

This item was submitted to [Loughborough's Research Repository](#) by the author.
Items in Figshare are protected by copyright, with all rights reserved, unless otherwise indicated.

Our challenge: latrine for all

PLEASE CITE THE PUBLISHED VERSION

PUBLISHER

© WEDC, Loughborough University

VERSION

VoR (Version of Record)

PUBLISHER STATEMENT

This work is made available according to the conditions of the Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International (CC BY-NC-ND 4.0) licence. Full details of this licence are available at: <https://creativecommons.org/licenses/by-nc-nd/4.0/>

LICENCE

CC BY-NC-ND 4.0

REPOSITORY RECORD

Sengupta, Chandan. 2019. "Our Challenge: Latrine for All". figshare. <https://hdl.handle.net/2134/29530>.



Our challenge: Latrine for all

Chandan Sengupta, India

THE DECADE OF the eighties started yielding remarkable results to the concerted endeavour taken in the field of water supply since the three preceding decades. However, progress in the area of desirable sanitary and hygiene practices were still slow. In fact the coverage of households by sanitary latrines was only about 9.5% at the national level according to the reports of the Census of India in 1991. The corresponding figure for the State of West Bengal was 12.3%. Subsequent to limited access to household latrines and lack of hygiene knowledge, the health indicators depicted were causing concern. The U5 mortality in rural West Bengal was 93.3 and 60% children born in the rural areas had low birth weight (National Family and Health Survey- 1993).

The incidence of sickness due to water borne diseases despite availability of safe and clean water, was an intelligible paradox. Open defaecation is considered to be a significant factor contributing to this paradox. Surface runoff resulted in contamination of water sources, used for drinking water, by human faeces. Unsafe disposal of childrens' stools, again a hygiene-related behaviour, led to parasitic infestation through the hand-to-mouth route and contamination of water sources. Poor water handling practices and degraded environmental sanitation were contributing to recurrent health problems in the rural households. Subsequently, loss of person-days at work, loss of school days suffered by children and household expenditures on treatment of water borne diseases were common in rural areas.

In appreciation of the above scenario the Government of India, as well as other bilateral agencies, as a priority focussed on the promotion of sanitation and hygiene education. While portraying the entire range of problems arising out of poor sanitary practices and hygiene knowledge, policy makers and project managers were realizing that the practice of open defecation was the most dangerous community behaviour. Hence a significant initiative was to change the practices of 90% of the population from open defaecation to latrine use.

However, the initial endeavours of the Government, during the mid-eighties and the early nineties were characterized by certain limiting factors. Firstly, the rural sanitation programme was not backed by the requisite political commitment to bolster any remarkable progress. Thus the resource allocation, leadership and enthusiasm needed to support the programme along the vertical hierarchy (reaching the grassroots) were wanting. Secondly, the programme was not appropriately responding to the community's

resistance to opt for latrines as an alternative to open defecation. This resistance was primarily due to a lack of knowledge about construction and use of latrines. Exposure to latrines was confined either to the expensive models having septic tanks, or public latrines (in railway stations, theatres, government buildings), that are, in most cases, ill kept and unhygienic. Against this backdrop the programme provided a (high value) latrine model with a superstructure not commensurate with the prevalent housing of the rural community. The programme was, moreover, supply driven and the latrines were highly subsidized. Thus, latrines supplied to the households, without ensuring effective demand, led to dismal levels of non-use and rejection of the assets.

Thirdly, the programme was technically and financially rigid with little option to cater to individual preference and affordability. Again, the delivery mechanism did not address the community demand effectively. As it is, due to limited exposure and knowledge about the merits of latrine facilities the household propensity to adopt the practice and opt for a latrine was low. There was no institutional arrangement to address these issues at the grassroots.

These factors led to dismal performance of the sanitation programme in the initial years.

Medinipur – Evolution of the Strategy

The Rural Sanitation Programme (RSP), conceived and supported by UNICEF, was initiated by the Government of West Bengal in Medinipur district. This programme was designed to address the above-mentioned gaps experienced in implementation of the sanitation programme. A large district like Medinipur, having a population of over 9 million (which is 1% of the population of India and about one eighth of West Bengal's population), was selected for programme implementation. In 1991 only 4.74% of the population in Medinipur had access to a sanitary latrine.

