WASH News and Policy Update

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SACOSAN SPECIAL ISSUE

WASH News and Policy Update is a bi-monthly e newsletter of the India WASH Forum. It is an open platform for engagement on contemporary issues, for an independent credible voice in the water, sanitation and hygiene sector. We are conscious of the need to engage with and understand other larger debates in the social and economic development scenario, of which drinking water and sanitation is a part. Hence we include in our news analysis and policy updates, events and developments from WASH and other related development fields. We welcome articles and reports from readers, to make this a learning and advocacy platform. India WASH Forum reports and documents are hosted on the India page of WSSCC website and on:

https://sites.google.com/site/indiawashforum2010/home/about-india-wash-forum

SACOSAN IV Sri Lanka

The South Asia Conference on Sanitation(SACOSAN IV) is scheduled for Sri Lanka from 4th to the 7th April in Colombo. The Conference is a unique bi-annual inter-ministerial meeting that has an exclusive focus on sanitation and hygiene in south Asia. There are perhaps only a few south Asia regional initiatives like this and hence this meeting provides an opportunity to learn and share and to reaffirm commitments and concrete actions to improve the sanitation and hygiene standards in the region.

The SACOSAN platform has been expanded to now include a pre-eminent space for the civil society organizations to also attend and make formal presentations, in the main SACOSAN conference. Increasingly governments are realizing that they cannot hold such conferences without active participation of CSOs.

In the 2008 Delhi SACOSAN meeting, the civil society organizations held a pre conference meeting and came out with a declaration asking for committed action from the governments, as well as the civil society commitments. This was done based on the limited participation that CSOs got in the previous SACOSAN meeting. Unlike the relatively large participation in the Delhi SCOSAN conference in 2008, a much smaller national contingent of 65 members per country has been agreed for SACOSAN IV.

The CSO collaboration has moved further from influencing SACOSAN ministerial commitments of governments, to also make commitments for CSOs in achieving improved sanitation, hygiene and health.

The process has been strengthened further in SACOSAN IV with the following initiatives by UNICEF, WaterAid, WSSCC, FANSA and WSP;

- A pre conference meeting of civil society organizations on 1-2nd April 2011 in Colombo to give local community leaders a space and voice at SACOSAN and to come out with a CSO Declaration for the ministerial conference.
- Peoples Perceptions Research and a film capturing the voices of the communities. The Research has been done by four countries and a Regional Report prepared.
- Traffic Lights Paper, monitoring progress against commitments made by the governments of four countries of south Asia.
- Score Card of progress against commitments made by Civil Society Organisations
- A South Asia Regional Synthesis Paper: Sanitation: Equity and Inclusion is being developed by WaterAid, WSSCC and UNICEF.

The Peoples Perception Research in India was conducted with more than 30 civil society organizations in India in Nov-Dec 2010. The work was coordinated by FANSA, WaterAid India and India WASH Forum. The Report has been compiled by Padmaja Nair and is included in this Newsletter. The India report contributes to the South Asia Regional Report of the Civil Society Organisations that will be presented in SACOSAN.

For details regarding the SACOSAN official meeting agenda please log on to: http://www.sacosan4lk.org/

The NGO host for the civil society organizations pre SACOSAN meeting in Sri Lakna is Centre for Environmental Justice http://www.ejustice.lk/sacosaniv.htm

Traffic Lights Paper: Measuring Progress Against Government Commitments

Traffic Lights Paper was introduced by WaterAid to measure the commitments made in the last AFRICASAN and later on it was introduced during SACOSAN-III Delhi. Generic areas were mentioned during Delhi SACOSAN paper. The paper received a good response as it is an easy monitoring tool to look back and proved to be very useful for civil society for policy advocacy.

In the light of this response a detailed Paper with 14 indicators was produced in November 2009(to look the progress after one year of SACOSAN-III) and presented in CSOs meeting in Negombo, Srilanka. There was detailed discussion on the process as well as contents of the paper and useful feedback was provided. The current indicators have been developed in the light of suggestions provided based on the commitments made in SACOSAN-III by South Asian Government to improved sanitation and hygiene in the region.

Objectives of the exercise:

- Monitoring the progress towards commitments made in SACOSAN-III
- Generate discussion and debate in countries on commitments during this process
- Creating a sense of realization and accountability about political commitments

Partners: WaterAid coordinated the process for producing the CSO Declaation in SACOSAN III, alongwith the large number of grassroots coalition partners of WSSCC and FANSA. For SACOSAN IV, UNICEF regional office South Asia has shown interest to collaborate, especially collecting information in the countries where WaterAid, WSSCC and FANSA are not present.

The Traffic Lights Paper is based on perception of CSOs. The format of the Paper was first circulated amongst the network members of FANSA, WaterAid India and India WASH Forum. A face to face meeting was called on the 14th February in Delhi where 15 CSOs were invited to complete this task. Each indicator was discussed in detail and the raking as well as justification was worked. Where there was a split in perceptions on the performance of the government against a specific indicator – voting was resorted to by show of hands. The first Draft Paper was shared with the CSOs for their comments and also with the Department of Drinking Water and Sanitation. Inputs from DDWS were incorporated in a separate column against the CSO scoring and again circulated among the network partners of WAI, FANSA and IWF in end of February. Given the constraints of time, a final meeting was held where Murali, Indira and Depinder, respecting the three organizations reviewed the inputs received from the government and the CSOs and came up with a final scoring and justification and comments against each indicator. This final paper is enclosed in this Update from IWF.

The purpose of the TLP is well served from the process we have followed and the additional effort we have put in to define the rationale and overall comments for each rating. Instead of just getting stuck to the colour of the indicator, putting a detailed narrative explains why we have given this rating and what more needs to be done, is very helpful.

It also shows that where the rating is Green – there could still be more that can be done. And that is the purpose of the TLP. We are not sitting in judgment over the government performance. The TLP helps us/CSOs be clear what is being done by the government and what more needs to be done, the government in turn is appraised of our perceptions and expectations. We are also not assuming a patriotic sentiment in trying to give more greens out of a pseudo nationalist pride. This is not what the CSOs should be doing anyway.

We have been liberal in giving a yellow scoring for the Indian government performance in many places where we had initially given a red score. We are interpreting the Programme Guidelines on Rural Water and Sanitation – as Policy announcements which is not the case. We have interpreted a minimum level of actions from the government as sufficient to show some progress. We have tried to be as consultative as possible but could not have a wider CSOs consultation that we missed out. A voting process where the finals draft of the Traffic Lights Paper was circulated for voting amongst a large number of CSOs in India and the final score against each indicator, as well as additional justification and comments compiled - would have been ideal.

In SACOSAN meeting in Colombo, a compiled version of Traffic Lights Paper from all the SAARC countries scoring will be presented in one formal session. UNICEF is compiling the TLP scoring for Afghanisatan, Bhutan and Maldives.

India WASH Forum

India Traffic Light Paper - Measuring Progress of Indian Government WASH Policy and Practice

No	Commitments	Rating/Score	Guiding Notes for Rating	Rating Rationale for the rating
1	Has any efforts made after SACOSAN-III to include water & sanitation as a **basic right** in national constitutions?	R no actions taken Y Process is started such as committee formulated or policy & programme documents mention water & sanitation as a right. G Mentioned in constitution	Since this Right was recognized two years ago. Mere recognition is not enough. Does any effort have been made to recognize this in the national constitutions, laws, rules and regulation? Do policy and programme documents reflect water & sanitation as a right or not?	Yellow India has signed the UN resolution on the right to water and sanitation. A Working Group for the 12th Five Year Plan on Drinking Water and Sanitation, has a sub group that is giving recommendations on Right to Water and Sanitation. Overall comments Strictly as per the criteria for this rating, **there is no progress made in terms of initiatives for changing the national Constitution**. Right to water and sanitation is not explicitly mentioned in the national Water Policy document. Only some vague references are made in the National Drinking Water Guidelines.
2.	Has any specific initiative been launched since Delhi to **progressively realize** the sanitation rights	R No new initiative/programme or plan after SACOSAN-III Y Some actions/programmes are planned and launched G well designed and planned initiatives with clear targets.	There might be sanitation programmes already in place, not necessarily all countries need to start new programmes. But some innovation or new initiatives might be started to fulfill this commitment. Is there any plan developed which demonstrates seriousness to progressively realizing sanitation right?	Yellow Some new initiative include: The 12 year strategy plan of Dept of Drinking Water and Sanitation. 13th Finance Commission devolved financial grants for improvement of urban service levels (including sanitation). Overall comment There is **little progress in terms of a Plan in place that is aimed at realizing sanitation Rights.**There is no mention sanitation as a Right in the Urban Sanitation Policy 2009. There exists no Rural Sanitation Policy for India.
3.	Has any specific initiative started to address the needs of women and vulnerable people, socially & economically disadvantaged?	R No new initiative and no efforts are made to include concern of these groups in existing programmes. Y Some efforts are made to address these issues G New programmes have been launched to address issues of women and valuable groups.	It is desirable but not necessary that entire new programmes are launched to address the issues of women and marginalized groups. However the serious efforts to overcome the challenges of exclusion need to be measured. Does existing programmes address equity and inclusion adequately, has any efforts been made after SACOSAN-III to incorporate these concern in current programmes or planning processes.	Yellow Monitoring of progress for SC/ST/minority populated areas. menstrual hygiene programme by health ministry (of providing sanitary napkins) in 200 districts Planning Commission has directed TSC expenditure with respect to SCs and STs must be spent in the proportion of 22% and 10% respectively. The financial reporting has to report the expenditure on Sts and SCs separately. The coverage data has to indicate the coverage of these communities in real time. Overall comment While many initiative seem to be in place, there is little impact on the ground in terms of results as observed by the CSOs.Access and affordability issues relating to water and

				sanitation for economically and physically disadvantaged people is remains to be addressed. Urban watsan Utilities, the Urban Sanitation Policy and the City Sanitation Plans – none of them make an explicit recognition of access to watsan facilities for slum dwellers be delinked from tenure and ownership.
4	Has sanitation been accorded **national priority**?	R inadequate reference in national development frameworks Y adequate reference in documents G adequate reference as well as fully resourced	This is a broad statement but could be measured at national level by looking the national development plans either PRSPs or 5-years plans or any other development frameworks. Do these documents sufficiently refer sanitation?	Yellow 12 year strategy of DDWS, Supreme Court ruling on watsan for the homeless, Indira Awas Yojana; Rajiv Awas Yojana for slum dwellers Overall comment Sanitation as a national priority should be prominently reflected in some important national documents in the Preamble or in the Commitment of the Government. Except for the Nirmal Gram Puraskar Scheme that the President of India honours, there is little to show progress for this.
5	Has adequate attention been accorded to the **capacity building** of Local Govt. Institutions?			Green Resource Centres (BRCs)guidelines in place; state finance commission giving funds directly to Gram Panchayats for sanitation; allocations for BRCs and WSSOs. Overall comment There is no Capacity Building Plan in place or a set of methodologies and tools for capacity building that are freely available and used for Local Govt. capacity Building as yet. Capacity building of LGIs is yet to take place. The funds available in the flagship national rural sanitation programme are not being used for LGI capacity building.
6	Has specific actions been taken to improve the working **conditions of sanitary workers**	R No Y Consultation are under way G Concrete actions are in place	This was CSO concern during pre-meeting in Delhi with special reference to manual scavenging. It is essential to look back after two year, is there any move.	Yellow National Advisory Council as a political advocacy body has taken up the issue of ending Manual Scavenging. Overall comment No progress made for improving the condition of sanitary workers. Their working conditions and salaries remain extremely poor. Some progress made in addressing the issues of manual scavenging.

