Chapter 3

KEYNOTE SPEECHES

3.1 Subsidy or Self-Respect?

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3.1.1 Background

3.1.1.1 How it all started?

By the end of 1999 Water Aid (a UK based international NGO) invited me (Dr. Kamal Kar) to lead an evaluation mission for their country programme on Water and Sanitation in Bangladesh implemented through their local partner NGO, VERC (Village Education Resource Centre). A Participatory Impact Assessment was facilitated involving the Water Aid and VERC staff in at least four districts spreading from the north to south of Bangladesh to understand the views of the rural people for whom the programme was designed and implemented with external subsidy. Among others things, one of my suggestions had been to review the subsidy strategy on sanitation, as the poverty in Bangladesh was not the same everywhere. Why provide same subsidy when the levels of poverty were different? Later on, Water Aid decided to commission a participatory poverty assessment to develop a differential subsidy strategy on household toilets.

Involving the total village communities in March 2000, when we initiated this work, we realised from them that external hardware subsidy for household toilet construction and "no open defecation" were two different things. We stopped our effort of developing any subsidy strategy and went all out for an open and participatory approach leading towards Community Led Total Sanitation (CLTS).

3.1.1.2 What is CLTS?

Community Led Total Sanitation is an approach that empowers and encourages the local community to extensively analyse their own environment, sanitary conditions and initiate collective local action to stop open defecation and move towards improved sanitation and hygiene behaviour using their own resources and talents without waiting for external help or directions and prescriptions. Triggered by participatory exercises (PRA) using visuals (mapping, walk of shame, flow diagram etc.) and realising the dire consequences of open defecation and filth it generally begins with total dejection, shame and disgust which crystallise in to a firm collective desire and plan of action to get out of it finally. Community cooperation, innovations, and social solidarity

Construction details of a low cost community designed toilet model. 1. Tin sheet and plastic is being used to construct an offset pit latrine. 2. With mud plastering the latrine is ready for use.

reinforce the collective local action for total sanitation. Finally the community celebrates their success and declares their village as totally sanitised by putting up signboard. These acts of empowered community sends strong messages to neighbouring communities, which also spreads through different social and religious chains and encourages others to stop open defecation.

3.1.1.3 An awesome opportunity and responsibility

Something truly remarkable and immensely important has been happening in Bangladesh. Pioneered with Village Education Resource Centre (VERC) and WaterAid, Bangladesh and then spreading also through other organisations including Plan (Bangladesh), the Integrated Food Security Programme (IFSP) of CARE, Bangladesh, World Vision and others, Community-Led Total Sanitation (CLTS) is transforming the environment, health and well-being of many thousands of rural people. It represents a paradigm shift with huge potential for poor people in rural South Asia and elsewhere. As the country where this first evolved, Bangladesh has made a priceless contribution to the rest of the world. Those who have organised this Conference have done good service by giving central importance to CLTS. And this gives all of us here an awesome responsibility. For the potential gains in well-being for rural women, children and men are vast. It is rare in development for there to be such an extraordinary but vulnerable opportunity. It is vulnerable because it demands imagination to understand and is easy, even with the best intentions, to undermine. It is extraordinary because we know already that if we can collectively get it right, the benefits to many millions of those who are poorer and living in the rural areas of South & South East Asia, Africa and beyond will be simply phenomenal.

Traditional latrines polluting water bodies

3.1.2 Realities, Vision and Challenge

The realities of CLTS are astonishing. With a facilitated, participatory approach, with no hardware subsidies and doing it themselves, communities have achieved total sanitation in well over 500 paras[*] in Bangladesh, and additionally more than another 500 are close to achieving it. CLTS has spread already from Bangladesh to Cambodia, Uganda and Zambia. In India it is being introduced in Ahmednagar and Nanded Districts in Maharashtra state. There is a bridgehead in Tamil Nadu, and Himal Pradesh, Madhya Pradesh and other States have shown interest.

These realities inspire a vision of a future rural South Asia with a movement for total sanitation, with major gains in well-being to millions, and in the longer term to tens or hundreds of millions, of rural women, children and men, many of them very poor.

The challenge is to us, development professionals, whether we are in governments, NGOs, funding agencies, the private sector or academia. For the approach is counterintuitive. It runs counter to our normal professional, institutional, philanthropic and personal beliefs and reflexes. To understand this, and to support CLTS resolutely, means unlearning at least as much as learning. We can so easily hear and see, but then revert to the habits of the past and get things wrong. The challenge is paradigmatic; it is to change how we see things and how we go about development.

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[*] * A *Para* is a neighbourhood/ hamlet of a village. Para can be a cluster of households of a village.

3.1.3 The Benefits

The benefits from CLTS are big and come quickly. Those here who have been to communities, which have achieved it can explain this to others who have not. With partial sanitation, the environment remains contaminated for everyone. With total sanitation, it becomes clean for everyone. The many reported and observed gains include enhanced self-respect and pride, physical well-being (especially for women and children), better health with notably less diarrhoea, lower health expenditures, and better livelihoods. A proxy indicator is the higher dowries negotiated where a bride marries into a totally sanitised village. The solidarity or social capital built up is a springboard for other community actions.

3.1.4 Why Only Now?

If CLTS is so powerful and so good, we have to ask why has it only happened now. The answer is that to discover and evolve CLTS needed a combination of three conditions: first, PRA methods, approaches and behaviours (analysis by people themselves through mapping, diagramming, transects and observation, and calculations); second, an absence of dependence-inducing hardware subsidies; and third, pioneering exploratory facilitation and dissemination. These only came together two and a half years ago.

