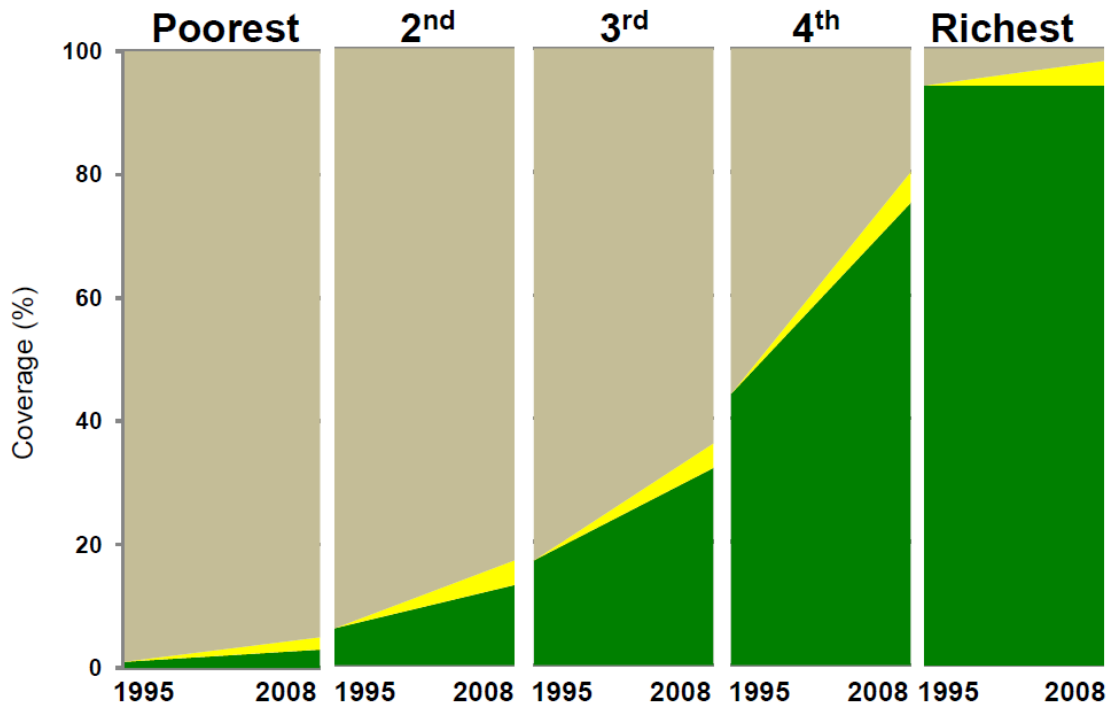
If we look at the figures, we find that Bangladesh was way ahead India in 1990 (row2) and the problem of OD was much lower than India (row3). However, the table suggests the hypothesis that the achievements in the field of rural sanitation, in effect

²⁷ The relevant figures are extracted from Dreze and Sen, 2013 while figures on accessibility to improved sanitation and OD are updated from JMP report on global sanitation and drinking water, 2013.

lead to the higher gains in terms of the other social indicators related to health and education. In regard to accessibility to the sanitation and washing facilities, Bangladesh leaves India far behind as more than 90% of the total households-including 56%, who have access to 'improved sanitation'-have access to some forms of, private or community, sanitation facilities and only 5% (in 2011;JMP 2013) of rural population resorts to OD while in India this figure is 66% (India Census; 2011). This huge gap on the sanitation index may well explain the surprising gaps between these two countries in the areas of child and maternal health and the life expectancy (which is higher in Bangladesh-69years than India-65years) as access to sanitation has much wider and deeper implications on the personal and social life of an individual. Greater access to improved sanitation in Bangladesh may even have causal linkages to gender empowerment showing advancement in the field of female literacy, child immunisation and fertility rate.

It would be interesting to find out, whether the exemplary achievements in rural sanitation are equitably shared by people, communities and areas in Bangladesh? JMP 2011 snapshot report on sanitation in South Asia,- studies the equitability of the achievements in the area of sanitation in the region and provides interesting data on the equity index in the context of Bangladesh and India. The population is divided into five wealth quintiles and the achievements in sanitation during 1995 to 2008 have been shown as below. The green represents the -'improved sanitation, the yellow, unimproved, while grey shows OD. As per data 166million people gained access to improved sanitation facilities in India during this period but the gains were mostly cornered by the rich sections of the society. Only 3% of the poorest benefitted out of this while 46% gained in the richest slab. This increased the number of OD in the lowest two quintiles.

India

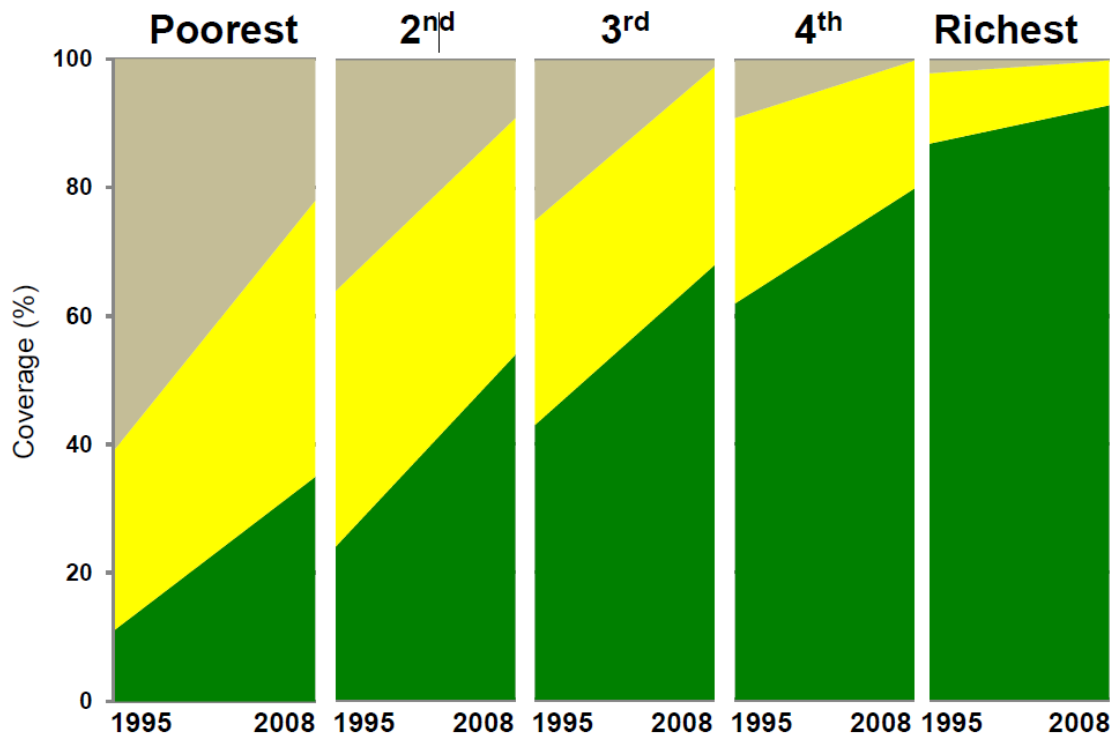


Graph1. Equity in Indian rural sanitation services

As the graph above makes it clearer, 60% of India's rural population got less than 25% share of the total sanitation facilities created during this period. A keen look at the highest quintile suggests that the proportion of the richest who use improved sanitation did not increase, though the proportion of them who use unimproved, increased a lot. The money was never a problem right from the start of the programme in 1986. The strategic and tactical failures compelled the GOI to keep on shifting the saturation deadline time and again, which is 2022 now. The proportion of the population practising OD is alarming and disgraceful. This also affirms the notion, apart from indicating the absence of improved or basic sanitation facilities for the larger section of the society, that richness does not automatically correspond to sanitary and hygienic behaviour which is part of self-respect and dignity in life.

