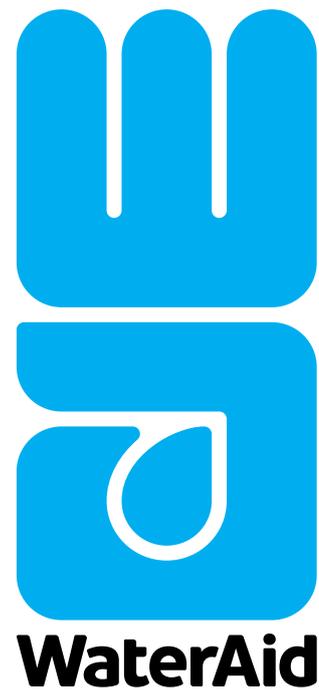




WaterAid/ Prashanth Vishwanathan

Social Accountability and System Strengthening for Water, Sanitation and Hygiene in South Asia







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5

Introduction

CASE STUDY 1

11

District Water Quality Platforms

INDIA

CASE STUDY 2

21

Social Accountability Mechanisms

NEPAL

CASE STUDY 3

27

WASH Facilities Help Improve Health Services

BANGLADESH

CASE STUDY 4

33

Citizen Report Card

CHHATTISGARH, INDIA

पंचायत सचिवालय जमीरा

प्रखण्ड-दुलमी, जिला-रामगढ़ (झारखण्ड)

ART BY
विशाल LAD
7959324524



Introduction

The landmark Declaration of Alma Ata (1978) set out an agenda of 'health for all by 2000'. This agenda was particularly important for South Asian countries, which had among the highest rates of maternal, neonatal, and child deaths in the world,^{1,2} as well as gross health inequalities across socio-economic and geographic groups. Since the Declaration, South Asian countries have taken several steps to address pressing health issues and health inequalities by strengthening the delivery of primary health care, bringing focus to Universal Health Care, quality of care, and a commitment towards the Sustainable Development Goals (SDGs) on health (SDG 3: Good health and well-being). The SDGs are unique in the way they emphasise the intersectionality between goals, calling for multi-sector action to affect change—an aspect that is particularly relevant for the achievement of SDG 3. The Declaration of Alma Ata was also significant as it drew attention to the social determinants of health. Over the years, South Asian countries have seen a slow, yet growing awareness of and attention to, the social determinants of health in influencing health outcomes, and the role of community participation in

demanding access to quality health services. Social determinants of health refer to factors outside the traditional health system that affect health; the conditions in which people are born, grow, live, work, and age. Safe water, sanitation, and hygiene (WASH) are important determinants, given the multi-faceted and complex pathways by which they affect health. The most widely known and direct connection is through ingestion of faecal pathogens present in drinking water, food, or hands, resulting in repeated infections such as diarrhoea and intestinal worm infections. Another direct connection between WASH and health status, is the consumption of water with a high level of chemical contaminants, such as fluoride, that also inhibit nutrient absorption, and consequently affect growth and lead to disabilities. Indirect pathways include exposure to an unsanitary environment (e.g., with poor drainage, sewage and solid waste systems) that provide a rich breeding ground for several vectors (such as mosquitoes, sand flies etc) placing the population at risk for diseases like malaria, dengue, and leishmaniasis (*kala azar* among others). In addition to influencing health outcomes at a

¹ WHO, UNICEF, UNFPA, World Bank (2015) Trends in maternal mortality: 1990 to 2015. Geneva: World Health Organization

² WHO, UNICEF, UNFPA, World Bank (2015) Trends in child mortality: 1990 to 2015. Geneva: World Health Organization

community level, WASH services are a critical component of the health system, and can contribute towards health care associated outcomes.

The Declaration of Alma Ata notes community participation in the “planning, organisation, operation, and control of primary health care” as an essential component of primary health care.³ While health systems are responsible for the delivery of health care, the role of the community in demanding appropriate and responsive services for all cannot be undermined, especially for safe water and sanitation, which are among the important conditions for promoting and maintaining good health.