3.1.5 The Paradigm Shift

The paradigm shift is from the TDPS (Target-Driven Partial Sanitation) of the past to the CLTS (Community-Led Total Sanitation) of the future.

The paradigm shift is sharp. The different elements in each paradigm are mutually reinforcing.

	PAST	**FUTURE**
	Target-driven partial Sanitation (TDPS)	**Community-Led Total Sanitation (CLTS)**
Start with	Things	People
Core activity	Constructing latrines	Igniting and facilitating processes
Latrines designed by	Engineers	Community innovators
Number of designs	One or a few	At least 32 so far
Materials	Cement, pipes, bricks etc	Bamboo, jute bags, plastic, tin etc
Cost	Higher	Can be under 50 Taka
Indicators	Latrines constructed	Open defecation ended
Sustainability	Only partial	100 per cent so far!
Motivation	Subsidy	Self-respect
Coverage/usage	Partial	Total

3.1.6 Non-Negotiable Principles for Rural CLTS

For rural CLTS the following principles are fundamental and non-negotiable.

- No subsidy for hardware (not for the poorest or anyone else)
- No blueprint design (only people's designs, not engineers')
- People first: they can do it

- Facilitate, don't provide/prescribe
- Go slow at first for faster later

Support or "subsidies" can come from outside the community in the form of training and support for facilitators. Support or "subsidies" for materials and land *come from within the community:* people who are landless or very poor, are helped with places to dig and basic materials by others in their own communities.

3.1.7 Scaling Up with Quality

The coverage to date is tiny compared with the scope. The big question is whether CLTS can become a self-spreading popular and national movement, in Bangladesh and elsewhere. This demands rethinking how we go about development.

For scaling up we suggest:

- *Repeatedly stressing there will be no hardware subsidy for anyone*. And avoiding any statements or actions, which could lead people to suppose that hardware support, might be coming. The recent national survey of sanitation coverage led people to hope and expect that hardware subsidies might be on their way: the self-serving understatements of sanitation coverage which resulted are less serious that the way the spread of CLTS was slowed and in some cases stopped. The hidden costs of the survey include a slower trajectory for the spread of CLTS, and the child and adult diarrhoeas and deaths that would otherwise have been averted.
- *Multiple approaches* and diversity, all adhering to the non-negotiable principles, and sharing experience in order to do better
- *Continual realistic feedback* leading to continuous adaptation and improvement of approaches and methods
- *All organisations to learn and change* and especially NGOs, which have to rethink and reinvent themselves. Instead of providing hardware subsidies, as some still do, they need to become facilitators, trainers and disseminators. If they do not do this, their net effect is likely to be negative.
- *Start nuclei of CLTS* and support spread outwards from them
- *Nurture lateral spread* with a key role for community consultants, catalysts and facilitators, encouraging a movement
- *Spend less.* Restrain budgets, targets and pressures to disburse. Governments, lenders and donors have to avoid big budgets and hold back pressures to spend and to achieve targets. Plan Bangladesh, when it switched from subsidised hardware to CLTS, only spent 20 per cent of its budget, but several times more households were covered, moreover with total not partial sanitation. (Low expenditure can be an indicator of participation and success)
- *Involve Government organisations.* This may be essential for going to scale, but is fraught with the dangers of top-down approaches, and inhibiting rather than enhancing spread of a movement. Pilot testing ways of going about this, and gaining experience, would seem vital. Champions within government could play leading roles.
- *Hasten slowly*. Urgency and priority, but patience too. Thickening up will take time but should become exponential. At the community level, the right speed is the people's speed. At higher

levels, and regionally and nationally, the right speed may be faster than cautious purists propose but slower than political leaders and planners would like.

As for quality, indications to date are that this is achieved through a social ratchet effect. Once CLTS is in place, social sanctions prevent backsliding. People share latrines. Temporary ones are replaced. Any who defecate openly are sought out and penalised. But sustainability and its mechanisms need to be monitored and lessons learnt.

3.1.8 The Challenges

The challenges are personal, professional and institutional. "We" and our normal views and reflexes are the problem. "They", people in communities, are the solution. We have to go about our professional work differently. Serious unlearning is entailed, and then continuous learning, adapting, improvising and innovating to enable CLTS to become a movement. These changes of understanding and behaviour apply at all levels – Ministers, senior officials, staff in funding agencies, and Government and NGO staff.

3.1.9 Vision, Guts and Realism

The potential is for huge gains in human well-being. We are at a turning point. The challenge is to keep in touch with realities, to learn and unlearn rapidly and well. It is to change public policies, institutional norms and personal mindsets. All this will take vision, guts and realism.

The vision is a clean and healthy environment and enhanced well-being and quality of life for the hundreds of millions of people – women, children, men, the poorest, the poor and the less poor - in rural South Asia and elsewhere.

The guts are to struggle to recognise, achieve and sustain the personal, professional, institutional and policy changes – of mindsets, behaviours, procedures, rewards, cultures and ways of going about development, needed to make that vision real.

Community has constructed their own toilets in a cluster without any external subsidy. Individual family's toilets are numbered, locked and are maintained by themselves. Borban village, Maharashtra, India

The realism is to be in close touch with what is happening in the field, with rapid honest and accurate feedback and learning. Successful programmes and initiatives quickly generate myths about themselves, and then appear successful when they are faltering or failing. CLTS is too important for that luxury.