In case of Bangladesh, the report observes that *“Open defecation rates across all quintiles decreased dramatically. Use of improved types of sanitation facilities more than tripled among the poorest and more than doubled among those in the second quintile.”* The distribution of sanitation facilities was highly equitable where all the quintiles benefitted almost equally. The practice of OD has disappeared in the top 60% of the rural population in sharp contrast with India. The table below presents a surprising picture-

Bangladesh



Graph2. Equity in Bangladesh's rural sanitation services

Apart from the above observations, many other surveys and field studies have collected the evidence of sustained latrine usages at scale, at the grass-root level. A study of the impact of CLTS on randomly selected villages in Bangladesh showed sustained use and proper maintenance of latrines by the user communities (Kar et al.; 2005). WSP after a study, with sample data from 3000 households during 2009-10, in 50 Union Parishads (the lowest level of self governing unit in Bangladesh) who were declared ODF in 2005, found that 89.5% of sample households own or share a latrine that safely confines feces. Only 2.5% people out of the remaining 10.5% (who come from the lowest two wealth quintiles),- do OD, while others have access to some sort of unimproved/traditional sanitation facilities. 70% of the surveyed households owned their latrines for the last three years, showing the durability of the sanitation facilities created (WSP; 2012). Bangladesh has used many approaches in the sector of sanitation services, though the local governments always had a leading role. The WSP study puts them into four categories- one, where local government is supported only by GOB, two, where donor agencies also helped the local initiatives, three, where NGOs using CLTS technique facilitated local communities and four, where NGOs other than those using CLTS approach,- contributed to the efforts of local governments in achieving ODF status. *The most encouraging finding of the WSP study is that all these approaches showed almost comparable high rate of sustained latrine use and low rate of OD across the sample communities. This also indicates that no single approach holds the secret to effective social mobilization for participatory sanitation (though it is quite possible that the initial experimentation of CLTS might have inspired other NGOs, foreign donors and the GOB to match its outcome) and the individuals and communities, themselves are highly aware and motivated towards demanding sanitation services and maintaining them without any external assistance. The sanitation facilities were found to be better managed in the female-led households than those led by a male in the surveyed areas (WSP; 2012,*

p5). Poverty, severe natural disasters such as cyclones, floods, tornados etc. and lack of local leadership were found to be the main reasons behind households and areas using unimproved sanitation facilities. This study underlines the fact that Bangladesh is not only way ahead to India in terms of the coverage of areas and population by sanitation services but also achieved exemplary success in guaranteeing equity to the poor and vulnerable.

How did they do it?

‘The roots of Bangladesh’s social achievements are not entirely transparent, and deserve much greater scrutiny than they have received so far’ (Dreze and Sen; 2013, p.59). The authors have found many contributing factors, mainly the role of women’s agency. They call it *‘a pattern of sustained positive change in gender relations.’* To support this, many instances are cited such as;-women’s participation in the paid workforce which is twice as high in Bangladesh (57%) as in India (29%), greater female literacy and education, higher girls’ enrolment in schools than that of boys, very large number of women have been mobilized and trained as front-line health workers (both by NGOs and the government) and so on. This,- all reduced the biases against women in the society, increased their say in decision-making within the households and in the society. This is evident in the higher male-female ratio (972 in 2011, 914 in India) and, reduced TFR (2.2 in 2011, 2.6 in India) which is the outcome of an effective, non coercive family planning programme. All this is achieved by an extensive service coverage, child and maternal health promotion, education and public communication. Women have greater representation at different levels of the government including Parliament (20% of the total membership. This is much lower at 11% in India). The authors continue underlining the impacts of this change in gender relations, saying-

“ elementary good health practices such as the use of sanitation facilities, full immunization of children, and oral rehydration therapy (to treat diarrhoea) have become widely accepted social norms in Bangladesh”(ibid: p.62).

The WSP study (2012) on scaling up sanitation services and sustained usage in Bangladesh, revealed the secret behind this success as follows-

- A national focus on sanitation by the GOB, collective action by central government, districts and sub-districts, incentives to Union Parishads for ODF status and local leadership likely helped to shift social norms around open defecation and sustain latrine use at large-scale.
- Continued sanitation promotion reinforces latrine use and is positively associated with owning or sharing an improved latrine.
- Access to local, private sector providers of sanitation goods and services helps enable sustained latrine use at scale.

However, Joep Verhagen has a different story to tell. This story revolves around the contribution of BRAC to complement and augment the government’s initiative in the field of water, sanitation and hygiene (WASH) promotion in Bangladesh. He emphasizes that GOB too has been central to the success in rural sanitation as it committed itself in 2003 to the task of rural sanitation by making the country ODF by 2010 (now the ‘Sanitation for All by 2013’ campaign is in full swing) but this GOB effort is greatly indebted to the initiatives, all-round interventions, innovations and continuous support from BRAC in the WASH sector for its achievements. He firmly

claims- *“The initial partners of the government in the field of rural sanitation such as CLTS and VERC have little presence in the sector,- in Bangladesh now.”* BRAC started its WASH programme (phase I) in 2006 with an objective to ‘assess knowledge, attitude and practice (KAP) of hygiene among men, women and children (of different strata-hardcore poor/poor/non poor-of the society), to find out people’s willingness to change their existing unhygienic behaviours and to generate demand for safe drinking water and sanitation, and willingness to pay for improved services. WASH covers half of the country, imparting safe water, sanitation and hygiene education to almost 38million rural population’ (BRAC WASH; 2006). WASH-I was started in 2006 with the financial support from the Government of Netherlands. As Babar Kabir says in an interview- *“ over a period of around 5 years in 150 Upazilas we managed to ensure that around 25million people were using hygienic and safe latrines, we reached more than 38million people with our hygiene promotion programme and about 1.8million people were assured of access to safe drinking water.”*²⁸ BRAC now enters into phase II of its WASH programme as a follow-up campaign sustaining the achievements and extending them to 98more Upazilas, including 25 hard to reach Upazilas benefitting 55million people. Replying to a question on how does BRAC manage this campaign? Kabir says- *“the 99% of our staff is field based. The BRAC WASH programme has around 9000 staff. They are supported by BRAC’s 80,000 health workers and 46,000 Village WASH committees (VWC). It is this huge army of WASH foot soldiers, that is driving the programme.....They are also supported in hygiene promotion by over 30,000 BRAC primary school teachers.”* The pivot of this whole campaign and sanitation strategy is the VWC. There is a VWC for every 200 households with 11members (6women and 5men keeping wider community representation). VWC meets once in every 2months supervised and facilitated by the BRAC field staff. The members of the VWC are chosen after a series of meetings with different groups of people in the village-- women, men, adolescent boys and girls. The potential community leaders are selected and trained to become VWC members. VWC takes all decisions as a team regarding water and sanitation planning, implementation, fund raising etc. within its jurisdiction. BRAC ensures that these committees meet regularly, keep their minutes and do their work without bias to any group of the village community. However, Kabir says- *“providing sanitation in the hard to reach areas will require innovative solutions....we will have to look into the issues such as low-cost technologies for areas with high water table, low-cost treatment methods for sludge for single pit latrines etc.”*

The GOB gives top priority to safe drinking water, sanitation and hygiene, and has a stratified subsidy-structure and specific policies for the poor/hardcore poor and the hard to reach/very hard to reach areas, but the secret lies not in the policies but in implementation. It lies in the processes of taking the idea of sanitation to the people/communities, convincing and engaging them in the campaign actively. BRAC acts as the most effective government partner in providing sanitation services and promoting hygiene education to rural population across the country. Banking on his decade long experience in rural sanitation in Bangladesh-both at the planning and

²⁸ Babar Kabir is a senior director with BRAC and also Director of BRAC WASH programme. In an interview with Joep Verhagen (IRC), on 25Feb 2013, he talked about WASH I (2007-11) and II in Bangladesh, its impact on water and sanitation, and BRAC strategy on rural sanitation etc. in detail. This interview was accessed on the IRC website. <http://www.irc.nl> on 23.09.13

implementation levels- Verhagen went on to reveal this secret:- *“BRAC does the social mobilisation, social marketing and necessary training of the individuals and communities through its vast network of institutions such as primary schools (30,000), health workers (80,000) and micro-credit groups (with almost 7million women members). They are trained, committed and locally available resource persons. Nearly 80% of them are women. It is strange, but true. BRAC is largely self-funded and does not depend on GOB for funds”* (Verhagen; 2013).

Verhagen supports the arguments of Dreze and Sen on the role of women’s agency in Bangladesh. On the question of how BRAC does it, he says- *“it’s rigorous and continuous hard work. Separate periodic cluster meetings of adolescent girls (also boys) and ladies (also men), children and elderly people, are held to listen and understand their problems and sanitary preferences. Intensive interpersonal communication (IPC) and intercommunity learning is facilitated by the BRAC staff in collaboration with the local government. The capacity building workshops of different stakeholders, government officials, local representatives and village-community leaders like Imams are organised to reinforce the efforts on orientation, social mobilisation and community participation. The follow-up is crucial to sustainability of sanitation services. BRAC follows a very high quality monitoring schedule, holding the field staff accountable as a team, and provides for a low cost set of alternative technologies for toilet construction for different areas and sections of the society. BRAC does the demand creation and rest all is done by the local people. Thus community is the key to BRAC’s approach.”***Verhagen, who has been instrumental in devising and using various promotional and monitoring techniques such as SenseMakers, QIS and Sanitation Ladder under the BRAC WASH programme,** however, is not carried away by BRAC’s success. He makes it clear simultaneously that- *“this does not mean India also needs some BRAC-like intervention for its sanitation problems. The governments of Thailand and Malaysia have done it alone, without any NGO or private sector’s help.”* To him, the lack of political will and disintegration of demand and supply are the main reasons behind the sorry state of affairs in rural sanitation in many parts of India. By disintegration of demand and supply he means that government supplies toilets without a natural demand from the people.