Accountability for WASH Services and Citizen’s Engagement

In South Asia, responsibility for the provisioning of water, sanitation, and hygiene is mainly vested with the State, imparted through State government departments and municipalities, and guided by national and sub-national government schemes or programmes. State-led audit mechanisms and regulatory bodies oversee the implementation of water and sanitation schemes and the quality of services. The latest Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) 2019 reported that globally, most countries have national standards for drinking water and wastewater management. However, institutions tasked with regulatory oversight for WASH service delivery are unable to undertake the required surveillance.

For instance, the Report notes that less than one-third of regulatory authorities publish publicly available reports for drinking water and sanitation. In addition, less than half of the regulatory authorities fully take corrective actions against non-performers. Despite having regulatory bodies, state-led audits and monitoring, joint monitoring undertaken by development partners, and tools for citizen engagement and oversight in place, accountability for public service delivery, especially for drinking water and sanitation, has been a key issue across South Asian countries. Critical lacunae include inadequate outreach to the most vulnerable people, disruption of services, services not aligned with the needs of the people, information gaps, and complicated procedures.

As public services have evolved and matured in South Asia, accountability of duty bearers for public services has not been limited to the upward authorities in hierarchy or to the regulatory bodies. Duty bearers are also answerable to the citizens as consumers and right holders, which in turn has resulted in institutionalisation of social audits, grievance redress mechanisms, and citizen charters. The Good Governance Act (GGA)-2006 of Nepal envisioned institutionalising social accountability mechanisms such as public hearings, public audits, citizen’s report card and citizen’s charter at the level of municipalities to increase accountability.⁴ The focus on transparency for good governance also led to more information flow in the public domain. The Right to Information

³ World Health Organization (1978) Declaration of Alma-Ata, available at: https://www.who.int/publications/almaata_declaration_en.pdf

⁴ CUTS (2013) Understanding the Context of Nepal for Social Accountability Interventions, available at: <http://www.gogofoundation.org/downloads/Understanding%20the%20Context%20of%20Nepal%20for%20Social%20Accountability%20Interventions.pdf>

laws were enacted between 2002–2014 in Bangladesh, India, Maldives, Nepal, and Pakistan.⁵ Usage of information technology has given further impetus to building interface platforms between citizens and duty bearers for demanding accountability. Greater recognition to the principle of subsidiarity, decentralisation for planning and fiscal devolution in the last two decades especially in India, Nepal, and Bangladesh, has created conducive conditions for planning and implementation of programmes and schemes at the local level.

However, in practice, this delicate and intricate interface of citizens with duty bearers in a way that balances the power of the State as well as the power in communities is poorly operationalised. On the limitations of social accountability approaches institutionalised by the State leading towards sensitive and responsive social provisioning, a study from India points out two reasons.⁶ First, the bureaucracy and service delivery organisations, in general, are deeply embedded in local patterns of political behaviour, and have inertia in practices associated with incentives and organisational culture of managers, coupled with ‘top down’ service delivery. Devolution of power and planning to the local level remains only on paper, with little disruption of power relations, deeper entrenchment of status quo, and weak state–citizen interface for demanding accountability. Secondly, despite the social pressure and demand for accountability,

there are issues related to the capacity of the system itself to respond; in terms of skill-sets, resources, and management systems. A recent study by BRAC Institute of Governance and Development acknowledges that in Bangladesh, the Local Government Act, 2009 and its complementary policies and provisions help in establishing an institutional framework such as the Ward Committee (WC), Scheme Supervision Committee (SSC), and Open Budget Meeting (OBM) for seeking accountability. Though the government has established these social accountability institutions in the Union Parishad, the absence of central funds to support their operationalisation has led to these platforms becoming patronage machines for generating and maintaining the political/social capital of the funders.⁷

Further, despite provisions for social accountability institutionalised in policy and programmes, they are, at times, not applied. The National Rural Drinking Water Programme of the Government of India provided for regular social audits by community-based organisations such as Village Water and Sanitation Committee (VWSC). However, the audit report of the programme from 2012–2017 observed that the social audit of the programme was not being conducted in most Indian States.⁸ Reaching the last mile or the most vulnerable populations has been an issue for public services. Tools of citizen engagement can be instrumental in empowering communities to share constraints