7	Has sanitation been sufficiently integrated within **Health policies** & Plans?	R No reference in health policies/programme or plans Y Some reference but vague G Specific reference within health policy with stated and resourced actions	Sanitation is an important health intervention and recognized in SACOSAN-III. Mainly in our countries health policies and plans focus on preventive health. We need to monitor and measure the progress on this important commitment	Yellow References are there in the Anganwadi/ASHA workers training manuals and their regular monitoring. Women and Child Development department has a menstrual hygiene focus Overall comments Sanitation and hygiene in the health Policies and Plans is not adequate. In the BCC messages of health programmes like Polio eradication there is no mention of sanitation and hygiene priority.
8	Have actions been taken to **mainstream sanitation** across sectors and ministries			Yellow Engagement with Rural development ministry for releasing the fourth installment of IAY only if a toilet is constructed and offering financial support for the same if needed. Support to Human Resource Development for construction of school toilet under SSA Overall comments Integration is not just about allocation of funds or financial management. There is no evidence of integration across government departments at the District, State and National level in terms of regular and open consultation and monitoring. Coordination even between the District Administration and the PHED is sometimes an issue(for financial approvals).
9	Do national policies or strategies for emergencies make provision for WASH services	R No reference Y Some reference but vague G Specific reference stated and resourced actions	Water and sanitation needs during emergencies are the most important and widely recognized needs; therefore it is important that countries have policies and plans to deal with emergencies with adequate provision of WASH.	Yellow The National Disaster Management Authority(Act in 2005) and the National Disaster Management Policy 2009 – both do not have even a mention or a reference to adherence to SPHERE standards vis a vis any entitlement including WASH. Neither is there a mention of any alternative minimum Indian standards to be adhered to in emergency and relief works relating to water, sanitation and hygiene.
10	Has a **national plan** of action been prepared	R No move since Delhi Y Process started eg. National consultation etc. G Plan developed	SACOSAN-III provided road map with five key components eg. Country commitment, Enabling policies, Accountable institutions, financing and monitoring & sustaining change. This was the core commitment of SACOSAN-III that all countries must develop a single national plan of action for sanitation to achieve the targets. We	Green The 12 year DDWS strategy document sanitation. This clearly mentions time lines against various goals for achieving Nirmal Bharat. The strategy document mentions moving from the current TSC approach to a more comprehensive approach of a National Total Sanitation Mission The 12th Five Year Plan to cover a special chapter on rural drinking water and sanitation. City Sanitation Planning initiative.

			need to look back after two years what is progress on this, because action plans are the concrete measures to translate policies and commitments for scaling up the programmes.	Overall comments There are sufficient number of plans. Some are repeat plans, examples are: Each state of India had to come up with its Vision Paper on water and sanitation – as part of the Sector reform process in 1999 – however this remained a paper exercise. There was a massive exercise on developing City Development Plans, that included sanitation as an element of planning. However it remained a consultant driven paper planning exercise. Now City Sanitation Plans are being developed.
11	Is there a **Sector Financing** Plan and adequate budgetary allocations?	R no finance plan and very less budgetary allocations Y vague plan but not costed and adequate budgetary allocations with separate sanitation line in budgets G yes a detailed financing plan is developed, implemented and monitored.	Financing is another building block for the robust sanitation sector. Financing is an important element for translating all the promises and commitments into actions. This could be a regular and separate budget line for sanitation, a well designed medium term financing plan for the sector etc.	Yellow The 12 year plan is being finalised by DDWS. Overall Comments While there is a 12 Year Plan being finalized by DDWS, there is no separate Financing Plan. The National Drinking Water Guidelines mention an open ended water entitlements for rural drinking water, without clarifying where the Finance for the same will come from and financial outlays have not even been estimated in this programme at the upper and lower limits. The TSC programme financial allocations are tied to annual budget. In some states matching funds from the state governments when they do not come, the central funds are restricted.
12	Is there a **Performance monitoring mechanism** for sanitation	R No move since Delhi Y Process has started/internal communication on the subject G Defined roles and responsibilities within ministries.	How to define common indicators. May be if more than one dept. e.g health, education, LG, environment etc have aligned their actions to sanitation Are these dept. coordinate, share information and jointly take sanitation initiatives Is their harmony among these depts. on sanitation approaches?	**Yellow** Scheme of national level monitoring exist on the basis of which the data is changed on MIS Each district, two blocks and 10 GPs is visited by the monitors. Quarterly progress meetings held of state secretaries, video conferences held. **Overall comments** Perfornmance monitoring is done only for validating the spending and the engineering aspects of the programme. This is a very limited definition of performance monitoring. There exists no mechanism to review Practice and Knowledge related aspects that are central to any WASH Programme Performance Monitoring benchmark. There is no performance monitoring mechanism that looks at the functioning of the CCDU, PMU, Water Quality Monitoring departments: for the managerial performance and outcomes.
13	Has the Inter-Country Working Group been activated?	R No move since Delhi Y ICWG meetings called	This could be done at regionally.	Yellow Two meetings held of the ICWG. There is no mandate that is programme of joint ICWG working available.

		G Agreement on ICWG mandate and work programme		Overall comments The rating of green is supposed to be achieved when there is a clear mandate and work programme of the ICWG. Merely having two meetings is not enough, that too over a two year period. Since the scoring for this indicator is to be done regionally – this cannot be based on one country CSOs review.
14	Has a broad-based alliance to **coordinate** progress been established?	R no coordination mechanisms in place Y coordination mechanisms in place but ineffective – or just being put together G effective coordination takes place	Dhaka declaration in 2003 mentioned to develop a broad based alliance to monitor the progress, we need to look what is progress of it after 7 years. Coordination has been recognized as an important element in subsequent conferences too.	Green Both ICWG (including the one held in India) meetings invited other stakeholders such as WaterAid, FANSA, UNICEF and WSP Post the rating exercise, WSP, UNICEF, WaterAid and FANSA were called fr discussions on the country paper, participation in SACOSAN and to discuss other matters relating to SACOSAN . these meetings were chaired by the Joint Secretary and in one case by the Secretary **Overall comments** Effective coordination requires more than just having formal meetings. Consultations on Country Paper preparation have little to do with developing a broad based alliance to coordinate progress on SACOSAN commitments. As per this criteria, there has been no attempt to look at progress made from the first SACOSAN till date. In the forthcoming Country Paper for SACOSAN from India, there is till date no suggestion on improved coordination on commitments. Effective coordination to monitor progress on SACOSAN commitments will require among other things: regular meetings, more extensive consultations that are well planned, circulating the Minutes of the Meetings and Agenda of the next meeting on some public forums like Solution Exchange, inviting comments and inputs for the meetings and actions decided and having clear follow up action points and results monitoring. If this is not done, coordination becomes a formality.
15	Is there a clear **institutional home** for sanitation	R no clear institutional home Y Institutional home but not fully resourced G Fully resourced institutions and delegated responsibilities	Fragmentation of institutional roles and responsibilities could be one of the major causes of not achieving the targets. Though this has not been specifically committed in any SACOSAN but has direct relevance in achieving other commitments.	Green For rural and urban sanitation – there is a clear departmental host in the government. Overall comments The India programme or rural sanitation and water – has a central funding component. Though clear institutional host exists, the same department : the PHED for rural drinking water and sanitation, and Utilities for urban watsan – are manned by Engineers and these institutions are weary of implementing sanitation programmes that have a major demand generation and social commitment component. Other departments of Panchayat Raj, Tribal development, Housing, Education and Health – too have a hygiene and sanitation component.

People Perception Research: India Country Paper

EXECUTIVE SUMMARY

1. SACOSAN is acknowledged as a platform to share experiences and aspirations for improved sanitation, hygiene and health. While it helps in raising the political profile of sanitation in the region and allows each participating country to show case it's achievements, it also provides space to bring the 'voice of the people' to the forefront. This study is an attempt to look at the status of sanitation and hygiene in India from the eyes of the poor and marginalized living in the rural and urban settlements across the county. It aims to open up a dialogue to influence the various participating governments to hear and 'listen' to what the people want.

2. The study is based on an extensive set of interviews and FGDs with communities across the country and in rural and urban settlements, wherein efforts were made to understand their perceptions on sanitation and hygiene, to document actual practices and define attributes of successful or unsuccessful interventions in the sector. In the ultimate analysis the study attempted to understand what the communities wanted in terms of sanitation and hygiene, in the communities own voice.

3. History indicates that sanitation and hygiene have not only been a part of rituals and traditions in India but facilities also existed – albeit with access only to the rich and powerful- even in ancient times. The foundation and institutions for sanitation as a service was however, laid during the British rule. But even then open defecation and insanitary conditions, especially in the crowded urban centers was the rule. Today, more than six decades after independence, while reportedly a vast majority of the population has access to safe drinking water, less then 50 percent of the population has access to toilets. Moreover, the difference between rural and urban coverage (34% and 81% respectively) borders on the alarming. So much so, it is feared that India, together with China, will prevent the global community to achieve the MDG sanitation goal that it had set for itself.

4. The government on its part, has responded with programmes and interventions, which over the years have transformed from supply driven approaches to demand driven ones, advocate lower subsidies and greater community involvement and provide a range of technical and low cost options. Consequently, corresponding changes in the institutional delivery mechanism with an increasing role for the local bodies have also been effected. In short, the people are in the center of these efforts. The study generates their perceptions against this background.

5. The community was encouraged to articulate their perceptions about sanitation and hygiene, especially reflecting their understanding and awareness about what constituted good sanitation and hygiene; describe the current practices adopted; describe the status of facilities; and finally recount their experience with interventions especially elaborating on their understanding of 'successful' and 'unsuccessful' interventions.

6. This is how the communities perceive sanitation and hygiene:

i. Understanding of sanitation and hygiene varied to an extent based on the location of the settlement, the levels of poverty and education and the existing status of water and sanitation facilities and services in the settlements.

ii. Understanding had a cultural perspective, and as such was closely related to traditional rituals of cleanliness and practices in some communities.

iii. Definitions of sanitation and hygiene largely revolved round cleanliness – cleanliness of self, cleanliness in the house and cleanliness of the surrounding environment.

iv. Cleanliness of self meant bathing regularly and wearing clean clothes as a routine. Washing hands was, however a less articulated attribute of sanitation and hygiene.

v. Cleanliness within the house meant keeping the house clean and food and water covered, and outside the house primarily meant ensuring sustained arrangements for disposal of liquid and solid waste.

vi. Open defecation was perceived as 'uncivilised', 'undignified' and 'unhygienic'. An open defecation free environment was voted as a key indicator of sanitation and hygiene.

vii. Sanitation and hygiene were perceived to have an impact on disease and health and to a marginally lesser extent on education and overall poverty. It was also considered to be a basic human 'right' by some communities, although the notions of 'right' were limited. Most of all sanitation was perceived to effected the dignity and security of women.

viii. Communities however acknowledged, that when it came to practice, many were still to adopt safe and hygienic practices, primarily because of a lack of education and resources. Most also lacked a sense of civic responsibility.

ix. Similarly use of toilets was relatively limited by some men who still preferred open defecation.

x. On the other hand while knowledge about menstrual hygiene management had improved significantly, practice of using sanitary napkins and safe disposal of soiled napkins was limited because of poverty and lack of facilities.

xi. Facilities for water and sanitation varied depending on the effectiveness of external support received and also on the ability of communities to fend for themselves. Communities struggle to cope with such a situation and are rarely able to initiate improvements unless they receive support from the government or an NGO.

xii. Effect of interventions were perceived in relation to the communities own needs and aspirations: functional toilets, effective system of disposal of garbage and liquid waste and adoption of hygiene practices by the entire community were identified as hall marks of successful interventions.

xiii. Success or failure of interventions were attributed to several related factors: extent and nature of involvement of the community, democratic leadership within the community, extent and nature of support provided by the state, extent of political interest and

support, adequacy and quality of design and arrangements for operation and maintenance.

xiv. A significant number of communities perceived that the effectiveness of projects could be improved with the involvement of NGOs.

7. While communities wants and aspirations are colored by their geophysical locations, socio- economic status and the baseline of facilities currently available to them, by and large they want broadly similar things. So what do the communities want…?

i. The communities want a 'clean' and 'healthy' environment …they want functional toilets, waste water disposal systems, and adequate and regular arrangement for disposal of the solid waste in the settlement.

ii. The communities- especially the women- want to live in 'dignity' and not face the humiliation of defecating in public.

iii. The communities want to be consulted when the state or other agencies plans and designs sanitation and water supply facilities for them.

iv. The communities by and large want the government and its agencies to be responsible for maintenance of community facilities.

v. The communities want that people should be motivated to keep their surroundings as clean as their houses. Informed community leaders want that hygiene promotion and education should precede or go hand in hand with the provision of facilities.

vi. Communities want NGOs and civil society organisations to be part of such initiatives, especially in educating and mobilising communities.

vii. And above all the communities want to be able to practice what they learn and know: poverty and difficult conditions of living prevent them from practicing what they know.

1. INTRODUCTION

The South Asian Conference on Sanitation, better known as SACOSAN, has over the years become an acknowledged platform for participating countries to share experiences and aspirations for improved sanitation, hygiene and health. While it helps in raising the political profile of sanitation in the region and allows each participating country to show case it's achievements, it also provides space to bring the 'voice of the people' to the forefront. This paper is an attempt to look at the status of sanitation and hygiene in India from the eyes of the poor and marginalized living in the rural and urban settlements across the county. It is an output of a larger multi- country study under a joined- up initiative of FANSA, Wateraid and WSSCC, that aims to open up a dialogue to influence the various participating governments to hear and 'listen' to what the people want.