The programme was implemented in the district under the supervision and guidance of the rural local self-government popularly termed as the Panchayats. The Ramkrishna Mission Lokasiksha Parishad (RKMLSP), a reputed NGO, was assigned the task of programme implementation. RKMLSP had a formidable existence in the district with ongoing projects in early childhood development and self help programmes. The programme managers worked with **the premise that there existed a demand for latrines, albeit latent**, and a demand responsive strategy was perceived to achieve the avowed objectives. The key strategy components were:

- 1) The IEC strategy was created with the objective of converting this latent demand to real and perceptible requirements of the rural household. The macro level messages transmitted through print and electronic media highlighted disadvantages in the health status caused by open defaecation. An analysis of the situation revealed that problems of security and women's dignity were strongly associated with open defaecation. Moreover, the practice was perceived as inconvenient for older family members and children, particularly when they had to walk for a long distance in search of an open and isolated space, or during monsoons. These problems were highlighted significantly while promoting the use of latrines through interpersonal interactions at the micro level.
- 2) **Technical innovations** were also significant in advancing the programme to its current status. In order to accelerate adoption of the latrine at the household level, latrine structures compatible to the dwelling units of the users were conceived. Again, a range of latrine models at differential rates was designed to cater to the consumers. The option to obtain latrines that were less expensive actually catered both to poor households as well as households who were moderately motivated to invest in a latrine. Interestingly, the less expensive latrines could be upgraded at a later stage with some additional attachments at an extra cost. Upgrading of latrines is a pointer towards a growing demand for latrines in the community.
- 3) A unique **delivery mechanism** was set up by establishing production centres to manufacture latrines and deliver the product to the households interested in purchasing sanitary latrines. Local women were trained to manufacture the sanitary wares using locally available raw materials. Representatives of the Production centres operated at the village level to motivate and prepare the households to opt for latrines. These representatives received an incentive for every household they could motivate. The order for manufacturing latrines was thus generated by the production centres that emerged as financially viable units.

Currently in Medinipur, the Ramkrishna Mission Lokasiksha Parishad (RKMLSP) is the nodal agency for all WATSAN activities at the district level. The RKMLSP supports the rural sanitary marts (RSM) at the block level with the help of 16 cluster level organizations (each cluster level organization manages 4 to 5 blocks or RSMs) and 1,000 youth clubs at the village level. The youth clubs, in accordance to their geographical locations, are affiliated with the respective cluster level organizations and are entrusted to propagate the programme at the grassroot levels. The coverage of households by sanitary latrines in the district has increased to 60% in 2001 (from 5% in 1991).

The State level Strategy for Environmental Sanitation

The Medinipur experiment started yielding results by 1993, as access to sanitary latrines in the district increased to about 20%. The demand responsive approach, offering a range of options to the user community, gained credence and latrine delivery through retail outlets was perceived as the vital programme component. The UNICEF model experimented in Medinipur was thus adopted as *the* strategy for the state of West Bengal. Reinforced political commitment of the Government was manifested as sanitation was being treated with significance equal to that of literacy.

The delivery mechanism for the State has been conceived in line with the existing *rural local self governance* system called the **Panchayati Raj Institution (PRI)**. The PRI is comprised of elected community representatives vested with the responsibility of executing the business of local governance and development. The PRI functions as a 4 tier hierarchy at the hamlet (**Sansad**), village (**Gram Panchayat** comprising of sansads (hamlets)), block (**Panchayat Samity** comprising of villages), and district levels (**Zilla Parishad** comprising of blocks). In this framework, the RSM was set up at the block level for serving the population within the block. Local NGOs were entrusted to operate the RSMs. UNICEF provided initial support to set up the RSMs, which were designed to evolve as financially viable units. The RSMs are represented by the motivators at the village level (every sansad has at least one motivator). The motivators are instrumental in implementing the sanitation drive and identifying the households uncovered by the programme. The information provided by the motivator is collated at the RSM. The motivators are given an incentive for every household they motivate to adopt a latrine.

At the village level, the forum for planning the water and sanitation strategy is the sansad (hamlet) level meeting. These meetings are attended by the Block Development Officers (BDO) - the government representative at the block level, RSM/NGO representative and other government representatives with the specific purpose of promoting water and sanitation project components. The motivator and the elected panchayat member of the sansad are largely responsible for execution of the water and sanitation related decisions taken at the sansad (hamlet) level.

Water and sanitation committees are also set up at the block and district levels headed by the **Janasasthya Karmadhyaksha** (elected representative in charge of public health). At the state level, the **State Sanitation Cell** coordinates this network. Apart from monitoring the programme, this cell also provides IEC and human resource development (HRD) support to the NGOs functioning at the field level.