Perhaps the most pressing need is to learn quickly and well how CLTS can evolve into a movement and even become self-spreading. The stakes could hardly be higher. More of the same past practices will not work. They cannot achieve total rural sanitation. But CLTS could. If the right things can be done at this critical stage, the gains for rural people will be simply phenomenal. Millions, perhaps tens or even hundreds of millions of people will gain in health, livelihoods and quality of life.

Can we muster and sustain the vision, guts and realism they deserve?

3.2 Where Are the "Ladies"? Sanitation, Hygiene Improvements and Gender

Ms. Rose Lidonde
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and
Mr. Jo Smet
IRC, The Netherlands

Distinguished guests, ladies and gentlemen:

On behalf of the Gender and Water Alliance (GWA), it gives us great pleasure to be present in this very significant conference to address gender issues, which are of considerable importance to achieve sustainable and effective hygiene and sanitation improvements. These are not only challenging issues pertaining to the Asia region but to the world as a whole.

At the turn of the century, according to WHO and UNICEF's Global Water Supply and Sanitation Assessment 2000 Report, some 2.4 billion people had no access to any form of sanitary means of excreta disposal. This is a major cause of the 4 billion cases of diarrhoea reported each year between 1990 and 2000, and an annual toll of 2.2 million deaths. Most of those deaths are infants and young children, which makes prevention an important gender concern. Sanitation is one of the issues that clearly demonstrates the problems caused by gender inequality in human society. As traditional water bearers and custodians, women shoulder a huge burden in coping with the lack of basic sanitation services. The lack of sanitary facilities faced by women contribute to keeping their hands dirty and poor hygiene behaviours. All these factors play an important role in the poor health and the conditions of indignity that families suffer. Yet societal barriers continually restrict their involvement in the improvement of programmes intended to alleviate their situation.
What do we mean by Gender?

Gender is not about women and girls only. Gender is all about men and women, not in the sexual difference but in the socially and culturally determined differences between women and men. These differences are made by people and therefore they can, and do, change. Particularly in personal hygiene and sanitation habits, needs and demands, women and men, adolescent boys and girls differ. Therefore, gender mainstreaming involves assessing all the implications that any sanitation and hygiene intervention can have for women and men. These differences need to be reflected in relevant policies, strategies and approaches that promote improved sanitation and hygiene behaviour.

In 2002, the coverage statistics showing the awful 40% of the global population without any form of hygienic sanitation, led world leaders meeting in Johannesburg, South Africa, to demand action by governments. The target to reduce by half the proportion of people without satisfactory sanitation services by the year 2015 gives a big impulse to the sanitation cause. However to effectively address hygiene and sanitation, factors affecting the different genders become of supreme importance.

3.2.1 Key Sanitation and Hygiene Issues and Gender Implications

It is important to note that various gender groups have divergent interests, which need to be taken into consideration while developing policies, strategies, approaches and planning for hygiene and sanitation services for the poor. A gender approach recognises the social and cultural differences and inequalities between men and women, boys and girls. In a gender approach, these differences and inequalities are applied to:

knowledge and skills, e.g. women know better what an hygienic latrine design is;

needs and demands, e.g. women and girls face more problems with privacy and safety around latrine use, and on hygiene promotion men and boys need also to be included in the education campaigns;

types and division of sanitation-related work, men know usually better how to dig a pit, how to construct the latrine with what local materials;

types of decisions, and who makes what decision, are socially and culturally determined but ideally men and women must share information and make jointly key decisions to ensure sustainability and impact;

financing and other inputs; men often control the finances, so convincing men for sanitation improvement is important; and

benefits and negative impacts, apart from improved health, a sanitation programme may create job opportunities. In many sanitation programmes, women were effectively trained as masons and plumbers.

Such a gender approach with all these aspects mentioned is a requirement for the development of policies and strategies to achieve more effective, equitable and sustainable sanitation and hygiene behaviour.

In India it has been observed that women from minority groups have no access to the latrines in collective sanitation bocks because they simply have no right to use the shared installations. Widely reported problems with communal latrines also include the high incidence of attacks on women using them and difficulty of ensuring they are kept clean and hygienic (D. Allely et al 2000).

Sanitation interventions have strong social, economic and environmental implications that should be considered in any type of national plan. Some of these key considerations that we would like to bring to your attention are the following:

3.2.2 Social

3.2.2.1 Health or convenience

Evidence shows that the provision of adequate sanitation services, safe water supply and hygiene education is an effective health intervention. It not only reduces the mortality caused by diarrhoeal diseases by an average of 65 percent and the related morbidity by 26 percent, but it results in a high reduction for governments on health cost related to poor sanitation and hygiene, lower worker productivity, lower school enrolment and lower retention rates amongst girls. It also contravenes the rights of all people to live in dignity (WHO/UNICEF, 2000).