The above studies and experience sharing by Verhagen -all underline the phenomenal success of Bangladesh in rural sanitation and propose common reasons and processes behind it, like sanitation being a top National priority, political will, role of women’s agency, involvement of multiple stakeholders, local-community leadership and last but not the least, the historic contribution by BRAC and its WASH (I and II) programme.

Whether they did it differently?

The famous quote from the Indian communication expert and motivation *guru*, Shiv Khara, is relevant here- *“Great men don’t do different things. They do things differently.”* The plentiful knowledge resources and expertise on sanitation, i.e. the understanding of the linkages between -safe drinking water, improved sanitation, health, education, economic growth and poverty eradication, the communication strategies, mobilisation tools and participatory techniques, etc., are available to all the countries alike. There is no dearth of funds for WASH activities also. All-round

efforts from the international agencies like WB, WHO, and UNICEF are ongoing to meet the UN's MDGs on health, water, sanitation and environmental sustainability in the problem areas of the world. But it is nothing less than the combination of strong political will, the multi-stakeholders' involvement, continued collective action at all levels, the intensity of motivation, the rigour of efforts, the focus on vulnerable social groups (hardcore poor and poor), the equity of service-mechanism, the passion for change, the local leadership, the active community participation, the pivotal role of women and finally, perhaps, a shared dream of all the actors, including common people of Bangladesh, to win the honour of being an ODF country, which made the difference on sanitation front in Bangladesh.

Joep Verhagen puts forth the pillars of the required policy frame under which Bangladesh mobilised its resources to achieve this exemplary success- *demand creation, supply chain, enabling environment and financial arrangement*.²⁹ Policy frames lead to nothing if not implemented well and updated with time as per the specific local needs. IEC, to me, is the invisible thread which binds all these aspects of sanitation policy together in order to yield required results. IEC not only connects a policy frame with multiple stakeholders and the targeted people/communities, but also,- listening and learning from the audience helps in developing an urge for internal supervision, self restraint, improved monitoring, necessary innovations, a sense of accountability, transparency and good governance in the executive apparatus.

IEC is the soul of demand creation. Bangladesh (GOB, CLTS, BRAC, JMP etc.) devised different IEC modules for different sections of the society -men, women, adolescent girls and boys, elderly, *poor, hardcore poor* and special regions-*hard to reach and very hard to reach* and then went on an untiring hygiene promotion campaign involving women and children particularly, giving leadership to the local communities. While India shifted its target for an ODF status until 2022, Bangladesh launched a vigorous campaign 'Sanitation for All by 2013' and gives all indications to achieve it. As said earlier, 56% of Bangladesh population had access to the improved sanitation by 2010 while other 37% use low cost pit latrines or other rudimentary facilities leaving less than 10% doing OD (JMP;2012 update). *This low-cost (pit latrine)arrangement to deter the poor/hardcore poor from OD, is some sort of a local innovation, laying foundation for the improved sanitation and health services in future which has a great positive impact on the lives of people in Bangladesh* (Dreze and Sen 2013, chap.3).

In sum, apart from the policy initiatives and an un-deterring commitment to the cause of sanitation shown by the GOB, the vision, and hard work by many NGOs like CLTS, VERK, WSP, SHEWA-B³⁰ and BRAC contributed to the success of Bangladesh.

Lessons on Information, Education and Communication

²⁹ Also see chapters 4,5,6,7,9,13,14 and 15 of Ian Smillie's book *Freedom from Want* which is a comprehensive study of BRAC and its exemplary contribution to the development of Bangladesh.

³⁰ Sanitation, Hygiene Education and Water Supply in Bangladesh (SHEWA-B) is a project, largely funded by the UK Department for International Development (DFID) and implemented jointly by UNICEF and Bangladesh Department of Public Health Engineering (DPHE) during the years 2007-11. This project aimed at providing safe drinking water and improved sanitation facilities to 30million people in the Chittagong Hill Tracts and some other very hard to reach areas of Bangladesh.

The successes or failures of social campaigns have their roots in local contexts (the cognizance of which is not always easy) hence the mystery of Bangladesh might need some deeper scrutiny. The success of Bangladesh in the field of rural sanitation, however, certainly offers relevant lessons for many South Asian countries, including India/UP. The ending paragraph of the chapter on comparisons between India and Bangladesh in Dreze and Sen's book puts forth the essence of the processes behind the achievements of Bangladesh, in a relatively short period and also, concrete lessons for India-

“ A ...pointer relates to the importance of social norms in health, education and related fields, and to the role of public communication and community mobilization in bringing about changes in social norms.....Tens of thousands of grass-roots health and community workers....have been going from house to house and village to village for many years facilitating child immunization, explaining contraception methods, promoting improved sanitation, organizing nutrition supplementation programmes, counseling pregnant or lactating women and much more. India, of course, has also initiated programmes of this sort, but it still has much to learn from Bangladesh, both about the required intensity of these communication and mobilization efforts, and about the need to overcome the social barriers that often stand in the way of such initiatives ”(ibid:p.64).

IEC, as mentioned above, is not a one-time, uni-dimensional activity from the policy makers or implementing agencies towards the beneficiaries of sanitation services. It is also an art of being informed and educated from a process of patient listening to the clients (here poor/hardcore-poor/women and other vulnerable groups). IEC has a role beyond *demand creation*. It informs and facilitates the *supply chain* by training the service providers and engaging private partners. IEC is central to the creation of an *enabling environment* for the sanitation campaign. This means a shared understanding of the task, proper orientation, capacity building and motivation of the concerned actors, facilitation and finally, assessment, apprehension and removal of possible hurdles in the way of sanitation campaign. An effective IEC can also ensure transparency in *financial arrangements*, timely release of funds, proper utilisation and fixation of accountability at different levels. The results in rural sanitation indicate that Bangladesh succeeded in using the IEC effectively on all fronts of the sanitation campaign.

The Bangladesh experience shows how the dream of ‘Sanitation for All’ is being realized by the GOB, NGOs and the whole army of grass-root workers- who are untiring, well guided, highly motivated and trained in communicating with people and soliciting community participation in the sanitation campaign with limited resources. UP/India has a lot to learn from it.

Chapter 4

Case of Uttar Pradesh: *the Bad and the Worst*

This chapter is the outcome of the work on UP, including field visits. Apart from the data available on the MDWS website, I have tried to collect latest data from the Directorate of Panchayat Raj (DOPR), UP about utilisation of sanitation budget, construction of toilets, the expenditure on the IEC etc. I have also interacted with the whole range of officials- Director, Deputy Director in charge of rural sanitation, the state coordinator of rural sanitation monitoring, DPROs,- sanitation specialists with the UNICEF office at Lucknow, the GP level officials and natural leaders such as VDOs, AWWs, swachchhata doots, school teachers, Gram Pradhans, members of VWSC, religious heads etc. in particular and the women and children in general, in the visited areas to assess the role of IEC, the problems with community participation and possible solutions.

Story of Rural Sanitation in Uttar Pradesh

Out of 1.1billion people practising OD worldwide, 626million live in India.128million of this total belongs to the state of UP (JMP; 2012). UP is the biggest contributor (40%) to the total increase of 8.3million OD doers in the country during 2001to2011. There was a mild increase of only 2.6% households gaining access to toilets within premises in rural UP against the India average of 8.8%during the same period(Census;2011). UP also leads the ‘missing toilets’ tally by 60.3% of its total numbers reported officially as against 34% India average(Census;2011). In this background when one compares the actual data collected from the field to the official figures(as shown on MDWS website)of toilets in UP during the preceding decade, it is found that UP is over-reporting 10times of actual numbers. Thus given the size, population, socio-economic conditions, political disinterest and the history of poor governance, UP becomes a key testing ground for the success of India’s rural sanitation campaign with 75districts, 821 blocks and 52,841 GPs in UP. The first phase of rural sanitation programme in UP was started in the year 1999 with the nation-wide launch of TSC, covering four districts-Lucknow, Mirzapur, Chandauli and Sonbhadra. By 2003-4 the campaign covered the whole state. The provisional progress data, based on the Baseline Survey 2012, has been depicted in Table2 under chapter1 which shows almost 34%of the rural population has access to toilets. As per the data available with the DOPR, Rs.2.65billion has been released for building toilets since the inception of the TSC till August, 2013. Out of which 88% money has been utilised for the said purpose (!). The item-wise physical progress, against the set targets under TSC, is presented below-

Sr. no.	Item Heads	Progress %
1.	IHHL (covering both the BPL and APL households)	84.6
2.	School Toilets	90.2
3.	Anganwadi Toilets	94.6
4.	Community/women sanitary complexes	100

Table6.
(Source: DOPR, UP)

Strangely, this data shows excellent performance. The table2 indicates a huge gap between demand and supply, whereas this data hints at a target driven approach, where the target is set according to the funds released and achievements are assessed on the construction of toilets or utilisation of the sanctioned budget. If we put the TSC and the Census2011 data together, we see that almost 80%of the rural HHs still needs toilets. This is a huge gap and according to an estimate by UNICEF, UP will take 78years to achieve ODF status at this pace of work (UNICEF; 2013). If we look at the state of institutional toilets, the situation seems a little better. Table2 shows only 3% of government schools and 10%of private schools don't have toilets while 27% of AWCs are without toilets. A factsheet obtained from the DOPR, claims that toilets have been made in all the schools and AWCs in UP. The latest data from the Department of Integrated Child Development UP, however, reveals that out of 187,997functional AWCs 23,352 are running in rented buildings and the data in Table6.does not include them. Likewise nearly 25000 *madarsas*³¹ are also not covered under TSC. Thus, UP, still needs to go a long way even to provide sanitation coverage to primary and secondary schools and AWCs. This aspect of analysis of institutional sanitation coverage leaves the official claims lagging far behind the actual demands. We are still not looking at the usability of the toilets, actual usage and sustainability issues here.