⁵ Surie Mandakini (2014) Strengthening Right to Information in South Asia. The Asia Foundation, available at: <https://asiafoundation.org/2014/12/03/strengthening-right-to-information-in-south-asia/>

⁶ Accountability Initiative (2014) Rights, Accountability and Citizenship: Examining India's Emerging Welfare State, available at: http://www.accountabilityindia.in/sites/default/files/rights_based_welfare_state_aiyar_walton.pdf

⁷ Brac Institute of Governance and Development (2018) State of social accountability and deliberative democracy in Bangladesh: Current dynamics and future pathways. Brac University, State of Governance

⁸ WaterAid India (2018) The State Of National Rural Drinking Water Programme. Smart Water and Waste World, available at: <https://smartwww.in/the-state-of-national-rural-drinking-water-programme/>

related to poor outreach or uptake of services, or help in redesigning the programmes. An empowered citizen engagement with a strengthened system to respond adequately with a balanced power relationship of mutual respect at each level, particularly at the local level, requires strengthening of people's voices, strengthening of service providers, and supporting an institutionalised interface mechanism.

Showcasing Models – Innovate, Multiply, Institutionalise

In view of existing spaces for enhancing social accountability and citizen engagement, and the limitations of approaches in South Asia, it is important to showcase, innovate, and multiply interventions in different contexts to influence the design and reengineering of approaches by government and non-government stakeholders.

The different case studies featured in this report from Nepal, Bangladesh, and India are an attempt to showcase the building of social accountability mechanisms and system strengthening, which though have been nudged by external agencies and civil society organisations, are built on the state's own provisions of strengthening citizen's engagement for accountability.

Nepal used a human-rights based approach, named the Sustainable WASH Project, to strengthen the WASH-related rights of marginalised communities and people in vulnerable situations, which are provided by the Constitution of Nepal. This was done by empowering communities to voice and demand their rights, and by enhancing accountability of service providers as well,

to ensure quality services. Social accountability tools included public hearings (Jal Kachaharis), public audits and community scorecards.

In Chhattisgarh, India, the Citizen's WASH Forum, a collective of non-government organisations and individuals, developed annual Citizen's Report Cards (CRC) to generate community feedback on the progress and gaps of the Swachh Bharat Mission (SBM), India's landmark sanitation programme. The CRCs have led to course-correction in SBM's implementation in the State and the introduction of innovative features such as a pilot intervention for toilets that meet the needs of the differently-abled.

The two remaining case studies included in this report focus on health. The Local Government Institution (LGI) – led 'WASH in Health' project in Bangladesh aimed to strengthen the capacity of the health workforce and local level health services for WASH, with the goal to improve the health of rural communities. By mobilising and building capacities of local government, community groups, and community members, the project enhanced institutional capacity to serve, increased demand in the community to receive services, and activated citizens to perform their responsibilities to ensure quality health care facilities. To combat fluoride contamination, people-centric District Water Quality Platforms have been implemented with promising results. The primary objective of the District Water Quality Platforms is to make the district 'fluorosis-free' within a specified time, as decided by the platform itself and by bringing synergy of all key departments as service providers. These district level water quality platforms focus on

TABLE 1: Summary of social accountability tools used in the case studies

Country	Issues/ focus area	Mechanisms for social accountability
Bangladesh	Community Clinics	Citizen Charter, capacity building of stakeholders on duties and responsibilities
Chhattisgarh, India	Swachh Bharat Mission (sanitation programme)	Community Report Card
Nepal	Right to Water and Sanitation as per the Constitution	Human-Rights Based Approach (HRBA)
INREM (India)	Water quality, specifically due to Arsenic and Fluoride contamination	District Water Quality Platforms

the most vulnerable areas of water quality-affected regions by connecting the needs of affected communities with the respective district administration, thereby ensuring delivery of services and their maintenance.

Further, the platform enables convergence of different departments to work on specific activities and monitor their outcomes.