The report describes the communities understanding of sanitation and its importance in preventing ill health and poverty, in promoting education and a better quality of life, and as a basic human right. It attempts to capture awareness about basic hygiene and at the same time describe the prevalent practices, including those related to the management of menstrual hygiene. It then goes on to reflect the community's perceptions about the 'success' or 'failure' of planned interventions by the state or other agencies.

The data base for the report is a set of 127 narratives developed through interviews with key informants and through Focus Group Discussions (FGD) in selected communities in rural and urban settings across 13 states[1] in the country. The interviews and FGDs were conducted with representative groups of men and women from the community and as such reflect the community's perceptions and not the individual's alone. Two types of communities were selected from the urban and rural areas: one where interventions had already been made by either a state or a non- state agency; and the other where no interventions had been made till the time of the study. These were further stratified into 'successful' and 'unsuccessful' project communities, in order to understand perceptions about projectised interventions and what the community considered to be a successful or failed project and the reasons for the same. 'Success' itself has been defined as the communities understand it and not it terms of the standard project evaluation or impact assessment criteria.

Selection of communities was further influenced by the need to capture a wide range of geo-physical and social contexts. Hence, the study sites included the flood prone plains of North Bihar, the forested tribal areas of Chhattisgarh and Jharkhand, the water stressed regions of Gujarat and Uttar Pradesh, the coastal areas of Kerala and Orissa as well as the Tusnami hit areas of Tamil Nadu, apart from Maharashtra, Madhya Pradesh, Karnataka and the all-urban Delhi. It also included tribal, Schedule Caste, *dalit* and a sprinkling of the other communities and their sub- groups. Thus, 47 urban and 75 rural sites were selected for the interviews and FGDs. Besides, there were 5 other sites which were described as 'peri-urban' by the researchers.

The respondents included both men and women from a wide ranging age group (35-70 years); many were community leaders and social workers and some had been formally elected as *sarpanch* or village *pradhans*, while others were ordinary citizens. Some were illiterate while most others had studied at least till the primary level; some were also graduates. While socially most belonged to the backward, *dalit* or tribal communities, in terms of occupation and income they were largely from the lowest income category and primarily dependent on agricultural labour and the unorganised sector in both urban and rural areas. The purpose of this variety was to capture the varying perceptions of various social categories and of men and women.

The interviews and FGDs were based on a set of broadly structured but open-ended list of questions. The field work was undertaken by members of FANSA and partners of Wateraid India, and included a list of 23 local NGOs, social activists and journalists. To some extent the responses were influenced by the interviewers and their familiarity and rapport with the

[1] Andhra Pradesh, Bihar, Chhattisgarh, Delhi, Gujarat, Jharkhand, Kerala, Karnataka, Madhya Pradesh, Maharashtra, Tamil Nadu, Orissa and Uttar Pradesh.

community. In virgin sites a single interview or FGD took an entire day as the interviewer had to first build rapport with the community. While the interviews and FGDs have tried to capture the responses as honestly as possible, some loss in nuances was inevitable in the process of translating the responses from the local to the English language.

2. BACKGROUND

Traditions and evolution…

In India cleanliness has been traditionally associated with religious rituals and customs of purity. While the day always began with a ritual bath, bathing preceded such tasks as cooking, eating food and praying. In fact, sanitation and hygiene facilities were not unknown in ancient times. Well laid out drainage systems, private bathrooms and even a few 'western' styled toilets are believed to have been in existence in the ancient Indian cities of Mohenjo-Daro and Harappa,[2] as way back as in 2600 BC. Studies indicate that India had already established town planning practices and codes for drainage systems as early as the Vedic times (Ganguly, 2009). Open defecation was however the norm even then and with adequate space available in the largely rural communities, the practice does not seem to have created undue problems or received attention.

In more recent times during the British period (especially from the mid 19th Century) the situation changed with deteriorating economic conditions in the rural areas and the crowding of cities. The concept of public health and sanitation as it is known today was introduced and local governments were entrusted with the responsibility of ensuring sanitation in the urban settlements with dedicated staff and budget. A conservancy department was created for sweeping the street and removal of trade refuse for which the owners had to pay a fee and sanitation activities were included in the process of urban planning. However, sanitary conditions were far from satisfactory and while the urban areas received attention the rural settlements were largely neglected.

Official reports of that time observed the existence of inadequate number of toilets, deficiencies in sewerage and surface drainage and the general overcrowding in cities like Calcutta. The persistence of high disease related death rates and the generally poor sanitary conditions then have been attributed to a combination of factors: the 'Eurocentric' priorities of the colonial government, residential segregation and neglect of the indigenous population, failure to respond to their actual needs and hence resistance to coercive sanitary measures by the state in response to recurrent epidemics of cholera, dysentery and plague. Besides, sanitary reforms were resisted by many of the educated and better off population who were reluctant to pay extra taxes for services. Hence, though the British are credited with having initiated sanitary reforms, these are also stated to have been biased and largely unsuccessful attempts. (Harrison, 1994)

Present status… alarming figures…

The mis-match between state provisions and the requirements of communities continued into the post-Independence period. And so did open defecation. Although water and sanitation was addressed from the First Five Year Plan itself and albeit ' increased coverage' was initially targeted as the key indicator of a sanitized settlement, results have been slow in coming.

The country seems to have performed better in the supply of safe drinking water. The percent of households with access to safe water across the country is stated to have increased from 68 percent in 1992-93 to 84 percent in 2007-08[3]. The urban coverage during this period increased from 88 to 95 percent and growth in rural coverage was equally impressive with 80 percent of the population having access to safe water as against 61 percent in 1992-93. Therefore, in the mid- term appraisal of the MDGs ,the Government of India (GoI-MoSPI, 2009) claimed that the country was on track for achieving the MDG target of providing safe drinking water; at the same time however, it acknowledged that sustaining water security was a challenge.

The bigger challenge however appears to be the status of sanitation in India, which is one of the most densely populated countries in the world and has one of the lowest sanitation coverage. According to the 1981 census only 1 percent of the rural households and 27 percent of the urban ones had access to sanitation. By the turn of the century in 2001 the total coverage stood at a dismal 36 percent with the rural coverage growing at a snail's pace to 22 percent and urban to 65percent. The growth rate continued to be slow and the 2009 India Country Report on the MDGs notes that the total coverage increased by 13 percent point to 49 percent by 2007-08. What was of more concern was the high rural- urban variation with only 34 percent of the rural households having access to toilets as against 81 percent of the urban one (GoI-MoSPI, 2009). The Ministry of Rural Development however, claims that rural sanitation gradually picked up pace when the Total Sanitation Campaign - a GoI supported programme - was given a fillip with the introduction of a an award scheme, the Nirmal Gram Puruskar, in 2003: by 2009 more than 22440 gram panchayats had received the NGP and the Campaign had apparently picked up pace with toilet coverage reported to have increased to 67 percent by the end of 2010[4]. However, the Joint Monitoring Programme report of WHO-Unicef (WHO-UNICEF, 2010), based on 2008 data (DLHS 3) states that the rural sanitation coverage remains as low as 31 percent and India, together with China, may be primarily responsible for pushing the sanitation MDG off track. The GoI, recognising the data

[2] Now in Sindh and Punjab respectively in North- East Paksitan

[3] 88% of the 1.2 billion population according to WHO-Unicef (2010)

[4] According to DISE only 31% of the boys schools and 59% of the girls school had toilets in 2009-10(NUEPA, 2011)

gap, is now in the process of identifying the reasons and plugging the gap.

The urban areas on the other hand present an appalling situation of another kind. The National Urban Sanitation Policy, 2008, indicates that only 8 percent of the urban households defecate in the open, while another 8 percent have access to community toilets and 19 percent to shared toilets. But the NUSP also states that 19 percent of the urban households do not have access to drainage networks while another 40 percent are connected to open drains. 37 percent of human excreta in the urban areas is unsafely disposed. Within this scenario, the slums in the urban area are the worst off with reportedly 17 percent of the notified and 51 percent of the non-notified slums having no access to toilets. (GoI-MoUD, 2008)

Hidden behind all these statistics are some grim facts about poor and 'unsafe' technology, defaulters within households and slippages even in NGP awarded villages (Araghyam, 2009; Taru, 2008). The cost of poor sanitation, especially in terms of disease and death, is mind boggling with the impact on children under 14 years alone in terms of health care requirements amounting to Rs.500 crores at 2001 prices! (GoI-MoUD, 2008). A recent study by the WSP-World Bank estimates the overall economic impact of inadequate sanitation in India as a whooping Rs 2.4 trillion, equivalent to 6.4 percent of the country's GDP. The costs include those associated with death and disease, loss in productivity, education, tourism and cost of treating and accessing water (WSP, 2010).

These percentages become more alarming when viewed against the sheer number of the actual population in the country: a total population of 1.02 billion (now touching 1.2 billion), an urban population of 286 million (27.8 %) and a rural population of 714 million; 5161 urban and 638, 365 rural settlements according to the 2001 Census.

Response and interventions…

In response to growing concerns, programmes and interventions over the years have transformed from wholly supply driven approaches to demand driven ones that advocate lower subsidies and greater community involvement. Programmes provide for a range of technical and low cost options and capacity building at the community level. Besides, there has been an increasing focus on improving school sanitation, especially providing facilities for girls. All this has led to a corresponding change in the institutional delivery mechanism with an increasing role for the local bodies in both the urban and rural sectors.

In India sanitation (as also drinking water supply) is a state subject, which means that the responsibilities for ensuring adequate safe water and sanitation is primarily that of the state governments. However, the federal government exerts significant influence on interventions through policy directions and substantial investments. International and bilateral agencies have also played a role in terms of funds and technical support. In recent years the Panchayati Raj Institutions representing rural governance and the Urban Local Bodies (ULB) are being geared to assume the primary responsibilities, reflecting the shift towards a community and people centered approach.

In India, although planned interventions and allocations to the water and sanitation sector were made as early in the first Five Year Plan, it was only in the 1980s during the International Water and Sanitation Decade that rural sanitation was given due recognition with the launch of the Central Rural Sanitation Programme (CRSP)in 1986. Initially supply driven, highly subsidized and with a provision for constructing of only a single technical model (twin pit, pour flush), it went through a change process that adopted an overall integrated approach and focused on hygiene and provision of toilets with equal emphasis. However, realizing that the increase in coverage over the years was a slow process (1% per year), a more dynamic campaign approach was adopted and the CRSP was restructured as the Total Sanitation Campaign (TSC) in 1999 under a reform mode.

The TSC, as the name indicates, adopted a campaign mode that was demand driven, emphasized the eradication of open defecation, followed the principle of 'low to no subsidy', gave priority to hygiene education, capacity building, behavior change and the greater involvement of PRIs, CBOs and NGOs as well as private sector participation. Individual household toilets, school sanitation and hygiene education, sanitation in *Anganwadis* and setting up of local rural sanitary marts and production centers are the key components of TSC. The programme has been successively revised over the years, primarily with the view to improve both coverage and use. An award scheme – Nirmal Gram Puruskar (Clean Village Award) was introduced as an incentive in 2003 and by 2008 a total of 12, 075 *gram panchayats* (Village Council), the lowest level in the three tiered local bodies system had been declared 'open defecation free' and awarded the NGP.

The disconcerting issue however, is that in spite of an innovative programme, the track records have been poor in a large majority of the states in the country; coverage as indicated earlier has been far from satisfactory. What is more telling is the evidence that even in the NGP awarded villages, the non use of toilets is as high as 34 percent(UNICEF, 2008).

In the urban sector the Integrated Low Cost Sanitation programme in 1981 was the first response to the poor conditions in India's cities. Manual scavenging, a practice that has been in existence for decades and is the cause and effect of severe social inequities in the society in India, was the trigger for the programme. Hence, the programme on one hand focused on bringing about policy and legislative changes to eliminate scavenging and rehabilitate scavengers and on the other support to convert 'dry latrines' to pour flush ones. The ILCS was strengthened with the launch of a series of programmes including the most recent and ambitious Jawaharlal Nehru National Urban Renewal Mission (JNNURM) and its sub Mission on Basic services for the Urban Poor (BSUP)in 2006. While JNNURM covers 63 major urban areas in the country a counterpart Integrated Housing and Slum Development Programme focuses on other cities. These programmes, together with the yet to be implemented Rajiv Awas Yojana, targets the grossly underserviced, poor and marginalized communities.

What is significant in these programmes is the complete shift from a centralised supply driven approach to one that conceptually puts communities in the center of development.