While the timely release of funds, the coordination of different departments, the tenure of the concerned officials and often, the changing priorities of government (from Ambedkar Gram vikas to Lohiya Samagra Gram vikas in UP)³² all complicate the task, the fact remains that the creation of actual demands, capacity building of different stakeholders, awareness generation, mobilisation of people, usage of toilets and finally ensuring an enabling environment for sustainable behaviour change—the factors we identified as central to the dramatic progress in Bangladesh- have drawn the least political and official attention in UP so far.

Hardware and the Software

IEC has been central to the TSC since its inception. NBA has adopted a Sanitation and Hygiene Advocacy and Communication Strategy Framework 2012-17 for an effective sanitation campaign. This document is prepared jointly by the MDWS and UNICEF. Likewise, UP also has a state level IEC framework for the whole NBA period-2012-22, prepared by Department of Panchayati Raj, UP with the help of UNICEF's state unit at Lucknow. The decade long TSC experiences necessitated rethinking the role of IEC as a tool, not only to create demands for household and institutional toilets but also to generate awareness for its usage, to promote individual and community hygiene, and finally to sustain this behaviour change in society. Safe

³¹ *Madarsas* are primary and secondary level schools meant to impart religious education to the children of Muslim community. These institutions are largely funded and managed by the community itself. Government provides them scholarships and other benefits but they don't fall under TSC/NBA institutional sanitation coverage. The above figure is obtained from the Minority Welfare Department, UP.

³² The Bahujan Samaj Party led previous governments have chosen certain villages as Ambedkar Gram (named after its political mentor Dr B.R Ambedkar), based on the higher proportion of SC population in the village and gone for saturating them with all development activities—roads, drainage, electricity, sanitation, education and social welfare. Additional budget was released for this. The present government led by Samajvadi Party, changed this priority and chose different villages such as Lohia Gram(named after its political mentor Dr Ram Manohar Lohiya) for all-round development.

hygiene behaviour includes use of safe toilets for defecation, safe handling of child faeces, hand washing after defecation and before cooking/eating and safe storage/handling of food and drinking water. The NBA, however, aspires beyond this to ensure safe solid and liquid waste disposal and environmental cleanliness. The IEC framework, as adopted by UP, can be presented below-

<i>No.</i>	<i>Level of intervention</i>	<i>Role to be played</i>
1.	State level	Formulation of IEC framework, issuance of technical and administrative guidelines, standardization of IEC materials and tools, area (flood prone, villages near cities and main roads, remote/inaccessible/hilly etc.) and community (SC/ST, BPL/vulnerable etc.) specific planning, training of trainers/ human resource development (HRD), placement of sanitation consultants/coordinators and motivators in the districts/blocks and finally doing a dedicated outcome-based monitoring of the sanitation campaign in the state.
2.	District level	Formulation of block-wise communication plan, identifying and training the stakeholders, creating a Social Forum by engaging community and religious leaders, media persons, activists, women groups, officers, organising special campaigns for providing sanitation services to the poor, vulnerable, elders, children etc., focussing on institutional sanitation(schools, AWCs, sanitary complexes for landless and women) and monthly monitoring of the outcome.
3.	Block level	Implementation of the communication plan in GPs using motivators such as panchayat secretary, ASHA, Anganwadi workers, generation of demands through mass awareness and community participation, revitalising VWSCs in GPs, striving to achieve and sustain ODF status for GPs and monthly review of the outcome.
4.	Village level	Awareness generation to create demands for toilets, activating VWSCs, involving schools and women self help groups to mobilise children and women for hygiene promotion, promoting IPC(within family, in the neighbourhood across communities), soliciting social support against OD and trying to bring a sustainable sanitation behaviour change.

Table7. The IEC framework of UP

Note: Though not in the IEC framework yet, UP being a large and highly populated state, a Division level³³ may be added to guide, supervise and monitor the sanitation campaign between the state and the district levels.

The IEC framework goes on giving details of activities under HRD, capacity building, IPC, community participation, awareness generation campaigns and evaluation. It also prescribes financial limits for different activities under IEC. 80% of the total IEC budget (which is 15% of the total outlay) is earmarked for the *software* and only 15% of it is allowed to be spent on the *hardware* of IEC. The remaining 5% is to be spent on monitoring and evaluation. The *hardware* here refers to the materials, articles such as hoardings, wall writings/paintings, kits, publications, sanity kits for schools (soap, nail-cutter, towels, bucket-mug) etc. while *software* refers to advocacy, mass mobilisation through IPC, community and group meetings, orientation workshops, training of resource persons, incentives to motivators, publicity campaigns, capacity building of GPs in general and VWSC in particular etc. The Department of Panchayat Raj, UP has divided IEC activities mainly in two categories. One, *mass communication*, which includes the use of slogan writings, wall paintings, group discussions, folk media, fair/exhibition, rallies, essay writing/debate etc. to promote mass awareness in the society. Two, *IPC*, which includes person to person, group to group (children, adolescents, women and elders) and intercommunity interactions, and strengthening of GP's institutional mechanism (identifying and training motivators in the village, capacity building of VWSC, making GP specific IEC plan etc.) to promote hygiene and sanitation behaviour and focus of sustained behaviour change. In this light, it is interesting to look at the IEC activities done in the selected districts³⁴ of UP to have an idea about how UP goes on implementing the IEC policy frame.

Name of the District	IEC activities undertaken in last three years			Outcome in terms of NGP
	2010-11	2011-12	2012-13 ³⁵	
Mirzapur ³⁶	Training of	Orientation	Intensive IEC	60 out of the total

³³ There are 75 districts and 18 Divisions in UP. Divisions are intermediary institutions, headed by a senior administrative officer, between the districts and the state. A Division normally supervises over 3 to 4 districts. This level can give a boost to the hygiene promotion activities, if used properly.

³⁴ I have chosen Lucknow, Mirzapur, Sonbhadra and Chandauli as sample districts. Lucknow is the capital of UP. It is supposed to be the model district for IEC intervention. Logistically, it is the most ideal district for an effective sanitation campaign supervised by the senior most officers, consultants and facilitators. It has plenty of resources- both human and material. Hence it can be said to be a district with favourable conditions for rural sanitation. Rest all are remote from the capital city, inaccessible, have poor infrastructure, lack resources and inhabit mostly poor and vulnerable population, i.e. SC/ST and other socially and economically backward castes.

³⁵ The figures in this column refer to the expenditure incurred on IEC between April 2012 to October 2012. The IEC activities are banned in UP by an order of the Director Panchayat, UP, since October, 2012 (following some complaints of corruption and deviation from standards) and a committee was set up to standardize the IEC activities. I have come to know that the committee has sent its recommendation to the government to lift the ban almost two months back but no decision has yet been taken on it.