Each of these case studies has focused on different issues, and used a particular approach or a combination of tools for social accountability. What binds these case studies is the importance given to social accountability to strengthen dialogue between communities (receivers of services) and with service providers in a manner that is people-centred, action oriented, and institutionalised.

Authors: Vanita Suneja (WaterAid) and Arundati Muralidharan (WaterAid India)





District Water Quality Platforms

Introduction

Fluoride, arsenic, nitrate, and other chemicals in drinking water pose significant health risks such as fluorosis and arsenicosis to our population. According to government data¹ (2016), approximately 21 million people in over 23,500 habitations are affected by arsenic and fluoride present in groundwater. The worst fluoride affected states are Rajasthan, Gujarat, Andhra Pradesh, and Telangana. Punjab, Madhya Pradesh, Karnataka, and Maharashtra are moderately affected.²

Chemical contaminants like fluoride occur naturally in underground rocks. Hence, community reliance on groundwater sources, coupled with malnutrition and poor access to health services, makes them vulnerable to the diseases caused by the same. These contaminants in drinking water leave many people with crippling deformities, skin diseases and cancers in fatal cases.

The National Water Quality Sub-Mission is responsible for water quality issues, with a major focus on arsenic and fluoride-affected habitations.

For such large-scale problems, the response at the national level has been patchy. Policies looking to address these problems tend to focus on water access. To provide access to clean drinking water, they focus on moving away from groundwater en masse, and have tried to implement access through surface water sources. Apart from implementation of regional pipe water supply schemes, such as Mission Bhagiratha in Telangana³, and thousands of community-level defluoridation plants in states like Madhya Pradesh, Karnataka and Rajasthan, issues related to contamination continue to affect millions. An audit of the National Rural Drinking Water Programme (NRDWP) and its Integrated Management Information System (IMIS) data on water quality undertaken by the Comptroller and Auditor General of India (CAG) in 2018, found major discrepancies between the IMIS data and physical records on drinking water availability within schools and anganwadis, irregularities in the dates of schemes implemented, and most importantly, differences between physical records and IMIS data on the status of water quality for different habitations.⁴

¹ Department of Drinking Water and Sanitation (Government of India), available at: <https://jalshakti-ddws.gov.in/>

² National Institute of Health and Family Welfare (Government of India) (2016), available at: <https://www.nhp.gov.in/disease/non-communicable-disease/fluorosis>

³ Government of Telangana State Mission Bhagiratha, available at: <http://missionbhagiratha.telangana.gov.in/>

⁴ Comptroller and Auditor General of India (2018) Report No.15 of 2018 - Performance Audit on National Rural Drinking Water Programme in Ministry of Drinking Water and Sanitation, available at: <https://cag.gov.in/content/report-no15-2018-performance-audit-national-rural-drinking-water-programme-ministry-drinking>

As a part of the Water Quality Network (WQN) for the past decade, and with its own programmes, INREM Foundation has worked in districts like Jhabua (Madhya Pradesh) and Nalgonda (Telangana) to develop an integrated approach to fluorosis mitigation. A key learning is that the intervention needs to work at a number of levels. At the individual or household level, this means that mitigating the effects of fluoride requires consistent access to fluoride-free water, better nutrition, and for fluorosis patients—diagnosis and rehabilitation. For this action to saturate a district and sustain over time, the district needs the aligning, motivation and bringing together of a number of relevant departments, local civil society organisations (CSOs), and individuals.

The right solution, therefore, requires alignment and collaboration between individuals and departments, whereby the needs of the community are properly heard and processed. The challenge thus is to create systems that properly connect and motivate individuals from communities and organisations to communicate openly and clearly, and translate this dialogue into action in a sustainable fashion. And through that all, an overarching system is required by which data is collected periodically in some standardised form that helps track progress and helps affected communities and CSOs hold the individuals and teams in power accountable.

