



# Improving Sanitation and Hygiene Practices

## of the Rural Poor through Community Institutions in Uttar Pradesh, India

### Process Documentation

#### Project evolution

The Water, Sanitation and Hygiene (WASH) program, implemented by the Rajiv Gandhi Mahila Vikas Pariyojana (RGMVP), was initiated in the last quarter of 2012. The primary focus of the project was to empower women by organizing them into microcredit-linked

self-help groups (SHGs), and through that mechanism to generate demand for improved sanitation among women. The program aims to impact an estimated 21,000 households across 80 villages in two districts (Sultanpur and Amethi) of Uttar Pradesh.<sup>1</sup>

#### Why was this intervention necessary? The field scenario

ICRW conducted both a qualitative situational analysis and a quantitative baseline study to assess the socio-economic parameters of the project area, as well as to understand the sanitation and menstrual hygiene practices of those in Sultanpur and Amethi. The study painted a grim picture with respect to sanitation in these villages. The findings revealed the following issues:

- The majority of women (97 percent) reported open defecation. Women travelled long distances (25-30 minutes) early in the morning and late in the evening to relieve themselves, compromising their safety and privacy.
- We found little knowledge regarding menstrual health and hygiene. Sanitary pads were not easily available in the villages and as a result, 90 percent of the women and girls were using cloth as an absorbent during menstruation. The used cloth was either buried or thrown away in open fields or rivers.
- Gender inequality was evident. Women and girls stayed within the confines of their homes during the day, and did not participate in any discussions related to community welfare and social development.

- We found little awareness regarding the cause and prevention of diseases such as diarrhea, cholera and other water borne diseases.
- Nearly all women (97 percent) had to fetch water more than three times a day to complete their household chores and for drinking purposes. Overall, we found that people consumed water directly without purification.
- Hand washing with soap was considered unnecessary. People typically reported rubbing their hands with sand or ash after defecation.

#### How it all began

RGMVP's implementation strategy focused on building the capacities of rural women through their SHGs.

The specific objective of the program was to nurture social capital through the community institution mode for improved coverage and complete uptake of behaviour for improved sanitation and personal hygiene on a sustainable basis.

#### Building Social Capital

The WASH program of RGMVP has followed the approach of developing social capital through community institutions of the poor. This model is particularly useful in ensuring sustainability of health and sanitation interventions, as CRPs are formed to encourage other members of the community to adopt and adhere to best practices.

## How the program operated?

The concept of social capital focuses on the importance of social mobilization through women's collectives in the form of SHGs. Social mobilization is needed to unleash women's potential abilities and skills. In this model, this was induced through the SHGs.

This approach ensures the long-term sustainability of health and sanitation interventions, as Community Resource Persons (CRPs) are created to encourage other members of the community to adopt and adhere to best practices.

The program interventions were designed keeping in mind the areas, where RGMVP worked to develop SHGs and Village Organizations (VOs) over the last three to four years, as well as new areas, where collectivization for new SHG formation had to take place as a result of the intervention. In both of these areas (with existing SHGs and new SHGs), a WASH component was incorporated or integrated to achieve improved sanitation and hygiene outcomes for the community. SHG members were sensitized and trained on gender, hygiene and sanitation to enable them to be advocates for improved hygiene and sanitation practices in their community.

**MODEL 1 (Intensified – matured SHGs): Layering of the sanitation and hygiene component within the existing mature SHGs that have been federated.** Women's collectives are assumed to have more power than individual women and, thus, are more effective in making demands from the system and encouraging demand for services. SHGs enable a more organic approach with respect to changing behaviour as compared to traditional norms related to sanitation.

**MODEL 2 (Integrated – new SHGs): Introduction of sanitation and hygiene activities simultaneously with the establishment of new SHGs.** A combination of hygiene and sanitation activities is introduced while simultaneously building the collectives as part of this model. Model 2 has been tested for its potential to rapidly scale up the idea of achieving social change outcomes through social platforms.