³⁶ Mirzapur has done good work on IEC and the results are self evident. This district is better placed in terms of infrastructures, resources and land fertility, raising the income of common man, though some areas, having sizeable SC/ST population, face acute poverty and unemployment. Apart from gaining distinction amidst vulnerable areas districts by 60 NGPs, it now aims at achieving NGP status for another 131 GPs and a block-*Seekhad* by 2014. It would, perhaps, not be out of place to mention that I have got the opportunity to spearhead, guide and supervise the TSC in Mirzapur as its Collector/District Magistrate during 2007-08, which was the period when TSC started gaining grounds in Seekhar, Narayanpur, Chhanbe and Rajgarh blocks.

	masons, health workers, GP members and sanitation and hygiene motivators at a large scale, news paper ads etc.	workshop for all the Gram Pradhans, GPA/GVA, BDOs and concerned district officials. A sanitation festival in all the GPs and schools to promote hygiene awareness. News paper ads, wall writings, use of folk media in selected villages etc.	activities (meetings with panchayat officials/ groups, film show, wall paintings etc.) in proposed 131 Nirmal Grams (clean villages), IEC activities covering all 34 GPs of proposed ODF block- <i>Seekhad</i> , training of GP members, masons, Anganwadi workers and teachers, organisation of hygiene clubs in schools and other promotional activities for toilet maintenance and usage in villages.	758 GPs
Sonbhadra	Training of Angawadi workers and little awareness generation through news paper advertisements, hoardings, banners and folk media.	News paper advertisements and Gram Pradhans' orientation workshop.	News paper advertisements, Gram Pradhans' orientation workshop, training of masons and organisation of sanitation fair.	07 out of the total 201 GPs
Chandauli	News paper ads and some hand bills printed.	Some <i>hardware</i> was supplied to blocks, hand bills printed and some loose money was given to block officials for unspecified IEC works.	News paper ads and some hand bills printed.	02 out of the total 620 GPs.
Lucknow	Very little or no IEC activities.	Training of masons, school teachers and other persons involved in the campaign.	An awareness programme at the district level and in few GPs and schools.	09 out of the total 498 GPs.

Table 8. IEC activities in the sample districts³⁷

The table above shows the relationship between IEC activities and the outcome in rural sanitation. *Mirzapur*, despite sharing all the characteristics of a vulnerable district with *Sonbhadra* and *Chandauli*, stands out with promising performance

³⁷ The description of IEC activities in these districts are based on the data made available by the concerned district officials and the Directorate of Panchayat, UP. This may lack accuracy.

emanating from a sensible work on the IEC front. It has, in the last 6-7 years, - tried to involve all the stakeholders, especially local, in the campaign, to build capacity and generate awareness at the grass-root level. Although, a lot more needs to be done yet Mr Vinod Kumar, the District Project Coordinator (DPC), Mirzapur says that *the toilet usage in Seekhad block and the other selected 131GPs are above 90%. He adds that out of 60NGPs, almost 80% have sustained toilet usage, due to good IEC and one witnesses a positive change in social behaviour towards sanitation and personal hygiene in these GPs.* This is not so in the context of other two vulnerable districts and Lucknow. The case of Lucknow is a peculiar example underlining the pivotal role of IEC. Despite keeping privileged position of a capital city district, abundance of funds, close supervision, media monitoring and standby consultancy from UNICEF like agencies, it gives a very poor show on the sanitation index. The grass-root level work is missing in all these districts, leading to less or no community participation and a discernible apathy towards the administration-led sanitation campaign. The village-specific discussions next, will make this argument much clearer.

Reaching the Poor and Vulnerable

I personally visited 8villages in total,-2 each from the 4sample districts mentioned above in this chapter and used official data for other 2 villages from Sonbhadra to substantiate my findings. I have tried to find out villages- in both favourable and unfavourable conditions, with largely vulnerable population, performing differently in sanitation. The villages of Mirzapur(Mzp) and Sonbhadra(Son) fall in vulnerable category, facing multifarious inabilities while villages of Chandauli(Chan) and Lucknow(Lko) are endowed with favourable conditions for an effective sanitation campaign. However, the field realities rebut hypothetical predictions. The following table presents the conclusion of the field work done in UP-

Criteria of selection	Name of villages	% of toilet coverage/usage (approx.)	Successful	Unsuccessful
Unfavourable conditions	1-Sukrit(Son) 2-Takiya(Son) 3-Kaneti(Son) 4-Akchhor(Son) 5-Khaira(Mzp) 6-Pasiyahi(Mzp)	25/20 80/15 50/70 30/25 40/90 30/85	1-Kaneti 2-Khaira 3-Pasiyahi	1-Sukrit 2-Takiya 3Akchhor
Favourable conditions	1-Shahpur Majh. (Lko) 2-Dalauna(Lko) 3-Jalilpur(Chan) 4-Ledua(Chan)	15/10 95/05 100/99 30/25	1.Jalilpur	1- Shahpur Majh. 2- Dalauna 3-Ledua

Table9. Application of methodology to sample villages

I will, first discuss the outcome from my visits to the villages with ***unfavourable conditions***. All these six villages (4from Son and 2from Mzp) belong to the vulnerable regions of UP. Geographically they are hard to reach- far distant from the state capital and hours' drive away from the city of Varanasi- the religious and cultural centre of Eastern UP. Socio-economic fabric of these villages is very weak as 50to90% of the population is SC/ST and OBCs. They are mainly daily wagers working in quarries, farms, construction sector or as part-time workers in *sari* and

carpet weaving industries in Mirzapur and Varanasi. Out of these 6 villages, 3 have failed even to achieve adequate sanitation coverage while 3, i.e. Kaneti, Khaira and Pasiyahi show promising results in sustained toilet usages. Kaneti and Akchhor, both are selected as Lohia grams for total development but the later shows little progress, having poor toilet coverage and usage.

The next category belongs to the *favourable conditions* villages. The villages of Lucknow district are highly privileged with most favourable conditions for an ideal sanitation scenario but both of them fail showing acute apathy towards the need for sanitation and personal hygiene. In Shahpur Majhigawan, an educated (intermediate), Scheduled Caste man, *Brijkishor* took lead in mobilising rural community for toilet construction with the help of local panchayat officials, attaining marginal success in breaking the customary jinx on using toilets while Dalauna, which was once saturated with toilets in 2010-11, now has all but a few dysfunctional toilets. The usage is less than 5%. Gram Pradhan himself never felt the need for a toilet in his house. AWW told me that all men and women go for OD. She was a local. She said in a dejected tone that *'she never heard of anyone including officials talking about toilets.'* She had a toilet at home. The women have no say in the decision making in the family or other village institutions. The villages in Chandauli district are situated in the vicinity of the city of Varanasi. They share both the benefits and hazards of urban life yet Jalilpur, an NGP in the year 2006-07, poses a sanitation model for the area while Ledua lags far behind. The administration endeavours equally to give a boost to the sanitation campaign in all the villages but the community at large stay unmotivated and totally disinterested in the administration-led campaign. I found Jalilpur to be a special case during my visit to this area. Former Gram Pradhan, Shri Prakash (a graduate and now the husband of present Pradhan) was, to my surprise, well versed with the current sanitation discourses, highly motivated, respected in the village community and able to motivate others by his personal conduct and social behaviour. He was also on some short exposure visit to Bangladesh to learn from its sanitation campaign a few years back. I had a look at the list of gram panchayat members and the VWSC members. All the members, except two, were educated. The VWSC members (including women) knew their job and discussed with me the issues related to OD and personal hygiene. They all appreciated the role of Shri Prakash in making Jalilpur a model village while Mr Prakash being humble enough to give all credit to the VWSC members, school principal and other community members. The local school and AWC sensitized children in many ways to promote hygienic living. The village started a new practice of collecting water and sanitation tax from village families for managing solid/liquid waste and ensuring regular and safe drinking water supply. Shri Prakash is competent enough to be utilized as a block or district resource person by the local administration.

The success of Jalilpur becomes important when compared to the situation of Ledua which is just in the neighbourhood. The Gram Pradhan, Mr Gufran Siddiqi says that despite all his efforts *the members of other community (non-Muslim) are not ready to contribute for toilet buildings and resort to OD. He adds that the Muslim families all have toilets made by own resources and don't practice OD. Muslim ladies, due to purdah (veil- religious custom), prefer to observe privacy.* This also exhibits the caste/community dimension of the local leadership and active community participation in social campaigns.

As we have seen that the IEC has, practically no or little strategic role to play in demand generation, sustained toilet usage and hygiene promotion as far as this part of UP is concerned. The DOPR and all the districts have an IEC framework on paper which is hardly translated into practice in the field. There are no logical linkages of IEC to demand and supply chain. Sanitation is not a political priority, which is evident from the year long ban on IEC expenditure by the government. The special committee,- to investigate into stray complaints about the misuse of IEC fund,- has already recommended the lifting of the ban. The decision, however, is pending for the last few months.