UNICEF supports the IEC and HRD activities undertaken by the State Sanitation Cell, apart from providing technical and advisory inputs in strategy formulation. UNICEF also provides two years of support for the estab-

lishment of the sanitary marts at the block level. After the first two years the RSMs are expected to function independently. The unit cost for establishment of a sanitary mart catering to an average of 25,000 families is about USD 6000.

Current Status

The Government of West Bengal has adopted UNICEF’s sanitation programme as a state policy. The Central Rural Sanitation Programme (CRSP) guideline at the national level has also been modified in line with the West Bengal model. Some highlights of the programme in West Bengal are cited below:

- Currently, in West Bengal, 42% of households have access to latrines in comparison to 12% in 1991. A survey to analyze the current status of sanitation in the State (*Situation Analysis of Sanitation Programme in West Bengal - unpublished*), conducted by the Government of West Bengal in 1998 revealed that 34% of the latrine owning households were earning less than USD 22 per month. Nearly 81% of the latrine owners had a monthly income of less than USD 65. This survey indicated that the socially marginalized sections of the society also had substantial access to household sanitary latrines. The strength of the latrine revolution could be judged by the fact that nearly 42% of the latrine owners are illiterate.
- A survey to assess the impact of the sanitation programme (*Impact Assessment of Rural Sanitation Programme in West Bengal*), conducted by the State Institute of Panchayat and Rural Development, Government of West Bengal in 2000, indicated that 35-40% of latrine owners in the state had actually upgraded their latrines. The *Situation Analysis of Sanitation Programme in West Bengal* also revealed that among households not owning a latrine, 72% of the women of the households had a strong willingness to opt for a latrine. This indicates that demand for household sanitary latrines are on the rise.

- To date, approximately 1.2 million latrines have been delivered through the programme. Another 1.5 million latrines have been built through initiatives other than the rural sanitation programme. During the last financial year, 300,000 latrines were delivered to rural households. The impact of latrine coverage has been manifested in a remarkable reduction in diarrhoeal cases/ deaths (Refer Table 1). It will be noticed that due to increased access to latrines, not only the admission of patients in the health centre has been reduced by about 80%, no case of mortality was also reported.
- As has been mentioned earlier, the unit cost to establish a sanitary mart is only USD 6000. The production centres employ local people, particularly women, to manufacture the sanitary wares, and in the process address local poverty issues. Local manufacture of sanitary wares has generated employment (2 million person days in 2000). The motivators (attached to the RSMs and working in the hamlets) also have scope for income since they get an incentive of 50 cents for every household they motivate to opt for a latrine. *This amount (i.e., 50 cents) is again built into the cost of the latrine.*

Future Perspectives

- The programme is currently aspiring to achieve universal access to sanitary latrines. RSMs are being set up in all 341 blocks of the State to achieve this goal. Till date, 272 blocks have been covered by sanitary marts and the remaining blocks are expected to be covered by the close of the year 2001. Simultaneous efforts to build capacity of the NGOs in social marketing strategies are being pursued. UNICEF is also supporting the Government to launch a comprehensive IEC campaign to promote personal and domestic hygiene behaviour of the community.
- The Census of 1991 depicted that only 4% of the primary schools had toilets. UNICEF has taken up the

Table 1: Reported Diarrhoeal cases in Block Primary Health Centre, Ramnagar Block, Medinipur District (Household coverage by sanitary latrines increased from 50% in 1995 to 90% in 2000)

Year	Admission (%)	Outdoor (%)	Health Worker (%)	Death (%)
1995	119 (100)	74 (100)	45 (100)	5 (100)
1996	265 (222)	109 (147.2)	156 (346.6)	9 (180)
1997	115 (96.6)	82 (110.8)	33 (73.3)	4 (80)
1998	72 (60.5)	42 (56.7)	30 (66.6)	-
1999	23(19.3)	18 (24.3)	5 (11.1)	-

Source: *Impact Assessment of Rural Sanitation Programme in West Bengal- SIP&RD, GoWB, 2000*

School Sanitation programme to cover primary schools with toilet blocks. This programme aims to cover all 51,000 primary schools with toilet blocks by 2003. The school sanitation programme is expected to have a positive impact on the Rural Sanitation Programme (RSP) and increase sanitation coverage at the household level.

CHANDAN SENGUPTA, Project Officer, Water and Environmental Sanitation, UNICEF, Calcutta, INDIA