# The process of change

## A. Creating structures for layering the intervention

- **Understanding the villages:** Social mapping and information related to key functionaries of the village such as the Pradhan (head of the local Governance), ASHAs (Accredited Social Health Activists), Anganwadi workers (AWWs, ICDS staff), Auxiliary Nurse Midwives (ANMs, health providers), SHG members, officials from the Village Health and Sanitation Committee (VHSC) were collected by the Community Health Trainers (CHTs) and Block Training Coordinators (BTCs) as the first step toward implementation. Regular meetings were conducted with members of the community to understand the landscape and profile of the villages. Special attention was paid to understand WASH-related practices in the villages such as hand washing, open defecation, access to clean drinking water and Menstrual Hygiene Management (MHM).
- **Strengthening the capacity of existing SHGs:** There were 316 SHGs in the 40 villages covered by Model 1, spread across 13 blocks comprising Block Level SHG federations (BOs) and Village Level federations (VOs). As many as 259 trainings on WASH and 169 trainings on MHM were provided to these SHGs, which enabled them to become social platforms for disseminating messages on sanitation and hygiene. Active SHG groups from Model 1 villages were then identified to intensify awareness on sanitation.
- **Formation of new SHGs:** The formation of new SHGs in Model 2 villages was not an easy task. A major challenge was to collectivize women who had never stepped out of their homes before. Initially, the women were quite skeptical about the function of SHGs. However, they were consistently encouraged and motivated through regular visits by the program staff, who ensured that the women joined the SHGs. In total, 190 SHGs were formed in 40 villages across 11 blocks over a period of one year. These were formed by existing SHG members and Community Health Trainers (SHG Leaders trained on WASH issues).



RGMVP staff holding a training and capacity building workshop for SHG members

## B. Sensitizing key stakeholders through capacity building

- To ensure proper implementation of the program and to encourage the adoption of best practices of hygiene and sanitation, trainings to build the capacity of the *Swasthya Sakhis* (voluntary woman health worker), VO (SHG federation at Gram Panchayat) leaders, SHG members, and Village Health and Gender Committees (VHGC) were provided.
- 135 *Swasthya Sakhis* from 13 blocks were trained on WASH in the Model 1 villages.
- Experts from Total Sanitation Campaign (TSC) of Government of India, WASH institute Patna and Vatsalya, a Lucknow based non-profit organization working on MHM were roped in to do the TOT.

## C. Reaching out to community through awareness campaigns

- **Generating demand for toilet construction and use:** In order to sensitize the village community on safe sanitation practices, dedicated events on WASH were organized by the SHGs, CHTs and BTCs in the form of campaigns, rallies, video shows, awareness games, puppet shows, etc. Important days such as Hand Washing Day, International Day of the Girl Child, World Toilet Day, World AIDS Day,

### Number of Awareness Events in Model 1 and 2 Villages:

- ◆ Puppet shows: 40
- ◆ School meetings and movies: 26
- ◆ Night meetings and movies: 32
- ◆ Day meetings and movies: 75
- ◆ Safai Abhiyan Rally: 35
- ◆ Aam Sabha Meetings: 75

World Disability Day, World Human Rights Day, and International Women's Day were also celebrated in the community and in schools, with a focus on sanitation.

- **Creating awareness through film facilitation:** Evening shows were organized to reach a large number of people in the community, especially men. Videos on WASH, open defecation, hand washing, and MHM were screened regularly and were followed by discussions. Efforts were made to ensure equal participation from men, women, and adolescents during these community meetings.

- **School-based awareness activities:** To promote good sanitation practices among children, and to ensure that girls do not drop out of schools due to menstruation, events focused on hand washing, and MHM were organized. Games, puppet shows, and painting competitions were also organized throughout schools in the villages to spread awareness and engage creatively with children and adolescents. Messages on gender equality were strategically disseminated as a core part of these events.
- **MHM training:** MHM trainings were organized by the CHTs with women and girls to promote the proper use and disposal of sanitary pads in the village. This was done by screening documentaries on MHM, and by using interesting games (*Dorigame* and six box puzzle for MHM) to facilitate the discussion. Meetings on issues related to women's health, hygiene and well being were also conducted to bust myths associated with menstruation. Women and girls were also informed about the role of ASHAs in facilitating the smooth supply and distribution of sanitary pads in the village.

## What is the impact?

### The intervention brought about positive social and behavioral changes in the community

- **Improvement in mobility, self-esteem and decision-making:** Active participation in the weekly SHG meetings led to a noticeable increase in women's self-esteem and confidence. Besides financial support for personal needs and aspirations, the SHGs also gave them a platform to voice their opinion, share concerns and support each other through their own networks during difficult circumstances.
- **Awareness and access to government entitlements:** As a result of the intervention, women gained greater awareness with respect to their rights and entitlements. They understood the role of the ASHAs, ANMs, and AWWs in promoting good health

"I used to stay within the confines of my home and was always scared of going out and meeting new people. My association with the SHG has made me a confident woman. Recently, one of our members lost her husband in an accident. Our SHG helped her in mobilizing funds and also supported her children to tide over the sudden crisis. It is during these circumstances that you realize the true potential of collectivization."

– An active SHG member



A woman waits to get her child immunized at the Village Health and Nutrition Day (VHND) Meeting





Low-cost sanitary pads purchased from the village ASHA

practices, nutrition and safe sanitation in the villages. Women and girls have begun approaching the village ASHAs to purchase pads at a subsidized price. ANMs and AWWs are now being approached regularly for immunization, iron pills, and nutrition packets (*poshahar*) for newborns and infants in the villages.