Against this background, the present study attempts to understand how people perceive and define sanitation, what sanitation and hygiene practices do they adopt and above all how do they perceive support from the state and other stakeholders.

3. COMMUNITIES AND NARRATIVES

The study was undertaken across multiple states and multiple communities in the rural, urban and peri- urban settings. Kerala and Tamil Nadu marked the boundaries in the South, Uttar Pradesh and Delhi in the North, Bihar and Jharkhand in the East and Maharashtra and Gujarat in the west with the remaining states located adjacent to these. A brief profile of the rural, urban and peri-urban communities whose voices are reflected here is as under:

Rural settlements or villages

The rural settlements are typically located away from urban centers and district headquarters, and in a few cases in remote and difficult to access areas. Some of the rural sites in the study like those in Kerala, Orissa and Tamil Nadu are located on the banks of rivers or in the costal districts, while others are scattered on the rocky plateau areas of Madhya Pradesh or the flood prone embankments of north Bihar, or hilly slopes of Uttar Pradesh. There are also a few tribal villages located in forest lands in Orissa and Jharkhand. While some of them are located close to national or state highways, many others, except for the remote tribal villages, have regular concrete or semi –structured roads connecting it to the surrounding areas.

> *The village* Khumbharora *is situated on a hilly slope close to the Mahoba- Khajurao highway at a distance of 6 kms from the district headquarters…*Kasidiha *is one of the tribal villages of Chendipada block of Angul district in the state of Orissa. The village is about 35 kms from the district headquarters ….Gaunaha is located along the Indo- Nepal border in the West Champaran district of Bihar…Chinnavilai is a coastal village along the Arabian Sea in the Kanayakumari district of Tamil Nadu…Kottayathukadavu is located on the banks of the Ashtamudi lake, one of the largest and deepest wetland in Kerala…*

The settlements, reflect a wide range of geo-physical characteristics. There are those located on the flood prone areas of North Bihar, where a constantly changing river (Kosi) has displaced communities several times in the last few decades. A unique settlement pattern is seen here with some communities living 'within' the embankment of the river, some outside it and some on it! Mostly, landless with little basic facilities, these are people who have not only become accustomed to disasters but also to being at the receiving end of 'relief' from the state and other agencies (Saraigarh Bhaptiya, District Supaul in Bihar). Then there are also settlements on the coastal belt of Tamil Nadu where communities, primarily dependent on fishing and related activities, have also faced disasters like the Tsunami in 2004 (Chinnaivilai, District Kanyakumari in Tamil Nadu); or settlements in the backwaters of Kerala, crowded for space on 'embankment' like areas (Kottayathukadavu, District Kollam in Kerala). Whereas settlements in Jharkand (Sindri, District Godda in Jharkhand) were characterized by their remote locations and stark surrounding, as were those located in the Bundelkhand region of Uttar Pradesh (Bohra, District Jalaun in Uttar Pradesh). While most of these settlements were water stressed areas, almost all the people who live here had to struggle to earn a living.

The settlement pattern in the rural areas is almost always based on community and caste groups and a typical village is made up of a number of closely located or scattered hamlets, generally identified by their caste. A mix of mud, bricks, stone and sometimes concrete houses are seen with thatched or tiled roofs depending on their location and levels of income. The size of the settlements varies from as less as 40 households to around 700 and in a few cases even more. Most of them have a government run primary school and an Anganwadi, and some, especially if they are larger in size, have a Middle and a High school. Private schools were also found in some settlements. Primary Health Centers however, were rarely reported, indicating that most communities in all probability had to travel to a neighbouring village or block to access medical facilities.

The communities were largely dominated by a mix of Schedule Castes and Other Backward classes, with a few Brahmins and Thakurs (upper castes). Some settlements in the villages of Orissa, Jharkahand and Andhra Pradesh were entirely populated by the Schedule Tribes. In Kerala settlements with a mix of Hindu, Christian and Muslim communities were also reported. The caste system in India, as is well known, has traditionally dominated the social, economic and even the political space. The modern day state, has in a way sustained the interest in the caste system, albeit differently, by caste based reservations and development interventions. Most communities were either agricultural labourers or engaged in small petty business and trade. Fever, cold, cough, typhoid, diarrhea, malaria and tuberculoses were the most common diseases reported across most of these settlements.

Slums in urban areas

The slum settlements in the urban areas that were part of the study presented a somewhat different picture: usually located in commercial or residential areas, along railway tracks and mostly congested settlements; generally large in size, with some reporting as many as 5000 households (Bholakpur in Hyderabad, Andhra Pradesh); categorized variously as 'notified' or 'unauthorised' settlements; consisting of a mix of communities and in the case of larger cities like Delhi, communities from different parts of the country; occupations include wage labour, employment in local factories, self employed as street vendors, petty shops and business, auto or taxi drivers, construction workers and in the case of women as domestic workers. .Most of these slums however had better access to education and health facilities, with many reporting several government as well private schools within the settlement or within easy reach. However, the common disease pattern appeared to be the same, except in the case of some slums that also reported diseases like skin and eye infections.

Arjun Camp is slum settlement located near National Highway 8 that connects Delhi with Gurgaon and Jaipur. …... It has approximately 1200 households with a population of approx 6000 people. The residents come from different North Indian states like Rajasthan, Harayana, Bihar and Uttar Pradesh ….The residents work as daily wage labourers, factory workers, auto drivers. Some are self employed in transportation business, trading, eateries and contractual construction work.

Budaga Jangam Basti is a 60 years old notified slum located near Khairatabad Railway station. It has been categorised as "Hazardous/objectionable" settlement by the Greater Hyderabad Municipal Corporation (GHMC). It consists of around 70 households all of whom belong to the Other Backward Castes. The slum dwellers don't own the land but have been given possession certificate by the GHMC.

Peri- urban settlements

Four of the study sites were located in 'peri- urban' areas or on the periphery of the urban areas, where the number of households varied from 120 households (Bavala, Ahemedabad, Gujarat) to 3200 households(Ullalu Upanagar New colony, Bangalore- Karnataka). The peri-urban settlements were marked by a mix of rural and urban characteristics, especially a settlement like Torvi in Bijapur, Andhra Pradesh, which has been recently brought under the corporation.

4. PEOPLE'S PERCEPTIONS

The study focused on some key areas to understand the people's perceptions regarding sanitation and hygiene. Understanding was gauged in terms of articulation of the attributes of sanitation and hygiene, its importance and relevance to disease prevention and overall health, as well as to education, livelihood, poverty and human dignity and finally as a basic human right. It also included discussions on awareness and practices in the community, especially practices related to menstrual hygiene management. The narratives generated information on the community's perception of the status of water and sanitation infrastructure and, more importantly, their perceptions regarding the success or failure of interventions.

4.1 Understanding of sanitation

Understanding of sanitation and hygiene varied to an extent based on the location of the settlement, the levels of poverty and education and the existing status of water and sanitation facilities and services in the settlements. Understanding also had a cultural perspective, and as such was closely related to traditional rituals of cleanliness and practices in some communities. Definitions of sanitation and hygiene however, largely revolved round cleanliness – cleanliness of self, cleanliness in the house and cleanliness of the surrounding environment.

Cleanliness of self…

Cleanliness of self, for all categories of communities definitely meant bathing regularly and wearing clean clothes as a routine. Washing hands was a less articulated attribute of sanitation and hygiene, largely identified as a key element by respondents and communities where interventions had been successful. Such communities understood hygiene as also washing their hands before handling drinking water and food.

*We try following the simple practices like washing hands before handling food, keeping drinking water covered and at high level so children do not put dirty hands in it…*Ram Avtar, Bohra, Jalaun District, Uttar Pradesh

…and of house and environment…

'Cleanliness' also meant keeping the house and environment clean and leading a 'civilized' life. Within the house it involved keeping the house clean and drinking water and food covered to prevent flies from sitting on it. On the other hand cleanliness outside the house and the surrounding areas meant proper and sustained arrangements for disposal of liquid and solid waste. While communities in the rural areas where there have been no interventions of significance defined sanitation outside the house in terms of simple 'drainage of water', 'disposal of garbage', and 'cattle waste', others where interventions had been effective also talked about 'underground' drainage systems and 'recycling of waste'. Communities in some settlements in the larger and more developed urban areas defined cleanliness in the settlement with reference to 'sewer lines' and 'garbage disposal systems', including dustbins at convenient locations that are emptied regularly .

*Access to sewer lines, proper garbage disposal system and latrines are some of the key aspects of sanitation…sanitation means concrete drainage and sewer lines….*Lingam and Sadhalu Yadagiri, community leaders, Budaga jangam Basti, Karitabad-Hyderabad

For such communities sanitation meant that the entire settlement was 'garbage free, sewage free and everyone used a community or home toilet'. They were also emphatic that facilities should be sustained and available 24 hours and sporadic cleaning once in a while did not define sanitation. Educated community leaders, even from settlements where there had been no interventions, had a more comprehensive understanding of sanitation and hygiene:

Sanitation is living a hygienic life. People must use toilet for defecation. Drink boiled clean water, eat covered food, wear clean dress and bath every day, cut their nails and hairs, keep the solid waste in specified place and reuse it, not throwing the solid waste in the street… Daisy Inbanayagam, the woman ward counselor of Navalady, Tirunelveli District, Tamil Nadu

Some slum communities, especially those living in better off residential areas, perceived sanitation to be a 'visibly attractive and free of foul smell' settlement, and one which was not a

source of embarrassment to them. How outsiders and visitors perceived the slum was important to the residents.

> *We used to feel embarrassed when guests coming to the village would make faces and cover their nose and mouth…*group of men and women, Kali Talai-Goras, Sheopur district, MP

Open defecation and toilets

Understanding of sanitation was closely related to the widespread use of toilets and consequently, an open defecation free environment. Communities across settlements, irrespective of location and or having been exposed to interventions- successful or otherwise- were unanimous in associating 'open defecation' with 'unhygienic condition'. They were emphatic about the need for toilets- community or individual- and more so in the case of crowded slum settlements. They especially mentioned an open defecation free settlement and surroundings as a key indicator of sanitation and thought that to defecate in the open was '*not a civilized act'* (Lalita Paik, middle aged woman, village Kadobahal, Bargarh district of Orissa).

Women's perspectives

For women, sanitation meant keeping themselves, their houses and their children clean. Women from crowded slums like Delhi were concerned that lack of space compelled their children to play in areas which were also used for defecation and disposal of garbage.

Women from some rural communities in states like Tamil Nadu said that a clean house gave them immense 'happiness' and 'pride'.

> *Sanitation is the basis for happiness and satisfaction. It urges me to get up early and remains as the first thought for the day to clean my home and surrounding clean. As the day starts with cleaning, the whole day them become very active and happy…* Punitha, NFE teacher, Chinnaviai, urban panchayat in the district of Kanyakumari in Tamil Nadu.

While even women from the rural communities where no interventions had taken place were aware of the importance of hygiene during cooking, many complained that they were unable to practice it because of lack of water and general poverty that gave them little access to resources. A typical example of such communities is Kota Dewar, a small hamlet in the district of Jaluan in Uttar Pradesh where around 50 households live in inhuman conditions and deprived of all basic facilities.

> *You have witnessed the condition of our village. There are no toilets, no drains and no roads. You can see water stagnating all over. Filth and garbage is scattered everywhere and all this is providing a breeding ground to mosquitoes… There is just one hand pump for the whole village. Even if we want to keep everything clean, we cannot do it due to shortage of water. I have not washed myself for last three days. There is such a long queue for water that it takes hours to get even a bucket of water, which is just enough for cooking…* Kiran and Kanchan, women from Kota Dewar, Jalaun district, Uttar Pradesh

Some communities could relate to the relationship between 'clean water' and 'sanitation' and thought that drinking clean water was an integral part of sanitation. But to most sanitation was just ' healthy behaviour', that included all the above described elements.

> *…sanitation means clean road, having latrines, proper drainage system in one's area… personal hygiene is also a part of sanitation. Proper sanitation system is related with cleanliness …*Imam Malik, Sarpanch of Peddarajpet, Warrangal, AP

Links with disease and health of importance…

The need and importance of sanitation and hygiene was rated in terms of its impact on disease and health and on the 'dignity' of the community, especially on the dignity of women. A few respondents, primarily those who were educated and had some exposure to other communities, also associated sanitation with overall 'well being' and a 'civilized way of life'. Importance of sanitation was often defined in terms of the impact on health, especially impact on children's health and education. Some parents indicated that having and using toilets was important because of the growing pressures from their children, especially those who had moved out of the village to urban areas for education or employment and were now not only more aware about both the benefits of toilets but were also under the pressure of their peers.