Whatever little IEC work has been done in these villages was generally in the form of *hardware*. The local actors are not aware of their roles in the campaign. The village officials- ASHA, GPA, AWW, teachers, safai karmchari etc. lack capacity building in order to solicit community support for their activities. They have little motivation to work on their own. The village panchayat committees, such as VWSC, are almost universally defunct. IPC and ICC are there on strategy papers but absent in the field. There is no mechanism of convening regular open meetings of *Gram Sabha*(the general body of village panchayat), keeping records of preferences and problems and ensuring community-decision making. TSC/NBA kept on saying that it is a ‘demand-driven’ campaign but in practice demands are ascertained by the availability of funds for a village (which is often delayed or constrained due to various reasons) while the supply mechanism does not ascribe any roles to the villagers except Gram Pradhan, who is legally required to sign the bills of payments. Vinod Kumar and Anil Kesari, both DPC in Mirzapur and Sonbhadra, respectively, say with full conviction that *whatever little they have achieved in terms of toilet coverage and sustained usage, was due to administrative intervention reaching local people, listening their problems and involving them to complement official efforts and initiatives in toilet building and using them.*

Looking, Listening and Learning

I chose 10villages- 8from the most backward/vulnerable areas of UP and 2from the centrally located, much supervised district of Lucknow-to substantiate my findings. The villages were selected keeping in mind the proportion of poor, deprived and vulnerable, i.e.SC/ST, OBC and minority, in the overall population. I had the opportunity to compare the bad to the worst. The official data when tested in the field gives real setback. When we talk of NGP, we only mean that these villages have almost 100% toilet coverage as per official records. We don’t mean toilets are technically perfect or provide ‘improved sanitation’ facilities. We don’t mean that all the members of the village community or family use them. We don’t mean that the coverage was due to community demand and the toilets will remain in use for years to come. We also don’t mean that village communities are observing required personal hygiene. Moreover, we never mean that these villages have good community sanitary complexes or satisfactory waste disposal mechanism. The dividing line between a successful and unsuccessful village here, has been the usage of toilets for defecation and the awareness of the people toward the need for toilets.

The people in these areas are very poor having little awareness of the impacts of poor hygiene on child and maternal health. They only think of hunger, thirst, food, water, employment, money and free gifts (house, land, ration cards, hand pumps, pension,

scholarships etc.) from the government. When you talk of toilets, they talk of subsidies. The poor always crib of bias by Gram Pradhan and panchayat officials against them in building toilets or asking extra money for it. When I talk of listening to the villagers, I only normally mean the male members of the village community. Women Gram Pradhans (including Jalilpur) are invariably represented by their husbands, sons or any other male family member. Children are not engaged in an effective way as the agents of behavior change in the households and society. I asked the children in the primary school of Shahpur Majhigawan whether they have toilets in their homes and use them. To my surprise, only 5 out of 50 raised their hands in affirmation while the official data projects this village to be very good in sanitation. Although toilets are being made in good numbers yet the majority of male members of the family and children normally go out in open to ease themselves. I interacted with one of the woman VWSC members both in Shahpur Majhigawan and Dalauna, - they were totally unaware of their roles in the committee.

The field visits and active interactions with different sections of the community made me learn that funds are not an issue, the toilet buildings are being provided, the officials are trying hard to plan the campaign and spend money in time. *The missing link, to me, however, has been the absence of local mechanism to identify, inform, educate and engage local agents of behavior change in the village community.* The cases of Jalilpur, Khaira, and Kaneti prove it. Pasiyahi was a marginal case of success as villagers were still not actively involved in the campaign, although it had comparatively better toilet usage. However, one should not misunderstand the emphasis on IEC, for an argument overrating its role in fighting all adversaries in effective community participation in the sanitation campaign. This, of course needs a lot of other things but *IEC is the thread which binds all the other factors such as demand, supply, finance, enabling atmosphere and actors such as government, private, NGOs, experts, media, community leaders, women, children etc. together to make the entire exercise yield required results locally.* The cases above show that the absence of effective IEC does not only fail efforts of social mobilization for the campaign but also generates a dependency syndrome in the communities.

In the course of my investigation of sanitation scenario in UP and the reasons behind its utter failure, I interacted with a lot of experts-both in and out the official circles-having considerable experience in the sector. It would be interesting to know their minds in this regards, especially on the role and importance of the IEC in participatory rural sanitation. The Director Panchayat Raj, *Saurabh Babu* raised many issues related to governance, technology and lack of demand from community. He finds the huge number of GPs difficult to monitor. He approves the CLTS model but keeps silence on its failure in UP. He agrees that the department uses old forms of IEC and blames GPs' poor-functioning for the failure of this campaign. *Vakil Ahmed*, the state coordinator of the sanitation campaign and a UNICEF consultant with the DOPR, says that sanitation is not a priority for people or the government. The department is not able to spend the money on IEC. He agrees that UP lags far behind in HRD while mentioning Mirzapur among a few others doing good work in rural sanitation. *Girish Chandra Rajak*, the Additional Director Panchayat, entrusted with the task of monitoring rural sanitation campaign, finds the absence of effective VWSC and the traditional form of IEC to be the main problems. Mr. Rajak has worked in almost ten districts of UP as DPRO looking after the work of TSC. *Amit Mehrotra*, an expert in the water and sanitation sector with an experience of 20 years,

presently in charge of UNICEF state office in UP, made a very interesting remark, *“Given the huge amount of IEC budget, i.e. Rs.3.69billion, for the NBA plan period (2012-22), the state has Rs.0.15million/per hour and a district, Rs.0.20million/per day to spend on IEC but nothing is being done.”* He complains that UP has no state level monitoring institution dedicated to rural sanitation, not even a single full time officer in the Panchayat Raj department. UP could not provide even block-level coordinators leave aside the village level motivators. IEC in UP to him is *“hardware with vested interests.”* When asked about the remedy to poor sanitation scenario in UP, he suggests *‘a policy change to have greater involvement of private actors as sanitation is a social commodity nowadays.’*

The above deliberations underline the significance of the IEC intervention in rural sanitation and the need for an effective mechanism to go for that in case of UP. Moreover, Nainital Statement³⁸ also focused on an all round campaign for collective behavior change in the communities, habitation-centric approach for awareness generation and triggering, role of women’s agency in ODF movement, increase in the IEC budget for hygiene promotion and capacity building among other recommendations.

³⁸ The Nainital Statement is the outcome of the recent National Workshop on Community-led approach in the context of NBA, held in April, 2013 in Nainital, Uttarakhand, India. The statement is based on learning from the TSC and suggests a policy frame for NBA to achieve its objectives by 2022. I obtained it from Dr Robert Chambers, a key participant.

Chapter 5

Conclusions: Making Sense on Sanitation

Bridging the Gap and Informing the Policy

This chapter aims at finding answers to my research questions after the analyses of the role of IEC in the rural sanitation campaigns in UP and Bangladesh and bridging the gaps in policy formulation and implementation to make the IEC intervention more effective. *The first question was how and to what extent can the IEC, contribute to achieve participatory rural sanitation in UP?* This implied a number of sub-questions regarding the basic ingredients of an effective IEC system in UP, the field experiences of IEC and its role in creating and sustaining demand for sanitation services and the much needed behaviour change in the rural communities. The field visits in UP suggest (Table9) that villages with effective IEC intervention showed better results in toilet usage (Khaira, Pasiyahi and Jalalpur) while poor performing villages had no or very weak IEC mechanism. One can say that local leadership, administrative priority and proximity to urban centres contributed to this achievement but IEC has been crucial to all this. Jalalpur had been the best of all in community participation- the children, women and elders had a role-, while others relied more on official initiatives and target-driven approach. I have earlier discussed the basic content and form of the IEC tool in UP, where there are very few takers for the *software* and the IEC largely meant *'hardware with vested interests.'* The system of IEC in UP, however, needs a lot of revamping and revitalisation. Despite having sound policy prescription draft on IEC, the state is unable to translate it into practice due to, perhaps, the absence of a local mechanism which involves village communities-rich-poor, men-women, upper castes-lower castes, children-elders, educated-uneducated etc. in this campaign. GP is the bedrock of this local mechanism. The VWSC, schools, AWC, SHGs, various religious, cultural and social institutions offer the set up for women, children, elders and the natural community leaders to act as agents of change in local settings when trained, facilitated and guided from the outside. The whole range of the grass-root actors in UP such as- Gram Pradhan, GPA, ASHA, teachers/education friend, swachchhata doot etc. fail to mobilise active community participation in the absence of an effective IEC system which emanates from the local institutions and operates across communities. Instead of a standardized IEC framework, UP needs a flexible IEC system with key roles to local languages, idioms and communication techniques to address socio-cultural norms and practices through interpersonal and intercommunity forum.