In South Asia women and girls in their puberty complain that if there is no toilet in the house or plot they cannot relief themselves during the day because they can only go to the sanitation field before dawn and after sunset. This forces them not to drink too much during the day, and creates great problems when they have diarrhoea. Better sanitary conditions provide real benefits to women in the form of greater privacy, convenience, safety and dignity and safe hygiene practices in the family. This means potential release of women's time and energy, much of which is invested in care of the family. Despite these apparent benefits demand for improved sanitation from poor women and men appears to be relatively low. Household sanitation usually does not have a high priority compared with other livelihood needs. For sanitation promoters, a key challenge is that those lacking good sanitation facilities are rarely convinced by the potential health benefits to make an investment for sanitation improvements. Social marketers find that convenience, privacy status and peer pressure are the areas more persuasive in motivating communities towards improved sanitation and hygiene. More and more poor farmers realise the benefits from decomposed human excreta or urine as a fertiliser for poor soils and good crops. Here men and women appreciate the livelihoods benefits: food for their family and surplus crop for potential market to generate extra family income.

3.2.2.2 School children suffer from poor sanitation facilities

A survey carried out in India among school children revealed that half of the ailments found are related to unsanitary conditions and lack of personal hygiene (UNICEF and IRC 1998). In India out of the more than 600,000 primary schools on average over all states, half of them have a safe drinking water source while only 1 out of 10 have sanitary facilities.

In many countries, schools have become unsafe places where diseases are transmitted rapidly due to poor hygiene behaviour and dirty sanitation environments. Poor sanitation in schools impairs children's growth and development, limits school attendance and retention of student's ability to concentrate and learn. About 40 percent of the about 1 billion school age-children are infested with intestinal worms. Girls do not drink during daytime as they do not want or their parents do not allow them to use dirty school latrines if any latrine is there at all. These girls may develop kidney problems. About 1 in 10 school-age Asian girls do not attend school during menstruation or drop out at puberty because of lack of clean and private sanitation facilities.

Improved sanitation and water supply in schools directly benefits girls' education. It is already harder for girls to attend and finish school. The presence of adequate sanitation facilities that can be kept clean, offer privacy and safety for older girls, are separate from those of boys, help parents send girls to school rather than stopping their education when they reach puberty. Sanitation at schools contributes to the reducing of inequalities between boys and girls. When planning the facilities the preferences of boys and girls should be taken into account. Urinals may be constructed for boys and more latrines and urinals for girls, all with proper hand-washing facilities.

Schools provide an excellent opportunity to create lifelong changes in behaviour. Childhood is the best time for children to learn hygiene behaviours. Children are future parents and what they learn is likely to be applied in the rest of their lives. Children often have important roles taking care of younger brothers and sisters and, depending on the culture, they can also question and influence existing practices in the household.

Building new sanitation and water facilities is not enough. It is critical that these facilities are properly used and maintained. Simply giving hygiene lessons in class will not necessarily change children's hygiene behaviour. Good organisation of cleaning and maintenance of the water supply

and sanitation facilities is of utmost importance. Badly maintained sanitation facilities may cause an even bigger health risk than scattered defecation.

Growing recognition of the importance of quality of primary education has inspired UNICEF, WHO, UNESCO and the World Bank to create a partnership to Focus Resources on Effective School Health (FRESH). The issues addressed in FRESH are water and sanitation facilities in all schools, life skills-based on health and hygiene education, the establishment of school policies for health promotion, and the establishment of school nutrition and health services.

Meanwhile Vision 21, an initiative of the Water Supply and Sanitation Collaborative Council and part of the Action of the second World Water Forum, has set specific school hygiene and sanitation goals for 2015:80 percent of primary school children are educated about hygiene and all schools equipped with facilities for sanitation and hand washing.

3.2.3 Economic

3.2.3.1 Costs of inaction

As well as the serious health consequences, the high diarrhoeal incidence and related deaths represent large economic losses due to non-productivity of men and women, health expenditures and negative publicity for countries and governments. The cholera epidemic in Latin American cities, deteriorated water supply and hygiene conditions spurred into action politicians and administrators who had thought the disease long overcome. The cholera epidemic in Peru, which lasted 15 months in 1991-1992, cost the country $200 million in lost lives, decreased production, exports and tourism (Suarez. R and B Bradford 1993). The annual cost of gastro-intestinal disease in the USA is estimated to be as high as US$900 million, whilst noting costs in developing countries could be higher (Payment, 1997).

3.2.3.2 Imbalanced investment

The current low sanitation coverage is partially explained by the low level of investment in sanitation compared to water supply. Of the total annual investment in water supply and sanitation (WSS) sector, approximately US$16 billion, only one fifth seems to be directed towards sanitation (WHO/UNICEF 2000). It is important that while designing improvement interventions in hygiene and sanitation the local disease patterns are well understood. Reviews by Esrey et al. (1985-1991) demonstrate that median reductions in diarrhoeal disease incidence are greater from sanitation interventions than from those in water supply only. Subsequent reviews of the impact of hand washing and household water treatment show very significant reductions in diarrhoeal disease in the absence of engineering intervention. Funds for behavioural aspects form only a small percentage of investments, despite the fact that human behaviour and specifically addressing gender dynamics is one of the key determinants for impact of public health. Often the women are the only target group of hygiene education while to make an impact, a critical majority of at least 80%, including the poor men and boys, in the community needs to practise on a continuous basis improved sanitation and hygiene behaviour. Investment strategies aiming to achieve maximum benefit must consider this gender aspect.

3.2.3.3 Gender issues in infrastructure and technology choice

For the vast majority of the 2.4 billion non-served people and their future families, trunk sewers and centralised sewerage treatment plants may not be a viable option. It may be that low-income urban communities can be connected to central schemes subsidised from charges to better off

communities. But in the meantime they need local systems that can alleviate the squalor and lack of hygiene and sanitation that threatens their lives. The aim is to adopt solutions to both the strength of the economy and the needs of the women and men with an overriding concern that they should be amenable to affordable management and maintenance, which will generally need the responsibilities of the users themselves.