Those who had a clear understanding of hygiene, perceived that living in unhygienic environment led to all kinds of diseases especially fever, malaria and diarrhoea. Following simple hygiene practices like washing hands before meals or cooking food, keeping the drinking water covered, etc., they stated would eliminate many of the diseases. They also understood that sanitation facilities saved a lot of time, especially for women- time that could then be spend on other productive chores. It would also ensure a clean environment for children to grow. They were clear that it would thus, also contribute towards reducing poverty. In fact they perceived a direct link between sanitation, education, poverty and dignity: adequate sanitation prevented illness, ensured that the community remained healthy which in turn also ensured that children could be educated leading to eradication of poverty and consequently ensuring dignity.

> *We waste so much time in going to the doctor and then waste so much money on medicines. By just paying a little bit of attention to sanitation we can save all that time and money and thereby enhance our economic condition…*Ram Avtar a prominent member of the community, Bhora village, Jalaun district, UP

But there were also those who had limited or no understanding of sanitation because of traditional thinking, a general reluctance to accept innovations and new learnings and because of poor levels of learning. For such communities sanitation was a mere 'facility' with no perceivable links with

health (Village Biladakhin, District Mahoba, UP; village Kotda, District Surendranagar in Gujarat and village Baurdibend, district Ahmednagar also in Gujarat).

…Also dignity, especially of women

Dignity and protection of women as one of the primary reasons for not defecating in the open was an issue often raised by men, from all communities, more so from Muslim communities, where women observed 'purdha'. While sanitation was thought to have an impact on the dignity of the entire family, women especially felt 'humiliated' when they had to defecate in the open. 'Privacy' becomes an issue, especially in economically better off but crowded urban settlements

> *everyone likes to have some privacy when in the toilets..* group of men and women, Arjun Camp, Mahipalpur, Delhi

Women , themselves were embarrassed to defecate in the open:

> *We find it shameful that we do not have toilets and that our men do not listen to us…* Group of women, Balerpada in Burla Notified Area, Sambalpur, Orissa..

Dignity of another kind was reflected by some upward moving communities where children had begun to move out to larger urban areas for higher studies. Here parents were faced with an increasing demand from children for toilets as they were now not only used to such facilities but were also embarrassed to invite friends and colleagues to a house without toilets (group of men and women; Pappanam village, Ramanathapuram district, in Tamil Nadu) .

Communities, especially slum communities, perceived open defection as 'unsafe'. On one hand women and girls were open to molestations and on the other settlements located close to railway tracks had frequent accidents- often fatal- because of the practice of using the tracks for defecation.

…Poverty, less so

Communities, especially women amongst them, perceived sanitation to be important in the context of raising prices as this also led to doctors hiking up their fees and a consequent increase in the communities medical expenses.

> *When the price of onion hiked, the Doctors in the hospital also increased the fee…*Punitha, NFE teacher, Chinnaviai, urban panchayat in the district of Kanyakumari in Tamil Nadu.

However, overall only few communities, primarily the more educated and aware, especially those living in the urban areas, could clearly articulate that poor sanitation meant poor health and hence increased medical expenses and reduced wage days and consequently had an impact on income levels. Similarly, relatively lesser number of respondents could clearly relate sanitation to education, and when prompted, women who were themselves educated (FGD group in Navalady, Tirinulveli district of Tamil Nadu) traced the links between sanitation and education and said that good sanitation lead to the better health of children who could then attend school regularly. It also meant savings on medical expenses which then could be invested in the education of children.

Nebulous notions of sanitation as a 'basic right'

While many members of the community could relate to the concept of sanitation as a basic human right and compared it to the right to education and right to vote, some give more importance to livelihoods. In fact communities where the majority of the households belonged to the below poverty line category with little or no asset, were dependent on daily wages and were largely from socially marginalized groups (Jhanda Chowk , Raipur district in Chhattisgarh; Kamalnehrunagar, Patna in Bihar,etc.) had other priorities like feeding their children and accessing water. They claimed that they were too poor and hence could not 'afford' to live in clean surroundings. For them and many others, 'right' to sanitation and hygiene was interestingly associated with the governments duty to 'provide' basic facilities. They thought that communities could demand facilities 'forcefully' from the government .

It was evident, that communities that had the benefit of intervention- whether successful or not- had a basic understanding of the concepts of hygiene and the understanding was directly proportional to the intensity of interventions and sustained monitoring, as evident from cases like the Darbhanga slum in Delhi, amongst others. Infact many acknowledged the contribution of hygiene education in the village or slums through an NGO or government initiative in giving them a better understanding of sanitation.

4.2 Awareness and practices

Interestingly, although those interviewed indicate adequate understanding of the concept of hygiene and its key constituents, some reported that while on one hand many in their community did not have an understanding of sanitation and hygiene and on the other many others did not practice safe methods of sanitation. This, according to them, was largely because of a lack of education or the inability to access infrastructure because of poverty.

Thus, while washing hands before a meal was practiced by most households irrespective of income or education levels, poor and socially marginalized communities often did not use soap because they were neither aware of the benefits nor had the means to do so. Similarly, communities (Kottayathukadavu) on the bank of rivers like Ashtamudi in Kerala were apparently not adequately aware about the consequences of poor sanitation. They continue to use wrongly constructed toilets that are extended into the water body and where the fecal matter goes directly into the river. The fact that this settlement is part of a Gram Panchayat that has been awarded the Nirmal Gram Puruskar(NGP) is additionally disconcerting.

> *People know that they should follow the basic hygiene like washing hands before handling food and keeping their surroundings clean yet they dump the garbage in the open fields. They go to the agriculture fields for defecation, not knowing that they are polluting the fields by doing so…*Munna, a literate dalit , Beni Pura, Jalaun, UP

Many households, across communities, reportedly maintained hygiene within their homes but disregarded the environment around them, indicating a lack of civic sense and responsibility and concern for others. They hence clean the inside of their house but throw the waste on the road outside, treating the common areas as dumping site for garbage. According to the community this is a matter of 'old habits' and mentality:

> *People are aware of everything- but cleanliness is limited to the confines of their own homes*…a group of men and women, Nala Camp, Rangpuri, Delhi

Literacy was again and again attributed as a reason for better hygiene practices; and so was culture and tradition.

> *…people are aware of basic hygiene. This is because of 50% literacy in the village. Cleaning and sweeping the houses, surroundings and roads are part of their culture. Early in the morning they used to wash the house and make decorative design outside the house which is a tradition in AP…*Group of men, including a sarpanch; Peddarajapet, Warrangal, AP

Toilets, when constructed were used by all members of the household only when the community had understood and accepted its importance. Otherwise the use was limited to generally women and girls, especially in settlements on the coastal belts of Tamil Nadu. Kerala and Orissa, where men used the large beach fronts as space for defecation. This was observed to be more so in the case of fishermen who put their boats out into the sea in the early hours of the morning.

> *All use toilet in their house. The common toilet is used mostly by the people who stay in rented houses and outsiders coming into the village …. There are common bath rooms and toilet in the village. We pay one rupee for toilet and Rs.5 for bathing and washing the cloth. There is sufficient water in these toilet*….Jenani and Rajini, middle aged, literate women from a Tsunami effected community that has received the benefit of both government and NGO intervention, village Ovari, Tiirunelveli district, TN

Many respondents, in both urban and rural areas, who reported adequate awareness and practice in their community attributed it to the effective interventions of an NGO or the government. Sustained monitoring and back up support over a period it ensured sustained adoption of practice. For instance in the Dharabanga Camp in Delhi, reportedly people have adopted and sustained hygiene practices, apparently because the NGO monitors hygiene practices of the households on a monthly basis and people were embarrassed to have their poor practices pointed out to them.

Menstrual hygiene management is apparently still a mixed bag and continues to be of concern. Many interviewees and groups of women reported that a significant number of women now used clean cloth, though the use of sanitary pads was restricted to some slum communities in the cities and a few rural settlements that were closer to urban areas. The cloth was cleaned and the women were also careful to maintain personal hygiene. This change in practice, especially the use of sanitary napkins, is more obvious amongst younger women and where there have been successful NGO or government interventions like in the case of Ovari village in the Tiirunelveli district of Tamil Nadu, Addagutta in Hyderabad district of Andhra Pradesh or the Vivekananda slum of Delhi. In such settlements even schools have been groomed to keep emergency stock of sanitary napkins for the girl students.

> *The ladies use napkins during menstruation. They dispose it in separate cover and put it in the waste or cover in the soil. It became a common practice among the ladies.* Jenani, village Ovari, Tiirunelveli district, TN .

However, in many communities women still continued with their unhygienic practices due to lack of awareness and poverty . In some cases like in the slums of Delhi, although women were aware of the need for personal hygiene, lack of toilet facilities prevented them from maintaining adequate hygiene. Thus, women who were forced to defecate in the open also disposed off their soiled cloth at the defecation site or in case of rural areas, buried it in the fields away from their homes. Women, in communities that had an arrangement for garbage collection would dispose of the soiled pad or cloth with the garbage. However, they felt humiliated when the garbage collector at times refused to touch such waste. And those who washed and reused the cloth dried it hidden from the site of other people, while others simply used a fresh piece of cloth – generally old sarees-every time .

> *We are poor and do not earn even enough for our food and clothes despite hard work, So hygiene can be given a miss. Women want to use sanitary napkins…we know about its use, but have to use cloth instead…Suryakaniti Nayak and other women, Balerpada in Burla Notified Area, Sambalpur, Orissa.*.

But all were particular about taking a bath after defecation and cleaning during menstruation, even those who are poor and uneducated; and the practice of 'untouchability' and isolation was maintained in most rural and many urban communities during 'those days'..

The overall picture that is thus generated is that while peoples' awareness about what constitutes hygiene and good sanitation had significantly improved, practice was severely limited due to poverty, lack of adequate resources, poor quality facilities and, to a large extent lack of civic sense and responsibility.

4.3 Status of the environment /WASH

The provisions of water and sanitation facilities within the communities varied, largely depending on the effectiveness of external support received and also on the ability of communities to fend for themselves. Three categories of settlements were reported : one where no sanitation facilities existed and the entire community defecated in the open; another where the settlements were well provided for and every household had individual toilets; and those where some of the households had access to individual toilets while others either used community toilets or defecated in the open. Households tended to use community toilets or individual

toilets constructed by government agencies if they were well constructed, had adequate supply of water and in the case of community toilets, was efficiently managed, preferably with support from the government.

In a typically well provided urban community where interventions have been reportedly successful it was observed that the settlement had one or more than one community toilet provided for by the concerned urban local body (MCD, Delhi). At times, like in the case of the notified slum Addagutta in Hyderabad, Andhra Pradesh the community toilet had been constructed with the collaboration of the government agency, NRIs and the private sector. And in some settlements, individual toilets had been provide by NGOs (Wateraid in Basti Godam, MP) or through government supported programmes..

In slums like Vivekanada Camp and the Darbangha Slum, both in Delhi, where the urban local body (MCD) has been proactive and where the community has responded with interest and maturity, the sanitation status is significantly impressive. The community toilets are well constructed with adequate water supply through dedicated borewells and overhead tanks, and in a few cases, an incinerator for disposing of soiled menstrual pads or clothes has also been provided. The toilets have separate bathing facilities for women. User fees are charged and maintenance in most cases is carried out by the local body or an NGO or outsourced to agencies that often charge nominal user fees. Those interviewed stated that most households had willing accepted the well managed community toilets. However, a user fee was a deterrent to some, especially men, who were reluctant to pay and continued to defecate in the open. Some children also find it difficult to use the adult size toilets.

In communities where NGO presence was evident, slum level water and sanitation committees have been formed and ably maintain community toilets. These slums also have a sewerage system, well constructed drains and arrangements for dumping and regular removal of waste, and at times even government appointed cleaners. Schools in such communities are well provided for with fairly well maintained and separate toilets for girls and boys. For maintenance, the school authorities have been motivated to hire cleaners.

Large communities (4200) like, Addagutta in Hyderabad have apparently graduated from initially well managed community toilets to individual ones, when use of toilets became a habit. Households who could afford used their own resources for construction while others made effective use of funds provided under government schemes. The community toilets meanwhile, gradually fell into disuse and disrepair. (narrated by Sulatan Yaadgiri, President of the Addagutta Founders Development Committee.)

Not all communities have however, been so fortunate. Many like in the Israel Camp in Delhi and Papanam in Ramananthapuram district in Tamil Nadu said that although community toilets had been built by the government in their settlements, these were soon abandoned by the community because of poor quality of construction, lack of proper arrangements for water and inadequate arrangements for operation and maintenance. Moreover in the Israel Camp the local mafia has apparently appropriated the water sources and has forced the hapless households to purchase water from them, while the government has apparently turned a blind eye.