“Initially, the ASHA would sell the sanitary pads at a very high price and her visits were also irregular. When we informed about our intention of meeting the village authorities, she immediately understood the seriousness of the problem. She now sells the pads at a modest price of Rs. 6 per pack.”

– A YWSHG member

- **Formation of Young Women Self-Help Groups (YWSHGs):** RGMVP’s model of social mobilization through collectivization further enables the formation of YWSHGs for unmarried women between the ages of 13 and 21 so they have access to and awareness of their rights and entitlements. In order to strengthen the SHG intervention, RGMVP took the additional initiative of forming 108 YWSHGs in 80 (Model 1 and 2) villages to assist in disseminating information related to menstrual health and hygiene as well as safe water and sanitation. The newly formed YWSHGs also sought to provide young girls a platform to express their thoughts and opinions, gain an understanding of

financial management through financial literacy, and gain access to government entitlements, such as the ability to purchase sanitary pads at subsidized rates from ASHAs, as well as IFA tablets, and immunizations.

“I want to become a teacher when I grow up. The money that I save here (YWSHG) would help me get admission in a good college.”

– A YWSHG member

- **Use of toilets and private bathing spaces:** As a result of the intervention, women in the select villages began using toilets that were initially constructed by the government, but were not in use. Because money remains a constraint for poor households, construction of low-cost “*kuccha*” toilets has also taken place in several Model 1 and 2 villages. These are temporary toilets that can be constructed at almost no cost, with locally available resources, and can be used for several years. These toilets require less water for flushing and cleaning.

#### Toilet construction

In Model 1, as many as 1,541 toilets are now functional (692 old toilets revived, 148 new and 107 *kuccha* toilets. 594 toilets have been constructed in the Lohia villages, where majority of the population belongs to Scheduled caste group).

In Model 2, a total of 421 toilets are now functional (47 new toilets, 52 *kuccha* toilets and 322 old toilets revived) and 15 new toilets have been constructed under the Nirmal Bharat Abhiyan.

- **Clean drinking water:** Water is now treated with alum (*phitkari*) before storage. It is kept covered to prevent exposure to dirt and flies. Women in the community agree this measure has brought down the incidence of cholera, diarrhea, and common stomach ailments in their villages.
- **From uninformed to aware citizens for availing the best out of government schemes:** In some of the villages dominated by the Lohia people (a scheduled caste), many toilets constructed by the government before the intervention were constructed through

external agencies without input from local families. These toilets were primarily built to achieve numerical targets, rather than altering the way members of the community use sanitation services. However, due to an overall increase in the awareness level of the community, the families are now more aware about why and how these toilets should be constructed.



*Government constructed toilets made functional*

## Challenges

Motivating women to join/form SHGs, and encouraging the village community to adopt safe sanitation practices has not been easy due to the prevalence of age old norms and deep-rooted gender inequality. Some of the implementation challenges faced by the program team (BTCs and CHTs) include:

- **Lack of awareness:** Although women were saving money every month with existing SHGs in Model 1 villages, they lacked knowledge and awareness with respect to their rights and entitlements. Furthermore, weekly meetings were not taken seriously by the members, and as a result, the implementation team found it difficult to initiate a dialogue about WASH with them.
- **Difficulty in forming new SHGs in Model 2 villages:** The biggest challenge that the program staff faced in Model 2 villages was the formation of new SHGs. Initially, women would not attend the meetings because they feared violence at the hands of their husbands or other family members. Their mobility and commitment was constantly questioned by their families. Additionally, there was a lot of skepticism regarding the functioning of SHGs in the villages as some of the previously run SHGs (by corporations) had become defunct and eventually fell apart.
- **Distance between the intervention villages:** The village blocks were scattered and were located at a distance, which not only increased the travel time for the BTCs and CHTs, but also prevented the replication of best practices in the neighboring villages. The implementing staff lost a lot of time in travelling from one village to the other.
- **Difficulties in breaking myths and superstitions related to menstruation:** There was a dearth of correct information and knowledge related to menstrual hygiene within the community and it was difficult to bring about a change in mindsets as a result of taboos associated with it. The elderly women of the village simply rejected the idea of worshipping, cooking, and even bathing during menstruation. Additionally, it was difficult to initiate a dialogue with women on this issue in the presence of male members of their family.
- **Involvement of men in the community mobilization activities:** The idea of organizing community meetings to generate awareness on WASH and MHM was difficult to implement. During the day, both men and women remained occupied with their work and as a result the meetings had to be organized as per their availability in the evening. Additionally, due to deep-rooted gender inequality and a broad communications gap, it was difficult to involve men in the community engagement process as cleanliness, sanitation, and menstrual hygiene are not considered priorities among them.