Failure to account for the needs of women, men, girls and boys of the household when designing installations has been the downfall of many sanitation projects (Allely et al, 2002). Even mothers who are aware that their children's faeces are dangerous often do not let them use latrines because there is a risk of falling in. At the insistence of the villagers in Sri Lanka programmes, special children's latrines were built near the kitchens where mothers could train their children in their use (Fernando 1982). In some countries during the night women prefer to use the children latrine that does not have a superstructure, because it does not house snakes and insects (Sugden, 2003). Another example is that the raised footrests are positioned by men giving discomfort for women who usually put their feet differently than men. In situations without a piped water supply system, installing a pour-flush latrine implies extra burdens on the women and girls in the household, as there will be greater quantities of water to buy, to carry, or draw.

Cultural practices and constraints also need to be taken into consideration when planning for sanitation. Apart from personal preferences, some customs are controlled by religious or social norms/taboos. For instance women in a state in India did not want to use shared latrines as these had closed compartments while before they used to chat with each other while using the latrine. Only after holes had been made in the dividing walls allowing the women to see each other, women started using the latrines.

Because sanitation is primarily a private or household activity, motivating greater latrine usage requires promotion and marketing techniques that offer householders a choice of systems for a range of costs. The focus here should be on social, where the marketer/promoter is concerned with the correct use and sustainability rather than the commercial marketing aimed at selling the product. The 100% sanitation approach in Bangladesh shows the success of village sanitation promoters, often women, and the wide range of latrine options offered.

3.2.4 Institutional

In spite of its importance to the health and economics of the nation, sanitation often lacks an institutional home. Frequently it is merged into the water supply and sanitation sector where the glamour jobs and investment priorities go to water supply. As a result, little support is accorded to sanitation and minimal investment committed to it. Detailed institutional, financial, implementation and operation and maintenance arrangements are well presented for water but that is not the case in sanitation and hygiene promotion; gender concerns are virtually ignored. The competing and conflicting roles and responsibilities among the subsections further complicate this. No clear regulatory frameworks are in place to guide the sanitation and hygiene promotion sector.

In contrast, where institutional arrangements have been clearly defined, more commitment is evident. For instance South Africa, which separates sanitation from water, has a clear policy focused on the provision of sanitation facilities and services. The policy aims to provide all South Africans with a basic minimum level of sanitation by 2010. The necessary institutional, implementation and financial means to achieve this goal are clearly set out in the policy, though there is still a lot that needs to be done in ensuring the different gender interests are addressed in service provision. While a multi-sectoral institutional approach is essential to hygiene and sanitation promotion, it requires addressing the gender dynamics of rich and poor women and men

in the delivery of the services. Equally important is building relationships between public authorities, the private sector, for sanitation mainly the small-scale private sector, and civil society. Capacity building and an environment for learning from experiences are needed in which the aspects of both men and women, young and old are fully taken into account.

3.2.5 The Way Forward

Government departments should develop or strengthen national policies to ensure increased focus on sanitation and hygiene with specific strategies to respond to gender issues.

Government should establish realistic national year targets for sanitation and hygiene within the framework of the Millennium Development goals that provide a guide to investment for the delivery of hygiene promotion and sanitation services that are sensitive to gender dynamics. Gender requirements in relation to sanitation and hygiene need to be catered for in terms of the investments, planning, implementation and operation and maintenance processes/needs.

Government departments need to establish or strengthen inter-sectoral co-ordination and collaboration to get gender mainstreamed in sanitation and hygiene promotion. Departments should speak as *one voice for gender in hygiene and sanitation.*

Government departments, NGOs and donors should embark on awareness raising programmes targeted at sanitation policy makers emphasising the fact that sanitation is not just a household or social issue but rather a development program that should be linked to gender and poverty eradication. It should be recognised that poor sanitation is both a symptom and cause of poverty and should be treated as such.

Government departments, NGOs and donors should develop tools for gender mainstreaming at institutional, programming and community levels that include indicators to monitor progress towards achieving gender-related goals and staff should be supported with training in gender-related knowledge and skills.

Hygiene behavioural change and improved sanitation should be seen as a process, not as a top-down decree. Affected poor women, men, marginalized groups and school-going boys and girls with their teachers and parents, must be consulted and involved in sanitation programme planning, implementation and follow up.

Participatory methods can be useful tools for encouraging involvement, developing consensus and creating commitment to action at all levels/sectors, while taking into account gender differentiated demands and preferences

The gender component needs reinforcement in hygiene and sanitation curricula and pre-service training for artisans, community, public health worker and teachers.