In the case of a well provided for rural settlement the facilities have again been provided through an NGO or state (TSC) supported programme. Individual household sanitation is the norm with anything from 50 (Bohra in Jalaun district , UP) to 100 percent(Chinnavilai, Kanyakumari district of TN, Chirattakkonam in Kollam district of Kerala) of the households being covered. The schools and anganwadis in these settlements have functional toilets for girls and boys and are maintained by people hired for the purpose. NGO support has been critical not only for the provision of facilities but also for making arrangements for operation and maintenance. However, while some settlements like Bohra in UP with partial coverage had designated sites for defecation in some others, like Chinnavilai in Tamil Nadu with 100 percent coverage, a small percent of men continued to defecate in the open.[5]

In most such villages adequate drains have been provided, individual soakpits are often to be found (Hivre Bazar, Ahmednagar in Maharsahtra) and the water points are well drained with platforms. However, adequate arrangements for solid waste management, including disposal of animal waste through proper collection and dumping at designated sites was seen only in some settlements where NGOs are active (Hivre Bazar in Maharahtra; Bohra in UP). Settlements like Chinnavilai had established a SWM committee and arrangements had been made for collection and segregation of household waste and composting. Waste was collected by paid waste collectors and each household paid Rs. 20 per month. Where such arrangements did not exists individual households built leach pits for waste water and separate pits for dumping solid and kitchen waste.

Similarly in peri- urban areas where interventions have been reportedly successful (Ullalu Upanagar New Colony, Bangalore in Karnataka) more than 75 percent of the households have individual toilets, while most of the others use the community based sanitation complex. Children and a few poor households apparently continue to defecate in the open. Water for the toilet is available through pipes at convenient distance.

Schools- both in rural and urban settlements- have mostly been perceived to be inadequately equipped to ensure sanitation and hygiene, except in communities where use of toilets has been widely adopted. Thus, communities reported the existence of toilets that are unused because of poor or no maintenance, toilets that are only used by teachers, toilets that are used only by girls and by some boys. In communities where toilets were not being used by most households, the children in schools, especially boys, preferred to urinate or defecate outside. Practice of hand washing in schools was only

[5] Chinnavialia is one of the Tsunami effected settlement where all households have been rehabilitated and provided with newly constructed houses with attached toilets.

reported by communities that had the advantage of sustained NGO interventions.

> *The NGO run school in the area does not have toilet facility and some students are sent back to the slum from the school in the morning, if they want to defecate. The toilets in the government school too are dirty, hence it forces many children to relieve themselves in the open. …* Group of women led by Munni Devi; Dalit Ekta Camp, Delhi

An inadequately provided rural and urban settlements, with or without project interventions, on the other hand presents a picture of limited or no individual household toilets, or toilets that have been poorly constructed or do not have adequate water supply, all of which has led to low or no usage. Similarly drainage is poor and there are no arrangements for collection of solid wastes. The schools and aganwadis in such settlements also reflect a similar picture. While most schools have toilet facilities, they are so poorly constructed, that most are not in use or used partially by the teachers. Communities struggle to cope with such a situation and are rarely able to initiate improvements unless they receive support from the government or an NGO.

4.4. Response to interventions

Planned and sustained interventions are obviously necessary in both urban and rural poor settlements to ensure enhanced coverage and use of sanitation facilities as well as adoption of hygienic practices.

Communities, obviously perceived the effect of interventions in relation to their own needs and aspirations. However, most identified functional toilets and effective system of disposal of garbage and liquid waste as key indicators of success. A significant number emphasised that hygiene practices also needed to be effective for interventions to be deemed successful. And almost all were certain that the entire community needed to adopt effective sanitation and hygiene practices for a project to be termed as successful.

The success or failure of interventions were clearly perceived to be influenced by the extent and nature of involvement of the community, democratic leadership within the community, the extent and nature of support provided by the state and it's implementing agency and extent of political interest and support. It was also largely influenced by the adequacy and quality of design and arrangements for operation and maintenance. Finally, a significant number of communities perceived that the effectiveness of projects could be improved with the involvement of NGOs.

Involvement of the community and support from local leaders was positive…

Where interventions have been successful, all stakeholder, especially communities, have participated with equal vigor. Awareness creation on effect of poor sanitation and hygiene has played a key role. Communities reported that impact of project was greater where toilets were constructed and other facilities provided, together with hygiene education inputs. This has also led to better upkeep and maintenance.

The extent of awareness of the community was perceived to be directly proportional to its involvement and consequent adoption of sanitation and hygiene practices. However, awareness had to be generated. In some cases communities have taken the initiative and demanded for facilities, especially slum communities in the larger urban areas. Interventions were identified as successful where communities worked together with the local administration in planning and prioritizing for services and facilities.

In the Dehripali slum in Orissa though 80 percent of the community is reported to have individual toilets and also using them, it appears to be more for convenience rather that health reasons and the remaining 20 percent are dis- interested. The existing toilets are reported to be poorly constructed and maintained and even those community members who want to improve the situation are daunted by the complication of the urban society..

> *Most of the poor people have built their houses in small spaces and hence they do not prefer to build toilets. They are neither aware of the of the problems related to bad sanitation, nor do they have intention to construct them….We live in a very complicated and competitive world where we do not have time for anything else then yourself and family matters.* (Jyotsana, a middle- aged woman from the community).

In slums like Kamlanehru in Patna it is poverty and lack of education which has led to dis-interest amongst the community.

Communities perceived that local leadership was critical to take the project forward. Local leaders on one hand motivated and guided the community and on the other, negotiated with the state and it's implementing agency. Leadership was assumed by the local ward councilors or sarpanchs form villages. But often these were ordinary members from the community itself who helped them to access funds and schemes. For instance in the Vivekanada slum in Delhi the MLA was supportive and not only allocated money from the discretionary funds but also consulted the community for other development interventions. Similarly, in the Darbangha slum, again in Delhi the community's advise on the 'slopes, routes and depths' of drains was readily accepted by the concerned government agency and in turn the former not only contributed in terms of labour but also voluntarily removed part of their huts to make space for the drains. In Khedutvas in Bhavnagar, Gujarat, the local leaders have apparently taken the lead in the government funded programme, wherein individual toilets are being constructed. The community reported that because of this, the progress of construction was good and funds were being adequately provided and utilised.

In the rural areas it was generally an enlightened and committed sarpanch, the leader of the village council or other natural community leaders who have often been the trigger for a successful intervention. For instance in Pedarajapet (Warangal, AP) the sarpanch who came to know about the TSC programme took the lead in calling a meeting of the community, sharing the information with them, forming a steering committee and even going as far as taking the

members of the committee on an exposure visit to a nearby NGP awarded village. All this enabled the community to effectively utilise the TSC funds and consequently receive the NGP award in 2008. Similarly in Chennaveli village, 98 percent of the community contributes towards the management of solid waste once they became aware of the dangers of dumping solid waste into the sea. To demonstrate and convince the community the local panchayat and the local NGO initially provided funds to maintain the services.

Projects have failed for lack of people's involvement and lack of local leadership. Munna from BeniPura village in Jalaun Uttar Pradesh sums up the lack of knowledge that prevents communities from adopting hygienic practices and sanitation facilities:

> *Situation of this village would not have been like this if the people were aware of the importance of sanitation. People know that they should follow the basic hygiene like washing hands before handling food and keeping their surroundings clean yet they dump the garbage in the open fields. They go to the agriculture fields for defecation, not knowing that they are polluting the fields by doing so*….Munna, Beni Pura, Jalaun district, UP.

…and so was it when women took the lead…

In several places, in both urban slums and rural villages, the community reported that women have played an active part in making the project a success. For instance in Sellipalayam in Tiruchirapalli district of Tamil Nadu, in a Schedule caste dominated village

where the local NGO had formed women SHGs, Vasuki, one of the leaders of the SHG took interest when the local NGO talked about sanitation. She arranged frequent community meetings and would request the NGO to talk to the community about sanitation and hygiene and its impact. While the NGO provided training and technical support, Vasuki provided loan from the revolving fund of the SHG to both members as well as non members and within a year almost all the 110 households had constructed individual toilets and had started to use them. Besides, when communities themselves monitor the interventions the success rate is higher.

But leadership could also be undemocratic and unaccountable…

Sometimes , leadership was perceived to be assumed in an uninformed, undemocratic and unaccountable manner. Communities reported that funds were inadequate because often it was misappropriated by the sarpanch or other local leaders.

In the Israel camp in New Delhi, drinking water sources have been appropriated by powerful members of the local community who now sell the water; the tubewell installed to supply water to the community toilet here has been appropriated by the local pradhan who now refuses to supply water to the community toilet, which has consequently been abandoned. In the Gehuwan Bariya pnachayat in Madhubani, migrant masons from the community who have been constructing toilets elsewhere in the country, have a tremendous influence on the opinions in the community. They have made the former believe that the basic unit cost of a toilet was Rs. 10,000, thus encouraging communities with limited resources to opt out of constructing toilets. Lal Saraia panchayat in the district of West Champaran in Bihar won the NGP in 2008. However, a majority of the toilets that were constructed about 3 years back have fallen into disuses because of collapse of pits and other damages because of the poor quality of construction, use of poor quality material, etc. as funds were perceived to be mis-appropriated .

Appropriate technology, good quality of construction and arrangements for maintenance were critical

Projects have failed because of poor implementation and follow up by the concerned state agency. In settlement after settlement, communities commented on the small size and inappropriate design of the toilets, the poor arrangements for water supply and the inadequate arrangements for maintenance of community toilets, collection of solid waste or cleaning of drains. Maintenance is in fact one of the most major issues as the story of several community toilets in the urban settlements in Delhi, Bihar, Orissa, Tamil Nadu and others indicate.

In the Israel Camp slum in Delhi though the state agency set initiated and completed the construction of a community toilet, it did not provide adequate water and did not set up any mechanism for operation and maintenance or provide for a caretaker. Further, the drainage was also insufficient. Hence, the toilet is not being full used. Therefore structural faults, no maintenance arrangement, lack of leadership and motivation and above all lack of water has led to the community asset remaining unused. A similar story was reported by the community in the Arjun camp slum in Delhi where instead of two toilets that were to be constructed only one was finally made with consulting the community. Thus, while the facility is in adequate in terms of numbers it is also poorly maintained. Local leaders made sporadic attempts to rectify the situation, but since response from the government was slow or absent, they soon lost interest. Communities also refuse to use structures, even individual toilets, where construction has been faulty. This lack of leadership and collective action in the community and disinterest on the part of the state agency has been repeated in several other urban sites and rural sites.

Involvement of civil society organizations and NGOs could improve the situation…

The role of NGOs was perceived as critical to prevent projects from failing. Their

NGOs provided guidance and motivation, built capacities and also at time provided funds. For instance in Kotbagi, Dharward, the NGO provided loans to the households in the panchayat was motivated to provide the remaining funds. There were several others like the NGO in Chennevilai village, which provided both hard and soft ware support. Infact most of the projects that have been claimed to be successful indicate collaboration between the concerned state agency and a local NGO

At the same time, NGO can also have a negative impact. Some communities like Gehuwan Baeriya in Madhubani, Bihar have lost faith in outside interventions because they have been cheated by an NGO some years back. Besides, they find the process of accessing facilities under government program long and tedious. And often construction of toilets over-clouds other supportive needs and targeted programmes lead to only partial coverage of the settlement.

In a village where there is no toilet for most of the people, having toilets for some wont' help…lack of water supply is a major reason….further many find the space for toilets very congested. ..we find it useless to have a toilet alone. Lalita, Kodobahal village, Orissa

Thus lack of awareness and education, sanitation not being a priority, poor technology and construction, lack of monitoring and follow up, lack of leadership and collective action, poor or no NGO intervention have all added up to the failure of several projects and also slip backs even in villages that have been recognized with the NGP award. The same reasons have led to several communities in both urban and rural areas being left out of project support.

Then what is the perceived role of various stakeholder…

The community is clear about the role of various stakeholders and what needs to be done to improve the situation. While the needs were specific to some extent depending on the status of existing facilities what emerged as clear needs could be consolidated as :

- Need for communities to be consulted and more involved. Involvement will only come through when they realize the importance of sanitation on one hand and when they have the means of providing for themselves. The community feels that while to a large extent the onus of generating awareness and involvement lies with the state agencies and NGOs, leadership within their community is also equally important.
- The state and its agencies should provide more funds and support, improve technologies, fully inform the communities of programmes, monitor implementation more effectively and also provide follow up support.
- The NGOs are seen as support agencies that would ensure state-community participation and effective use of funds.