The second part of questions belonged to Bangladesh. I sought answers to the nature of IEC, its role in rural sanitation and the lessons to learn in order to bridge the existing information asymmetry in the vulnerable areas of UP. Bangladesh has attained phenomenal success in rural sanitation campaign and the enquiry into the secrets behind it (chapter3) reveals an instrumental role of IEC, both on the part of government and other actors, for community mobilisation and the sustained behaviour change. Although it is difficult to say that the success of Bangladesh rests only on effective IEC interventions- as scholars and activists mention political will, the historic role of CLTS and BRAC and the constant concern of donors etc. to be the factors- yet none denies the centrality of IEC in awareness generation, hygiene promotion and capacity building of different actors in rural areas. I cannot be sure

about the vulnerable areas and populace being benefitted equally throughout the country but scrutiny of the equity aspect (Graph2) suggests far wider coverage of poor by sanitary services in Bangladesh than India (Graph1). Bangladesh relies more on IPC-ICC and outcome based spending while UP targets at spending the budget and creating the hardware. Bangladesh was much ahead in the race against OD compared to India in 1990 (Table5) but the pace at which it created services and ensured equity in its distribution since then, despite being much poorer, makes it exemplary for UP/India. The community-centric approach of BRAC shows a way to be effective with reduced costs in scaling up the sanitation campaign. It has created a trained army of local workers dedicated to the concerns of health, basic education, sanitation-hygiene, self-help and vocation. Upazilas have been assigned specific roles in sanitation campaign with enhanced budget on IEC while in UP/India sub-divisional level governance has no role in it. GOB has been constantly committed to an all round crusade against OD. *The utmost political will, comprehensive alliance building for social mobilisation, role of women's agency and a grass-root oriented approach of collective behaviour change brought all the difference in the rural sanitation campaign in Bangladesh.*

The relative success stories from the most vulnerable areas of UP tell that local actors-Gram Pradhan, VWSC, teachers, village officials, women and children do have a central role in making rural sanitation campaign a success. The lack of an effective IEC intervention seems to be a key hurdle. The poverty, illiteracy, poor-infrastructure, the caste-community and gender issues, when coupled with political and administrative apathy, create complex problems for an active community participation in social campaigns including rural sanitation. All this constitute an issue of political economy but IEC can be an effective tool, if planned and implemented well, to bring about behavioural change in the targeted audience in specific sectors. Bangladesh did it well while UP seems to be at the primary stage.

If we have to draw some policy lessons from Bangladesh we can say that UP, first needs a trained, dedicated force of locally available agents of change, i.e. natural leaders, second, the use of local institutions such as school, AWC, VWSC, SHGs and other panchayat forums as harbingers of hygiene promotion and third, enabling women and children, especially, to act as frontline army for community mobilization. This local mechanism has to be facilitated by a district and state level dedicated forum for rural sanitation with a focus on software (IPC-ICC, horizontal and vertical learning etc.) of the IEC. UP once tried to identify and train two local natural leaders per GP for participatory sanitation in lieu of some monetary incentives but soon the department found it to be a wasteful expenditure and stopped paying them for their services. UP has sufficient budget for rural sanitation but what it needs,-is the political will, a well laid down and an enabled bottom-up mechanism to go for an emphatic IEC intervention to succeed in the area of rural sanitation.

Knowing my limits

This research paper is constrained on following grounds-

1. The issues of IEC, vulnerability, equity, community participation and public policy are highly contested and need more extensive and intensive literature review than has been possible for me, given the short time frame.

2. The academic atmosphere at the ISS, The Hague, gave space and time to read and write but I had to return to India after the month of August and to full professional duties. I completed the major part of my research paper after that amidst other personal and professional engagements. This affected my accessibility to quality research material and close consultation with my supervisor.
3. Limited personal experience in the field of sanitation is another limitation. Although, I had long indirect connection to the topic, supervising rural sanitation campaign in UP as field administrator yet I am not a sanitation specialist.
4. Being an active administrator, might have brought a bureaucratic bias to my research. I might have missed the real peoples' perspective.
5. Reliance on the secondary data might have compromised the quality of research, especially regarding the facts related to Bangladesh.

Need for Further Research

Rural sanitation has been and will remain a top-most concern till the world achieves MDGs. Even afterward, the urge for environmental sustainability will remain basic to human civilization and sanitation will be an essential part of dignified social life. The public and private initiatives need to find an answer to the miseries of individual and social lives. Thus, we need further researches, wider inquiries and deeper scrutiny in the area of rural sanitation in general and in the role of IEC/BCC for engaging communities to the campaign, in particular. The case of Bangladesh also needs further investigations and empirical analyses, especially in the context of vulnerable areas and population and the role of IEC therein. Despite all this, I hope that this study will assist the whole range of researchers, policy makers, administrators and activists to understand the achievements of Bangladesh more clearly and address the issue of rural sanitation in UP more sensibly.

2013-11-25
21 Gulistan Colony,
Lucknow, UP
India-226001

References:

1. Abraham, R.A. and K.S.K. Kumar (2008) 'Multidimensional Poverty and Vulnerability', *Economic and Political Weekly* 43(20): 77, 79-87.
2. Adger, W.N. (2006) 'Vulnerability', *Global Environmental Change* 16(3): 268-281.
3. Ahmed, Rokeya: Achieving 100% Sanitation: Water Aid Bangladesh and VERC approach, Presented in a regional workshop organized by WSSCC in March 2006 on "Women & Sanitation" at Rajiv Gandhi Foundation, New Delhi, India. Ahmad R (2005) "Shifting Millions from Open defecation to Hygienic Practices" Water Aid report prepared for the ADB, dated 15 August 2005.
4. Ahmed, S. (2001). Empowering Rural Women? Policies, Institutions, and Gendered Outcomes in Natural Resources Management. *Development in Practice*, 11(4).
5. Ajith Kumar et al, WSP: A Decade of the Total Sanitation Campaign: Rapid Assessment of Processes and Outcomes, Vol.1, 2010.
6. Barkat, A, Sabina, N (2006). Barriers in poor people's access to public health facilities in Bangladesh. Dhaka: ActionAid, Bangladesh.
7. BRAC; WASH Programme of BRAC: Towards Attaining the MDG Targets: Baseline Findings, 2005, BRAC/RED, Dhaka, Bangladesh.
8. Chambers, R (2004); *Ideas for development: reflecting forwards*, IDS at University of Sussex, Brighton, UK.
9. Chambers, R (2007); *Overview: Immersions: something is happening, participatory learning and action* 57 December 2007 Pp-9-14.
10. Chambers, R (2007); *Who Counts? The Quiet Revolution of Participation and Numbers*, -Brighton: IDS.
11. Chambers, R (July 2009); *Beyond Subsidies – Triggering a Revolution in Rural Sanitation*, In Focus, Policy Briefing, Issue10, IDS at University of Sussex, Brighton, UK.
12. Chambers, R (2009) *Going to Scale with Community-Led Total Sanitation: Reflections on Experience, Issues and Ways Forward*, - IDS Practice Paper, Brighton:-IDS.
13. Chambers, R, (2011); *Reflections on India's enormous sanitation challenges and some opportunities*, IDS website,

14. Chambers, Robert (2011) CAMPAIGNS FOR TOTAL SANITATION WITH CLTS: A checklist of 65 practical actions. (Available on R. Chambers' archives).
15. Chambers, R and Medeazza (June 2013); (Economic and Political Weekly, Sanitation and Stunting in India: Undernutrition's Blind Spot.
16. CLTS foundation: Workshop Report on 'Sustainability of Rural Sanitation Initiatives in India' December 8- 11, 2012, Ranchi, Jharkhand, India.
17. Colebatch, Hal, Policy (3rd edition, 2009), Open University Press. Ch. 2 (What's The Idea?); Ch.3 (What's Going On?), pp.7-45.
18. Department of Drinking Water Supply, Ministry of Rural Development, GOI: Guidelines on Central Rural Sanitation Programme Total Sanitation Campaign, 2004.
19. Dreze, J. & Sen, A. India: Participation and Development: Oxford University Press: 2002.
20. Dishari Project(2006), Annual Progress Report. Dhaka: Dhaka Ahsania Mission.
21. Dishari Project(2007), Annual Progress Report. Dhaka: Dhaka Ahsania Mission
22. Dishari Project(2007a), Periodic monitoring and evaluation report on the role of local government in promoting total sanitation. Dhaka: Dhaka Ahsania Mission
23. Dyalchand, A. et al (2009); What Communication and Institutional Arrangements Influence Sanitation Related Social Norms in Rural India? As available on internet dated 2August 2013.
http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/CLTS_Soc.
24. Dyalchand A., Kapadia-Kundu, N. & Khale, M. : "Promoting Hygiene & Sanitation Behaviours: A Manual for Programme Planning in Rural India", 2001, Institute of Health Management, Pachod, Maharashtra, India.
25. Fatema, K. (2006). Implementation manual for local government institution led total sanitation and hygiene promotion. Dhaka: NGO Forum for Drinking Water Supply and Sanitation
26. Gasper, D.; 2004, The Ethics of Development; *From Economism To Human Development*, pp. 84-112, Edinburg University Press.
27. Government of Bangladesh. (2005). National Sanitation Strategy 2005. Dhaka: Government of Bangladesh. As accessed on 1stAugust13
http://www.dphe.gov.bd/pdf/MR11_SanitationStrategy.pdf.
28. Government of India (2012): Census of India 2011. Houses, Household Amenities and Assets. Government of India.
29. Grown, C., G.R. Gupta and R. Pande (2005) 'Taking Action to Improve Women's Health through Gender Equality and Women's Empowerment', *The Lancet* 365(9458): 541-543.
30. Gutierrez, Lorraine M.;(Mar 1990),Working with Women of Color: An Empowerment Perspective Social Work; 35, 2; Research Library, p. 149
31. Hanchett et al., Long-Term Sustainability of Improved Sanitation in Rural Bangladesh: June 2011, WSP.