3.3 World Development Report 2004: Making Services Work for the Poor

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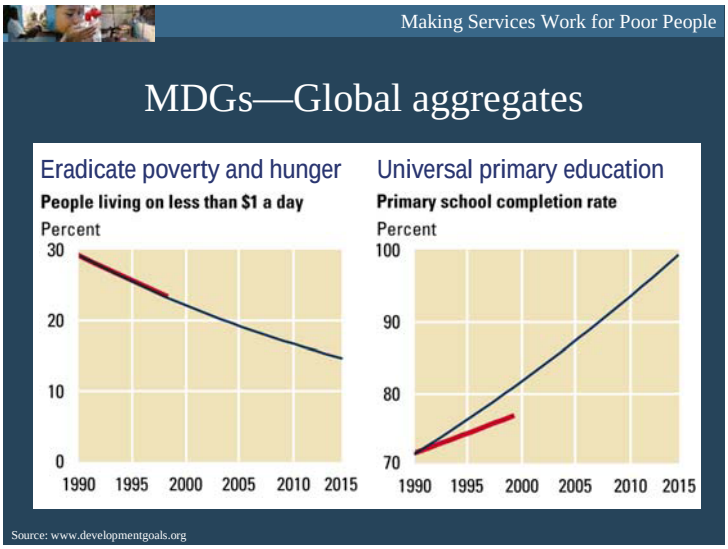
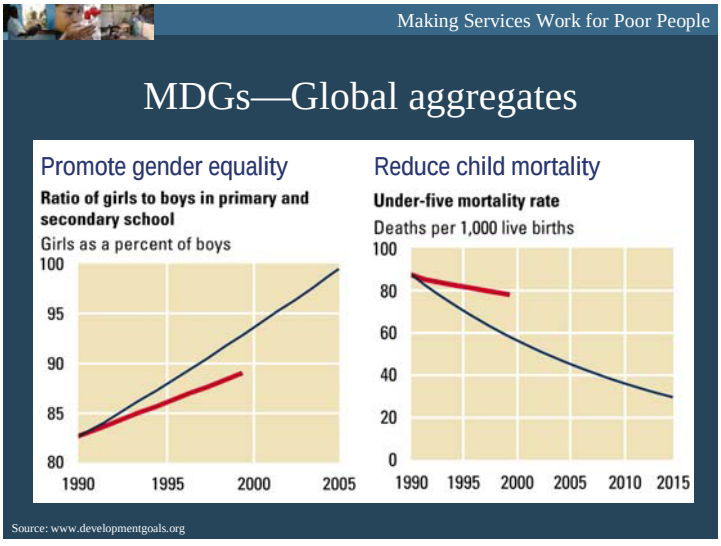
Messages

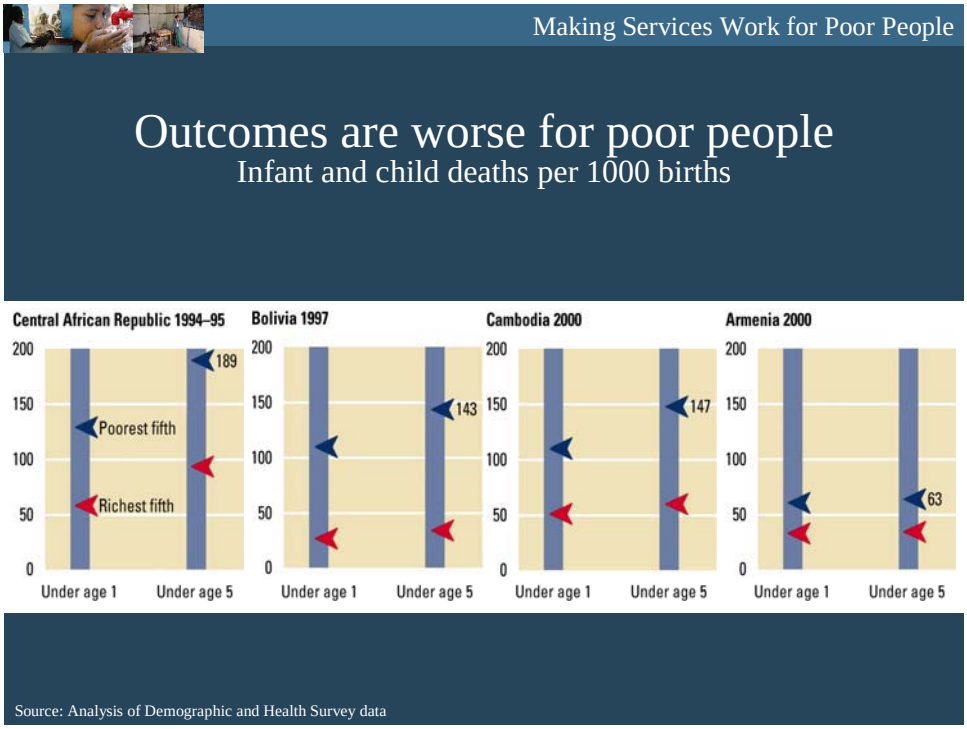
- Services are failing poor people
- But they can work. How?
- By empowering poor people to
  - Monitor and discipline service providers
  - Raise their voice in policymaking
- By strengthening incentives for service providers to serve the poor