As such it appears that the communities do not perceive new roles for the principal stakeholders. Instead it envisages a more committed and participatory involvement.

WHAT THE COMMUNITY WANTS

Then what do communities want?

While communities wants and aspirations are colored by their specific geophysical locations, socio- economic status and the baseline of facilities currently available to them, by and large they want broadly similar things.

- The communities want a 'clean' and 'healthy' environment for themselves and their families, especially their children. Hence, they want functional toilets, waste water disposal systems, and adequate and regular arrangement for disposal of the solid waste in the settlement.
- The communities want to live in 'dignity' and not face the humiliation of defecating in public. They specially want to ensure the dignity and safety of the women and the girl children. The communities want the outside world to perceive their settlement as visibly clean and worthy of interaction.
- The communities want functional, individual toilets. Those who are aware and can afford it have begun to construct and use it on their own. However, those who are poor and powerless want the government to make the necessary arrangements. In fact those who even have a vague notion about the concept of 'rights' perceive that it is their right to demand such facilities from the government.
- Communities, especially in urban slum settlements and in rural areas where space is a problem or where funds are short, want functional community toilets with adequate water supply. Communities want that these toilets should be located at distances that are convenient and safe.
- Communities want that both individual and community toilets should be well constructed, both in terms of design and quality of construction. To ensure this the community wants the government and NGOs to provide adequate funds, to ensure adequate supervision and also ensure transparency and accountability.
- Further, the communities want that the design should be location specific and not a standard design that is adopted irrespective of geo physical conditions and community requirements.
- Above all the communities want the government to ensure adequate supply of water before construction of toilets.
- At the same time the communities want to be consulted in planning and designing the sanitation and water supply facilities, especially toilets. In fact the communities want the government to be flexible in this regard.
- The communities want that the government and concerned agencies should provide them with adequate and timely information before the start of any interventions.
- The communities by and large want the government and its agencies to be responsible for maintenance of community facilities.

- The communities want that people should be motivated to keep their surroundings as clean as their houses. This would primarily mean not defecating outside, not throwing garbage out into public places and not letting waste water out into the open.

- Informed community leaders want their members to be made aware and educated about safe sanitation and hygiene. They want that hygiene promotion and education should precede or go hand in hand with the provision of facilities.

- Communities want NGOs and civil society organisations to be part of such initiatives, especially in educating and mobilising communities.

- And above all the communities want to be able to practice what they learn and know: women know that they need to maintain hygiene while cooking, use clean cloth or sanitary pads during menstruation. However, abject poverty and difficult conditions of living prevent them from practicing what they know.

- The women want more: they want dignity, privacy and safety for themselves; and they want hygienic conditions and health for their children who can then go to school

6. CONCLUSIONS

Sanitation interventions were first launched in India almost three decades back and participatory community centered programmes came into vogue towards the end of the 1990s. Yet the communities perceive a mis- match between what they need and what is being provided: by and large they perceive a lack of understanding, awareness and information; a lack of resources and a lack of support.

Many communities relate hygiene and sanitation to cleanliness and the visible appearance of their home and surroundings and less to health. However, those that have perceived the link between sanitation, hygiene and health are also quicker to adopt practices, especially if it concerns the health of their children. Where support has been committed with interactive processes, adequate time and resources being provided, communities have responded well and adopted and internalized new habits. In such cases it would be safe to assume that such communities would sustain the change. In other cases adoption of practices and acceptance of facilities have been limited to such time as the facilities functioned or external support was available. In fact discernable communities themselves perceive the importance of hygiene education and feel that facilities without education is less effective.

Practice is in turn not only influenced by understanding and awareness but also the ability to adopt facilities and hygienic practices. Communities are frustrated in their efforts by lack of resources, state support and especially in the case of urban communities, a lack of space. Communities have also indicated two critical issues regarding facilities: firstly that water is an integral part of sanitation and secondly that community toilets are for a transitory period and most communities would graduate to individual toilets. Both have an implication on the technology and strategy. It calls for a long terms vision in planning. Communities have also indicated that community based maintenance does not mean complete withdrawal of state support. In fact where state agencies have made adequate arrangements for operation and maintenance of community facilities, the communities in turn have responded by using and paying for it.

Communities perceive that more projects have failed because of a lack of involvement and commitment of both communities and the agencies and consequent lapses in technology, planning, implementation, supervision, support and above all accountability. Local leadership, especially where women have been involved, has been most effective in taking the sanitation agenda forward.

Clear messages with implications for sector policies and strategies emerge from the above discourse with the communities:

- The communities, at least most of them and especially the women, do not want defecate in the open anymore. They want individual household toilets that are well constructed and provided with adequate water supply; and they want financial support and guidance from the state and civil society organizations. *This calls for dynamic and innovative funding mechanisms that encourage communities to contribute from their own sources or access easy loan facilities.*

- The communities want that the state or NGOs establish an efficient system for solid waste removal and drainage for waste water. Most communities are willing to contribute for the services but are reluctant to entrust the management to it's own community members. *This calls for an effective waste management system with public –private participation.*

- There is evidence that there is an improved understanding amongst women about menstrual hygiene management . However, most women are still constrained by their inability to practice what they know. The two deterrents are: inability to purchase sanitary napkins and lack of toilets and adequate water facilities. *This calls for a concerted campaign (like the global hand- washing campaign) to promote the use of sanitary napkins*.

- And lastly, communities everywhere have indicated that where state or other agencies have failed to work with integrity and accountability the benefits to the community have been almost absent. *This calls for more transparent accountability mechanisms and increasing responsibilities for the local bodies.*

History tells us that open defecation and poor sanitary conditions existed in the nineteenth and the early years of the twentieth century when the sub- continent was ruled by 'others'. The poor were the biggest sufferers then. Open defecation and poor sanitary conditions continue to exist even after 65 years of independence- and the poor continue to be the biggest sufferers.

"Grassroots Voices for Safe and Sustainable Sanitation in South Asia"

Pre-SACOSAN-IV Consultation Meeting of CSOs(Draft Agenda)

1st & 2nd April 2011, Hotel Tammarind, COLOMBO

Purpose: To provide adequate space and opportunity for CSOs and Community organizations to share their experiences and articulate for addressing the sanitation crisis in South Asia. Based on this collective grassroots wisdom, a consolidated input will be generated to the inter-ministerial processes of SACOSAN-IV, to be held from 4th April – 8th April 2011.

Key Results Expected:

- Review the progress made on the issues identified by CSOs and commitments made by the national governments in SACOSAN III and identify priorities to be addressed in SACOSAN IV and beyond.
- Consolidated CSOs statement to SACOSAN-IV recommending specific actions to be initiated by the South Asian National Governments for achieving the accelerated progress on Sanitation and suggesting the possible support role of civil society therein.
- Capture the ideas of cross regional CSO/CBO leaders for effectively conducting the different parallel sessions being coordinated/facilitated by the WA, WSSCC, FANSA in SACOSAN-IV.
- Advocacy Action plan beyond SACOSAN-IV to address the sanitation issues of the South Asian Region.

AGENDA

Day-1 (01 April 2011)

08:30 - 09:00	Registration	CEJ
09:00 - 09: 10	Welcome	CEJ
09:10 - 09:50	Participants Introduction (*creative Ice-breaking session*)	Communications Team
09:50 - 10:05	Objectives and Plan for the 2-days	FANSA
10:05 - 10:20	Opening Remarks by Coalition Partners	WA/WSSCC/FAN
10:20 - 10:30	Address by Govt. of Sri Lanka representative	
10:30 - 11:00	Inaugural Speech[6]	Guest-of-Honour
11:00 - 11:20	**Break**	
11:20 - 12:00	Setting the Scene – Introduction to SACOSAN, past declarations, CSOs' journey from Delhi to Colombo[7]	Communications Team
12:00 - 13:15	Peoples' Perceptions – Key findings from the Study	Ayub Qutub
	Film, Comments and Observations from the Group	
13:15 - 14:15	**Lunch**	

[6] 15 minutes' speech and 15 minutes reflections/discussions (Speaker is yet to be identified – a speaker whose participation would increase the profile of the meeting and attract media and SACOSAN's attention)

[7] Idea: Drama-type representation of the past – representatives from each country (in their national costumes) to enact SACOSAN-like ministerial delegations participating in the conference

14:15 - 15:30	Voices of Community Leaders	
15:30 - 18:00	Inter Country Group Work on Key Issues (*the allocated time includes introduction to the group tasks and 15 minutes Tea Break*)	
	Inter Country Small Groups to discuss thematic issues[8] ➢ Reaching the unserved – addressing exclusion and inequalities – options for change ➢ WASH in schools including the special sanitation needs of adolescent girls ➢ Strengthening monitoring and accountability in WASH sector ➢ Issues of urban sanitation including public toilets ➢ Sustainability of sanitation services / programmes ➢ Sanitation and health-Creating a case for Health sector to prioritize WASH	Facilitators and Rapporteurs for each group need to be identified and briefed about their expected outputs[9]
18:00 - 18:15	Closing of Day I	

Day-2 (02 April 2011)

08:30 - 08:45	Recap from the Day-1	
08:45 - 10:00	Presentation of Group Reports in the Plenary from the Day-1 and Discussion	
10:00 - 11:15	Traffic Lights Papers – Review of Commitments of (*with the introduction and use of washwatch.org as a web based monitoring tool*) SACOSAN-III Declarations	Mustafa Talpur & Ian Ross
	CSO Commitments at pre-SACOSAN-III *Observations, Comments and Discussion*	Prakash Amatya
11:15 - 11:40	**Break**	
11:40 - 13:00	Sharing of 1st draft CSO statement and input from the Group (*in plenary*)	Convenor of the Drafting Committee
13:00 - 13:45	**Lunch**	
13:45 - 15:15	Media Stunt Event[10]	Communications and Media Group
15:15 - 15:30	**Break**	
15:30 - 16:30	Does the Rights-Based Approach make a difference to sanitation outcomes? Research presentation from Bangladesh, Nepal, Kenya and	DfID

[8] The outcome of group discussion will provide material and support the sessions in official conference

[9] Rapporteurs from each group are expected to hand over the note of key points to the committee on CSO statement drafting (Drafting Committee of CSO statement is expected to present the first draft statement by 11:30 am on 2nd April 2011)

[10] Includes briefing about media stunt

	Rwanda[11]	
16:30 - 17:30	Ideas for follow-up action after SACOSAN IV	Communications and Media Group
17:30 - 17:45	**Break**	
17:45 - 18:15	Adoption of CSO Statement	Drafting Committee
18:15 - 18:45	Closing of CSO Meeting	

* * * * *

[11] Includes 15 minutes presentation and 45 minutes' discussion

SACOSAN III Delhi Declaration 2008

We, the Heads of Delegations from Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan and Sri Lanka, participating in the Third South Asian Conference on Sanitation (SACOSAN-III), in New Delhi from November 16 to 21 2008, attended by Ministers, elected representatives, government officials, professionals, academia, civil society, non-government and community organizations, development partners and the private sector:

1. Recognise that access to sanitation and safe drinking water is a basic right, and according national priority to sanitation is imperative.

2. Confirm our commitment to achieving National and the Millennium Development Goals (MDGs) on Sanitation in a time-bound manner in all participating countries of South Asia.

3. Assert that achieving total and sustainable sanitation in all rural and urban communities in our countries is not only possible but also is our cherished goal reiterated in SACOSAN-I at Dhaka (2003) and SACOSAN-II at Islamabad (2006).