The community meetings were considered a sheer waste of time.

- **Alcohol abuse:** On several occasions the evening meetings were disrupted due to the presence of abusive men under the influence of alcohol. The BTCs and CHTs had to take strict action by filing police complaints against these men to keep the negative influences at bay.
- **Open Defecation:** At the beginning of the intervention, the community was very comfortable with open defecation and toilet construction was a

“On some occasions, we were threatened and verbally abused by the goons in the village. During the evenings men would turn up drunk and create chaos to disrupt our meetings.”

– A BTC from a Model 2 village

low priority for both men and women. Additionally, they did not see any direct impact of safe sanitation on health. Moreover, men viewed open defecation as an opportunity to socialize with their friends.

## What holds them back?

### Challenges faced by the SHG members

Apart from the implementation challenges, the SHG members also highlighted some socio-economic factors that act as barriers in their personal growth and development:

- **Poverty:** Among many women in the community, the primary reason for not joining SHGs has been a lack of savings due to poverty. Since there are different classes of women in Model 1 and 2 villages, the amount of money that they save each month varies significantly (between Rs. 25 – Rs. 500 per month). Women from poor families face significant challenges in their day-to-day lives. Not only do they find it difficult to join SHGs and save money, the volume of household work, along with the added responsibility of looking after children and the elderly, made it virtually impossible for them to step out of their homes.
- **Lack of decision-making abilities:** In Model 2 villages, women faced a lot of resistance during the initial stages. Some women also reported experiencing domestic violence and lack of support at home.
- **Increased burden of workload:** Men do not share the workload in most of the households. Women who joined or participated in the SHG meetings

had to wake up early to finish the household work (fetching water, cleaning, cooking, getting children ready for schools, etc...) before stepping out. This added to their stress and physical exhaustion.

“We earn a meagre 100-150 rupees a day, which is barely enough to feed a family. Toilet construction and maintenance requires more money than we can afford. Also, if at all it has to happen, it will be the men of the family who will decide.”

– A poor woman from a scheduled caste village under Model 2

- **Changing the mindset of men:** Despite large scale toilet construction in some villages, it is a challenge to motivate men to use these toilets when they are surrounded by jungles and open fields.
- **Gender gap in priorities:** Although toilet construction was a priority for women, the decision to actually construct the toilet entirely depends on the men in the family. Further, even if there was a toilet in the household, cleaning and maintaining it was considered solely a woman's responsibility.

## Recommendations

- **Adoption of safe sanitation practices has to be a demand driven process:** There is a need to entrench the WASH program implementation into

a larger norm-changing process. While on the one hand there is still no stigma attached to open defecation, on the other, there is an overwhelming

emphasis on the concept of purity and pollution in the rural parts of India. The construction of toilets is often seen as accumulating pollution near homes; therefore people who live in rural households still prefer to defecate in the open. There is a need to divert investments towards larger awareness generation efforts in the rural community, as well as enable women to prioritize toilet construction over other needs. Moreover, sanitation programs need to be integrated with long-term village development plans in order to achieve the desirable outcomes.

- **Collectivization efforts (SHGs) require deeper introspection:** Current SHG platforms have to examine if they are actually transcending into the true empowerment for women. If SHGs are not able to raise women's aspirations then they are less likely to endorse sanitation as an important need for ensuring health and hygiene. The purpose of collectivization (being part of the SHG) has to go beyond just "saving money" for meeting their immediate financial needs.
- **Alternative technologies for toilet construction:** Considering the space and structural constraints in the villages, there is a need to make the community

aware of the different available alternatives for them (low cost – soak pit/ leech pit toilets).

- **Increase supply (toilet construction) to augment behavioral change:** While toilet construction alone cannot end open defecation, it has been observed that both women and men prefer using toilets when large scale construction happens in any village. However, it is important to involve both men and women in the process of toilet construction because when they build it themselves, they are more likely to construct and maintain it according to their needs.
- **Community toilets:** Since many rural households do not have adequate space for building toilets, the construction and use of community toilets must be promoted within a village. Additionally, these should be constructed after fully reviewing the village profile and landscape.
- **Political commitment:** There is a need for greater political will at the state level that prioritizes safe sanitation and hygiene as a desirable goal. Without adequate support from the state governments, it is impossible to make the villages open defecation free by just following a programmatic approach.

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<sup>1</sup> The larger WASH program was implemented in 120 villages of Sultanpur and Amethi district of Uttar Pradesh by Rajiv Gandhi Mahila Vikas Pariyojana (RGMVP) and Shramik Bharti. While RGMVP adopted the collectivization approach to integrate WASH component, Shramik Bharti used the Community Led Total Sanitation (CLTS) approach to generate demand for toilet construction at the community level.