MDGs—Global aggregates

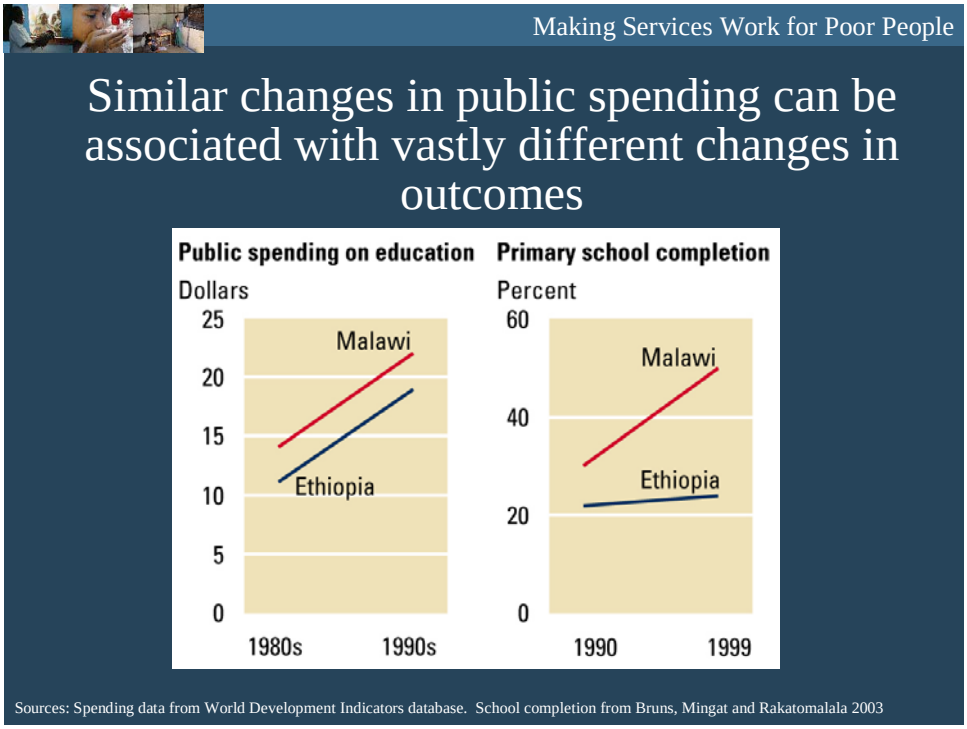




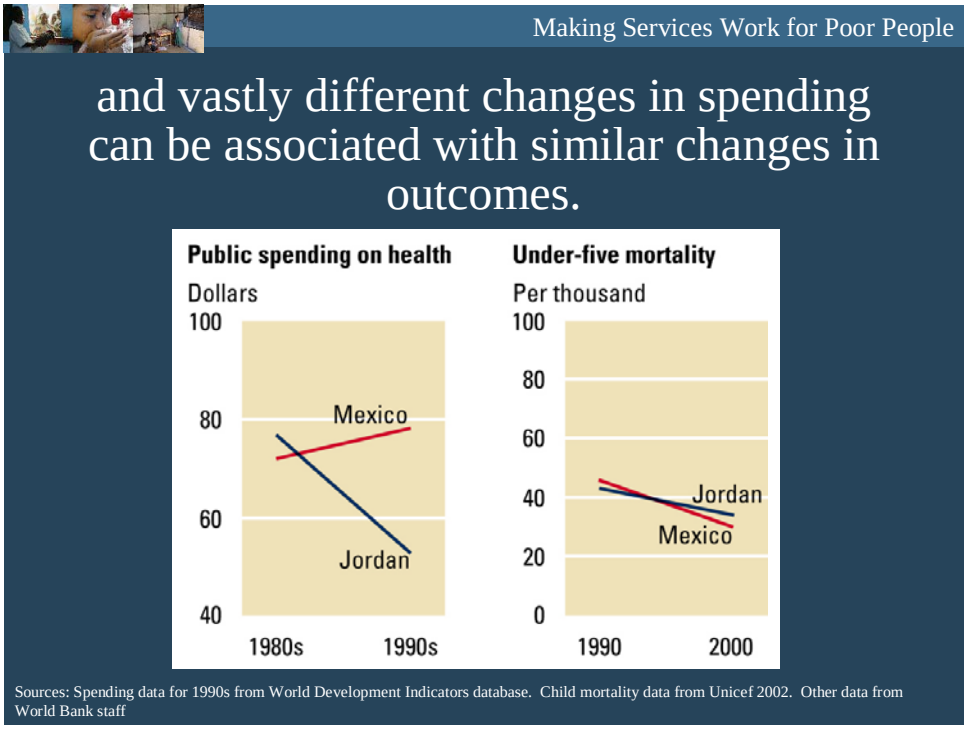
Outcomes are worse for poor people (Infant and child deaths per 1000 births)



Similar changes in public spending can be associated with vastly different changes in outcomes



and vastly different changes in spending can be associated with similar changes in outcomes.



How are services failing Poor People?

- Public spending benefits the rich more than the poor
- Money fails to reach frontline service providers
- Service quality is low for poor people
- Demand is insufficient

Examples of low service quality

India: Absenteeism rates for teachers in primary schools: 50 percent

Bangladesh: Absenteeism rates for doctors in primary health care centers: 74 percent

India: Delhi & Chennai get 4-6 hours of water per day

Bangladesh: Arsenic reduced rural drinking water access from 97 to 75 percent

How to make services work for poor people?