4. We draw attention and reiterate our commitment to the following key principles and specific actions that need to be implemented at household, local, sub-national and national levels to accelerate performance and rapidly achieve our sanitation goals:

    a. Ensuring that the present and future generations enjoy a healthy environment, with clean air, soil and fresh water resources;

    b. Achieving sanitation for all will be an inclusive process, involving all stakeholders at all stages, especially local governments, community and grassroots groups;

    c. Sanitation will not be considered merely an infrastructure or financing challenge, but one that requires effective policy, institutional and fiscal incentives to change behaviour, working in partnership with religious leaders, communities, institutions (e.g. schools etc.), local governments and service providers; and strengthening their capacities and accountability in mobilizing, implementation and monitoring;

    d. Promote thinking of sanitation as the full cycle of proper arrangements, safe conveyance and sanitary disposal/re-use of liquid and solid wastes (including solutions that do not adversely impact the quality of land and water resources), and associated hygiene behaviour;

    e. A range of sanitation provision and service options will be available to choose from. Basic access to sanitation facilities will be ensured to all by reducing disparities through appropriate budgetary policies, with active participation, contribution, decision-making and ownership by communities;

    f. Incentives and support will be provided for the poor and people in vulnerable areas;

    g. The needs and concerns of women and most vulnerable (e.g. infants, children especially girl-children, the differently-abled, the elderly) will be addressed as a priority. Innovative mechanisms e.g. micro-finance by Self Help Groups, will be effectively promoted;

    h. Socially and economically disadvantaged households will be mobilized to form groups; and supported to access sanitation and other development programs;

    i. The special sanitation needs of women (e.g. menstrual hygiene management) will be integrated in planning, implementation, monitoring and measurement of program outcomes. The key role of women in managing sanitation and hygiene in community settings will be enhanced;

    j. Greater thrust will be placed on promoting adequate sanitation in schools e.g. separate facilities for boys and girls, supported by safe drinking water and with adequate child-friendly facilities. Hygiene education will be incorporated into the school curricula to promote good hygiene behaviour and upkeep of facilities;

    k. Collaboration between countries will be strengthened to develop capacities, sharing of best practices, and to promote mechanisms for independent monitoring;

    l. Behaviour Change Communication and information sharing will be effectively utilized for creating demand for clean and healthy environment, and for promoting good hygiene behaviour; in partnership with Media and using Information and Communication Technologies;

    m. Sanitation and hygiene needs to be integrated into health, education and other related policies, and regulations effectively enforced;

    n. Technologies (e.g. which require less water and/or no water) and the practice of “reuse and recycle” of human wastes, and solid and liquid wastes (including conversion into energy), will be promoted;

o. Collaborations with the private sector (including toilet associations and groups of sanitary goods and service-providers) will be strengthened in developing sanitation standards, technologies and products that are appropriate, affordable, ecologically-friendly and easily accessible;

p. For urban areas, an integrated city-wide approach will be adopted to ensure the safe management (including treatment and disposal) of human wastes, and all other solid and liquid wastes (including medical, industrial and commercial wastes, etc.);

q. The urban poor, especially those in slum settlements, will be facilitated and supported to obtain access to safe sanitation as a part of the integrated city-wide sanitation plans; and

r. The critical role of personnel involved in sanitation work will be recognized, and measures taken to raise their dignity.

Actions and Commitments

In this International Year of Sanitation 2008, we commit ourselves to achieving our national goals and the Millennium Development Goals on Sanitation in a time-bound manner, and shall take the following actions:

1. Continue advocacy and awareness to sustain the momentum given to sanitation explicitly at the regional, national, sub-national and local levels, in policy, budgetary allocation, human resources, and implementation;

2. Strengthen community efforts and developing capacities of Local Governments, non-governmental organizations, youth and community groups to work in partnership for sustainable sanitation solutions;

3. Ensure occupational dignity, health, safety and improve the profile and working conditions of personnel involved in sanitation work;

4. Prioritise sanitation as a development intervention for health, dignity and security of all members of communities especially infants, girl-children, women, the elderly and differently-abled;

5. Mainstream sanitation across sectors, ministries/departments, institutions, domains (private, household, schools, community, public), and socio-political persuasions, so that sanitation is everybody's concern and prioritised in their respective programs (e.g. railways or tourism agencies promoting access to sanitation facilities as a part of their programs);

6. Develop and implement approaches, methodologies, technologies and systems for emergencies, and disaster situations, and for areas, with special characteristics/ terrains or groups suffering temporary displacement;

7. Advocate globally the recognition of climate change impacts on sanitation provision in South Asia, and develop and implement strategies and technologies that adapt to and mitigate impacts;

8. Enable flexibility and variety in options and practical solutions to suit local conditions, preferences, and resources;

9. An inter-country Working Group, led by country focal points, will meet periodically to promote research and development, collaborations, exchanges of innovations, experiences and expertise; networks among intra-country groups and agencies will be created for sharing of knowledge; and

10. The Indicative "South Asia Roadmap for Achieving Sanitation Goals" (cf. Annex) may be consulted by the participant countries to develop their national Action Plans for implementation over the 2009-2011 period.

The momentum gained by the three SACOSANs will be further continued by the hosting of the Fourth SACOSAN in Sri Lanka in 2010, and the fifth SACOSAN in Nepal in 2012.

We are grateful to and thank the Government and people of India, for successfully hosting the Third South Asian Conference on Sanitation (SACOSAN-III).

Civil Society Declaration Nov 2011: Our demands for urgent action from governments at SACOSAN III Delhi

We, the participants of the Pre-SACOSAN Civil Society Meet organised on 16 and 17 November 2008 in New Delhi by the Freshwater Action Network South Asia (FANSA), WaterAid and the Water Supply and Sanitation Collaborative Council (WSSCC), and those involved in a series of country level consultations; representing NGOs, CBOs, grassroots representatives and civil society organisations from Bangladesh, Bhutan, India, Nepal, Pakistan, and Sri Lanka, submit the following declaration to the delegates of SACOSAN III.

There is a sanitation crisis in South Asia demanding urgent action. Ten lakh children have died from diarrhoea in South Asia in the 2 years since SACOSAN II. At 1 billion, the region has the highest number of unserved and underserved people. This represents human suffering at an unprecedented scale, obstructing people's right to lead healthy, productive, dignified lives.

Since the organisation of the first SACOSAN in 2003 in Bangladesh, the governments of South Asia have subscribed to two Ministerial Declarations, committing to an ambitious programme of action. These commitments must be honoured - the need for more political commitment, better coordination and partnerships and good governance continue to constrain progress in the sector.

While we agree that some progress has been made against these commitments, there is a need to speed up and scale up the delivery - the human cost of this crisis means that business as usual is not an option. We have identified the following eight key issues that need to be addressed in order to achieve equitable, substantial and sustainable growth in the number of people able to access safe sanitation and hygiene services. We commit ourselves to work on these issues, to create models, seek innovation, and demonstrate best practices, working alongside communities, governments, international agencies and the private sector.

The right to sanitation and water
Access to sanitation is not only a development imperative; it is also a human right, firmly grounded in international human rights law. For better health outcomes, sanitation requires water supply in close proximity. Most governments in the region have recognised the right to safe drinking water and basic sanitation in the "Message from Beppu" at the first Asia Pacific Water Summit in 2007.

We call on governments to reaffirm their prior recognition that access to safe drinking water and basic sanitation is a basic human right and a fundamental aspect of human security and dignity.

Governance
Progress in the sanitation sector is constrained by weak accountability due to poorly defined institutional arrangements and the lack of accurate data on the real situation. Local governments, CBOs and CSOs are often sidelined in the process of planning and implementation. Recent advances in the right to information in the region can be used to improve service delivery outcomes and better governance.

We call on governments to:

• Establish accountable leadership at the national level, ensuring coordination among all relevant line ministries.
• Place local governments at the centre of planning and implementation of all sanitation programmes, coordinating activities of all actors at the local level.
• Create a dedicated budget line for sanitation with adequate financial provision to achieve universal access targets set by governments, and ensure judicious use of subsidies.
• Put in place mechanisms for independent assessments of the status of sanitation and the process of implementation of programmes.

Health outcomes
Improved health is a key outcome of sanitation. Sanitation and hygiene promotion are the most cost-effective health interventions. We need better information on health impacts, both to improve the effectiveness of sanitation programmes and to convince policy makers of the need to invest in sanitation.

We call on governments to:
• Involve the health sector in designing sanitation programmes and in monitoring health impacts.
• Develop and strengthen mechanisms to collect, validate and analyse incidence of excreta related diseases which should form the basis of policy and programme design.

Urban sanitation
Urban sanitation, including solid and liquid waste management, is a critical issue with implications for the environment and the dignity of the urban poor.

We call on governments to:
• Ensure that all urban and peri-urban communities have access to sanitation, de-linking access to basic services from land tenure and ensuring land tenure security, and that all public places have sanitation facilities.
• Prepare city/town/peri-urban area wide maps of existing infrastructure to improve transparency and make informed investment decisions and interventions in which all stakeholders can participate.
• Facilitate and scale-up local initiatives and promote appropriate and improved technologies using a decentralised approach and partnerships between communities, public and private sectors.

Manual scavenging
The practice of manual scavenging is a violation of human rights, a grave infringement of people's dignity, and the worst form of caste-based discrimination. Laws to eradicate the practice have been passed in some countries but these are not enforced.

We call on governments to:
• Acknowledge and record the continuing practice of manual scavenging in order to allow for accurate assessments of the scale of the practice.
• Put into place improved waste management practices and technologies to avoid human contact with harmful waste and ensure safety of workers until the practice is eradicated.
• Eradicate manual scavenging by 2010, and support alternative livelihoods and education for all former scavengers and their families.

Sanitation in educational institutions
Many schools in the region do not have adequate sanitation and hygiene facilities, keeping children, especially girls, out of school. Sanitation and hygiene promotion are about behavior change. Behaviours are formed at a young age and school sanitation and hygiene education can build a healthy future generation; children are also effective agents of change.

We call on governments to:
• Make budgetary provision for government schools and regulate private schools to construct and maintain sufficient and gender-friendly sanitation and hygiene facilities (soap and water supply) with facilities for menstrual hygiene management.
• Include hygiene as an integral part of education and improve monitoring of school sanitation and hygiene education programmes.

Menstrual Hygiene
Unsafe menstrual hygiene practices place a heavy and unrecognised burden on women in the region. This remains a taboo subject, surrounded by religious and cultural myths, and a blind spot in sanitation and hygiene promotion programmes.

We call on governments to recognize menstrual hygiene as integral to hygiene and health and sensitise and build capacity

of people on Menstrual Hygiene Management by integration into sanitation, hygiene and health programmes.

Exclusion
Sanitation programmes currently are not reaching a significant proportion of the population. Especially vulnerable groups include - differently-abled people, those affected and infected by HIV/AIDS, tribals and discriminated castes, religious minorities, migratory people, construction workers, urban non-tenured slums dwellers, floating and homeless populations, those affected by natural calamities, Internally Displaced People and people living in hard to reach areas.

We call on governments to:
• Raise awareness at all levels on issues of exclusion and build commitments to excluded
groups into policy statements and implementation guidelines.
• Include methodologies to identify the poor and marginalised and adopt inclusive approaches
in all sanitation programmes and monitor performance in reaching these groups.

We as CSOs in the region continue to commit to:
• Strive for the recognition of the right to safe drinking water and basic sanitation in our countries' constitutions, laws and sector policies and support communities to realize this right, highlighting the plight and experience of excluded communities, amplifying their voices and complementing their actions.
• Lobby governments through advocacy, legal action and awareness raising, to enforce the laws and government schemes to end manual scavenging and achieve sanitation for all.
• Demonstrate and implement innovative sanitation and hygiene models in communities and schools, embodying inclusion, equity and community initiative and generate evidence of successful approaches.
• Facilitate local communities, CBOs and government institutions to create partnerships that support local initiative and strengthen capacity at local level.
• Raise awareness on school sanitation and hygiene, addressing the special needs of adolescent girls, including menstrual hygiene management.
• Focus our resources on working with excluded groups to enable them to live dignified and secure lives and share our experiences widely.

Civil society has a long history of engagement in sanitation and hygiene behaviour change. We are committed to supporting the SACOSAN process to tackle the sanitation crisis in the region by jointly implementing and monitoring progress on past and future declaration commitments. We submit the above to you in a spirit of collaboration, recognising that all actors will need to work together to achieve sanitation for all.

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About India WASH Forum

India WASH Forum is a registered Indian Trust since 2008 with thirteen Trustees from all over India. It is affiliated to the WSSCC Geneva and is a coalition of Indian organizations and individuals working on water, sanitation and hygiene.

A unique feature of IWF is its non-hierarchical set up. The Trustees of India WASH Forum are represented in their individual capacity and do not represent the organsiations they are associated with. The agenda and activities that India WASH Forum are determined at the initiative of the Trustees and support from organisations and individuals. We receive a very small operations grant from WSSCC and undertake learning events, engagement and support with other organisations and initiatives and bring out this bi monthly News & Policy Update.

Our Charter includes the following commitments;

- **Promoting knowledge generation** through research and documentation which is linked to and supported grassroots action in the water-sanitation-hygiene sectors. Special emphasis is given **to sector-specific and cross-cutting thematic learnings.**
- **Supporting field-based NGOs and networks in their technical and programmatic work.** The IWF would also consistently highlight gender and pro-poor considerations, and provide a national platform for interest groups working in the sector to come together.
- **Undertaking policy advocacy and influence** work through
  - Monitoring and evaluations
  - Media advocacy and campaigns, and
  - Fact finding missions
- **Undertaking lobbying and networking to promote common objectives** in the sector.

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