32. Horizontal Learning Programme (HLP) Brochure: <http://www.horizontallearning.net/Files/Brochure.pdf> entered on dated 31-05-13.
33. Jena, R.A., PEO (PC) GOI: Evaluation Study on Total Sanitation Campaign; 2013
34. Kabeer, Naila, (1994); *Reversed Realities: Gender Hierarchies in Development Thought*. Verso.
35. Kabeer, N. (1999) 'Resources, Agency, Achievements: Reflections on the Measurement of Women's Empowerment', *Development and Change* 30(3): 435-464.
36. Kabeer, N. (2010) 'Women's Empowerment, Development Interventions and the Management of Information Flows', *IDS bulletin / Institute of Development Studies* 41(6): 105; 105-113.
37. Kapadia-Kundu N, Dyalchand A, (2008): Understanding Behavioural Pathways to Health with *Sadharanikaran*, An Ancient Indian Theory of Communication (in print).
38. Kapur Mehta, A. and A. Shah (2003) 'Chronic Poverty in India: Incidence, Causes and Policies', *World Development* 31(3): 491-511.
39. Krishnan, S. (2012) 'Vulnerability in Disasters', *OPTICON* 1826 (14).
40. Kumar, R., S. Kumar and A. Mitra (2009) 'Social and Economic Inequalities: Contemporary Significance of Caste in India', *Economic and Political Weekly* 44(50): 55-63.
41. Kullmann, Craig, Developing a Sanitation Behavior Change Framework: SaniFOAM: Workshop Report, February 21-22, 2008, Durban, South Africa. Pp. 1-21.
42. Kar, Kamal(2010): Facilitating “Hands-On” Training Workshops For Community- Led Total Sanitation: A Trainers’ Training Guide, CLTS Foundation.
43. Kar, Kamal with Chambers, Robert (2008) *Handbook on Community-Led Total Sanitation*, London: Plan international (UK)
44. Kar, Kamal and Pasteur, Katherine (2005) *Subsidy or self-respect? Community-led total sanitation. An update on recent developments*, IDS Working Paper 257, Brighton: IDS.
45. Lennon, S., 2011. *Fear and anger: perceptions of risks related to sexual violence against women linked to water and sanitation in Delhi, India. (Briefing Note)* London: SHARE-Sanitation and Hygiene Applied Research for Equity and Water Aid Available at: http://r4d.dfid.gov.uk/PDF/Outputs/sanitation/VAW_India.pdf, Accessed 05 July 2013.
46. Lindblom, C., and E. Woodhouse, 1993. *The Policy-making Process*. Englewood Cliffs, NJ: Prentice Hall.
47. Mahon, T and Fernandez, M., *Menstrual hygiene in South Asia: a neglected issue for WASH (water, sanitation and hygiene) programmes*, *Gender & Development*, 18(1) pp. 99–113; 2010.

48. Meher, R.: 'Livelihood, Poverty and Morbidity: A Study on Health and Socio-Economic Status of the Tribal Population in Orissa', *Journal of Health Management* 9(3)2007: 343-367.
49. Mohiuddin, H., & Ali, M. A. (2005). Total sanitation: a community stake. Dhaka: NGO Forum for drinking water supply and sanitation.
50. Ministry of Drinking Water and Sanitation GOI: Report of the Working Group on Rural Domestic Water and Sanitation: September 2011.
51. Ministry of Drinking Water and Sanitation, GOI: Nirmal Bharat Abhiyan Guidelines, 2012.
52. MDWS, GOI with UNICEF; National Sanitation and Hygiene Advocacy and Communication Strategy Framework for 2012-2017.
53. Perez, Eduardo with Jason Cardosi et al, 'What Does It Take to Scale Up Rural Sanitation?' 2012, WSP.
54. Perkins, D.D. & Zimmerman, M.A. (1995). Empowerment Theory, Research, and Application. *American Journal of Community Psychology*, 23(5), 569-579.
55. Policy and Sector Reform to Accelerate Access to Improved Rural Sanitation by Fred Rosensweig, Eddy Perez, Andy Robinson, June 2012, WSP.
56. Rahman, M; 2009, 'Sanitation Sector Gap and Gap Analysis: Bangladesh' Global Sanitation Fund. WSSCC. Accessed on Google Scholar on 17.09.2013.
57. Reddy, Suresh B. and Snehalatha M.: Sanitation and Personal Hygiene: What Does It Mean to Poor and Vulnerable Women? *Indian Journal of Gender Studies* 2011 18: 38.
58. Rao, K. (2010) 'Diet and Nutritional Status of Women in India', *Journal of human ecology (Delhi)* 29(3): 165-170.
59. Robinson, R. (2008) 'Religion, Socio-Economic Backwardness & Discrimination: The Case of Indian Muslims', *Indian Journal of Industrial Relations* 44(2): 194-200.
60. Robinson, Andrew James: *Scaling Up Rural Sanitation in South Asia: 2005*, WSP.
61. Rowlands, J. (1996). Empowerment Examined. In D. Eade (Eds.), *Development and Social Diversity* (pp. 86-92). Oxfam: Oxford.
62. Saxena, N.C. (2005) 'Bridging Research and Policy in India', *Journal of International Development* 17(6): 737-746.
63. Singh, Rajiv Kumar and Ziauddin; Manual Scavenging as Social Exclusion: A Case Study; *Economic and Political Weekly* , Vol. 44, No. 26/27 (Jun. 27 - Jul. 10, 2009), pp. 521-523.
64. Smillie, Ian: *Freedom From Want: A History of BRAC*, Kumarian Press, 2009.
65. Spears, Dean: *Policy Lessons from Implementing India's Total Sanitation Campaign*, Princeton University. India Policy Forum 2012.
66. Spears, Dean (2012b): 'Effects of Rural Sanitation on Infant Mortality and Childhood Stunting: Evidence from India's Total Sanitation Campaign', Rice Working Paper, 3 July 2012.
67. Tripathy, Tulika; 'Safai Karmi Scheme of Uttar Pradesh: Caste Dominance Continues'(Sep, 2012), *Economic and political weekly*.

68. Tyagi, A., Economics of Sanitation Initiative (ESI) report on India, WSP, 2011.
69. UNICEF: A Sanitation Handbook, 1997.
70. UNICEF: Water, Sanitation and Hygiene: Annual Report 2010.
71. UNICEF: COMMUNITY APPROACHES to TOTAL SANITATION: Based on case studies from India, Nepal, Sierra Leone, Zambia Field Notes: (2009) UNICEF Policy and Programming in Practice, UNICEF, New York.
72. UNICEF, Sanitation in Uttar Pradesh; 2013, published by UNICEF office at Lucknow, UP.
73. Verhagen,Joep; 'Making sense of sanitation monitoring in Bangladesh' as available on <http://www.source.irc.nl/page/76836> dated July 8, 2013.
74. Verhagen,Joep; Interview taken by Hari Om on 23August,2013 at IRC, The Hague, Netherlands.
75. Wood,G., 2009. Situating Informal Welfare within Imperfect Wellbeing Regimes. *In: Conference on Politics of Non-State Welfare*, 2009-05-08 - 2009-05-09, Cambridge, MA.
76. WSP Lessons Learned from Bangladesh, India, and Pakistan: Scaling-Up Rural Sanitation in South Asia. report on South Asia published in May 2005.
77. WSP: Rural Sanitation in Bangladesh: Progress and Challenges, (2006)
78. WSP: Training of Trainers' Manual on Community-driven Total Sanitation: Module 1: Guidance Notes, 2007.
79. WSP: One Fly Is Deadlier Than 100Tigers: Total Sanitation As a Business And Community Action In Bangladesh And Elsewhere by Urs Heierly And Jaime Frias with inputs from Soma Ghosh Moulik and Shafiul Azad Ahmed, 2007. SDC-WSP-WSSCC.
80. WSP: Benchmarking Local Government Performance on Rural Sanitation: Learning from Himachal Pradesh, India, 2010.
81. WSP: Economic Impacts of Inadequate Sanitation in India (Washington DC: Water and Sanitation Programme, WB), 2011.
82. WSP: From Dreams to Reality: Compendium of Best Practices in Rural Sanitation in India: 2012.
83. WSP: Long Term Sustainability of Improved Sanitation in Rural Bangladesh; 2012 available on www.wsp.org/scalingupsanitation accessed on 31July2013.
84. Wuyts, M., Mackintosh, M., Hewitt, T., eds., 1992. Development Policy and Public Action, Oxford University Press. Introduction; Ch.3: Questioning the State, Ch.11: Development Policy as Process.
85. Zaidi, S. Akbar (1988) 'Poverty and Disease: Need for Structural Change', *Social science & medicine* 27(2): 119-127.