Growth is essential, but not enough
Increasing public expenditures is not enough

A framework of relationships of accountability

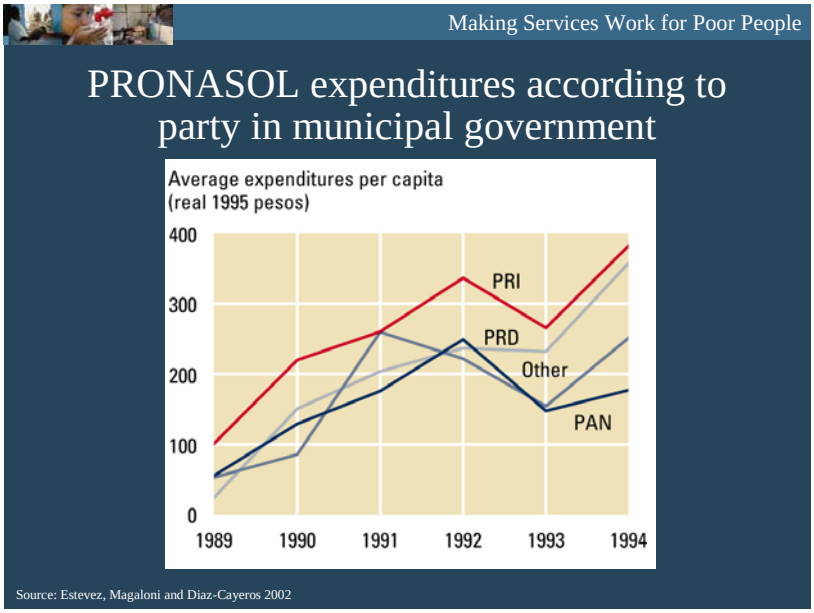
A framework of relationships of accountability

A framework of relationships of accountability

Mexico's PRONASOL, 1989-94

- Large social assistance program (1.2 percent of GDP)
- Water, sanitation, electricity and education construction to poor communities
- Limited poverty impact
    - Reduced poverty by 3 percent
    - Even an untargeted, uniform per capita transfer would have reduced poverty by 13 percent

PRONOSOL expenditures according to party in municipal government



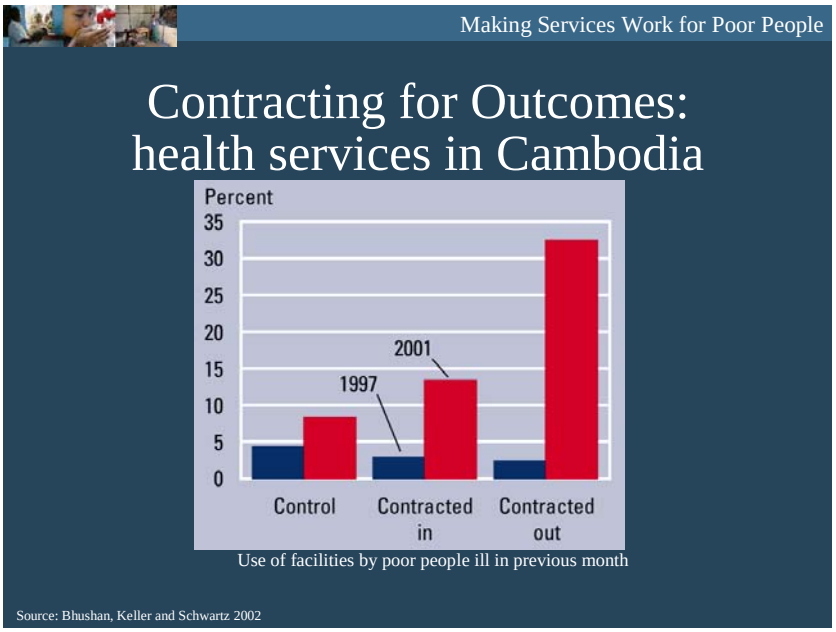
A framework of relationships of accountability

Policymaker-provider: Contracting NGOs in Cambodia

- **Contracted out** : NGO managed & could hire, fire, & transfer staff, set wages, procure drugs
- **Contracted in** : NGO managed and could transfer but not hire and fire staff
- **Control group** : Services run by government

12 districts randomly assigned to each category

Contracting for Outcomes: health services in Cambodia



A framework of relationships of accountability

Choice: female secondary school assistance in Bangladesh

Girls to receive scholarship deposited to bank account set up in their name if
Attend school regularly
Maintain passing grade
Stay unmarried
Schools receive grants based on number of girls enrolled

What *not* to do

Leave it to the private sector
Simply increase public spending
Apply technocratic solutions

What is to be done?

Expand information
Emphasize outcomes
Tailor service delivery arrangements to service characteristics and country circumstances
Carry out impact assessments

Applying the WDR to rural sanitation

Measuring outcomes, not inputs
Subsidies weaken client power
Distorts choice and community participation
Paves the way for patronage
Exacerbates market failure
Boosts demand for latrines, not sanitation
Solutions that strengthen role of community
Measuring impact to know what works

Measure rural sanitation outcomes correctly

Usually measured as building latrines
Creates incentives to construct, not to *use* latrines
Outcome to measure: extent of open defecation
Orients accountability correctly

What does a latrine subsidy do?

Sanitation is a community outcome
So, co-production of sanitation is key
Household subsidy distorts community participation and co-production
Paves the way for patronage

How to create community outcomes and co-production?

Techniques and mechanisms of mobilization of communities
VERC in Bangladesh

NGO Forum and others
Reward the community and co-production
community subsidies for outcomes
Nirmal Gram Purashkar program in India
Use local governments to facilitate community participation

Total Sanitation

Scaling up

Impact assessments
Learning from systematic evaluation: pilot
VERC in Bangladesh
Maharashtra in India
Drive capacity creation by central and local governments
Credible rationale for additional resources

Implications for urban sanitation

Supply of sanitation, not demand, the problem for networks
Property rights and regulation
Dar-es-salam cesspit cleaners
Orangi style co-production linked to networks
Community toilets in Pune

Services work for poor people when accountability is strong.