People-Centric District Water Quality Platforms

INREM Foundation and SaciWATERS anchor the WQN with a focus on fluoride and arsenic respectively in India. WQN brings together a wide set of stakeholders on the issue.⁵ The larger network is born out of the experiences around the 'Fluoride Knowledge and Action Network'⁶ that started in 2013, which at the outset tried to bring together what was then a disparate community of practitioners, researchers, and activists to join hands for a unified response and sharing of knowledge and experiences.

In the fluoride-affected districts—Balasore, Nalgonda, Jhabua, Dungarpur, Chikkaballapur—where INREM has intervened with partners over the past decade, a model of 'People-Centric District Water Quality Platforms' for addressing fluorosis issues is being tested (and iterated) in six states of India. These states are Rajasthan, Telangana, Karnataka, Madhya Pradesh, Odisha, and Assam.

In each district, WQN and INREM support a team that convenes a District Platform by getting the right people and representatives of district-level departments. The primary goal of each of these 'District Water Quality Platforms' is to make the district 'fluorosis-free' in a specified time period as decided by the platform. This platform then systematically works towards this in the following way: engaging in a goal articulation exercise, and coming to a consensus on timeline and roles

⁵Both the organisations are currently working on a European Union Supported Programme on Water Quality in India: 'Civil society voices, vulnerable communities and localized platforms for addressing Water Quality.' The project kicked off in 2018 and will conclude in 2021.

⁶ Supported by Arghyam.

based on local priorities and opportunities presented by the skill sets and programmatic focus in each of these districts. These platforms enable convergence between different government departments such as water supply, health, and women's welfare.⁷ Additionally, efforts such as 'Speaking Wall'⁸ and surveys ensure that the involvement of local citizens is maximised. Overall, the emphasis is on sustainable solutions that are ecologically sound, address the most marginalised people, and at the same time can be scaled up within the respective districts.

These district-level water quality platforms have led to coordination of the efforts at scale. Witnessing alignment, planning, and action in a district in their own state, serves as a building block to scale up efforts on a much wider scale. For e.g. in Assam, action that started in Nagaon, has led to the state beginning to form a state-level response through action in another three districts i.e. Kamrup, Hojai and Karbi Anglong. In Rajasthan, a similar effort based on the Dungarpur model (the first district platform in Rajasthan) is now planned to be replicated in three more districts i.e. Rajsamand, Sirohi and Jalore. The current direction is to work within the water and sanitation mission of a state that is willing to work on the model (at this time in Assam and Rajasthan) that helps to take the District Water Quality Platform approach as a building block. The idea is that in the same way that the district is a model to be learned from and replicated across a state,

Role of District Platforms

- Connecting the needs of affected communities in the most vulnerable areas of water quality affected regions with the respective district administration.
- Enabling convergence of different departments to work on specific activities and monitor their outcomes for required services.
- Periodic monitoring of the status of water quality and health impacts through field surveys. At the moment, these are being piloted by the INREM teams in each district, but will soon be handed over to government staff that will be trained, mentored, and supported to carry these out in the long run.

similarly these pioneer states could facilitate national-level action against fluoride and related issues such as arsenic and other water quality problems.

Setting Up the Platforms and Enabling Processes

There is a nodal department specific to each district, which anchors the platform. The district collector heads the platform. Its members meet every month and report their progress to the district collector every quarter.

These meetings and advocacy efforts have resulted in convergence between at least four departments—Water Supply, Health,

⁷ More detail in subsequent sections of this Case Study.

⁸ A painted wall is put up at a prominent point in the community where the latest water quality data of water sources is mapped along with a method for communities to share their voices. This is a touch point that is being actively developed and iterated.

Integrated Child Development Services (ICDS), and Education—in every district where the platform has been constituted. Along with this, other local stakeholders such as civil

society organisations (CSOs), local university departments, and other institutions need to be involved on this common platform.

Members of the District Platform

- District collector and sub-collector, CEO–Zila Parishad (ZP)
- Nodal department
- Other department representatives such as water supply (Public Health Engineering (PHE), Rural Water Supply and Sanitation (RWSS) or others), Health and Family Welfare, ICDS, Education
- Civil society organisations working on drinking water, irrigation, watershed, nutrition, agriculture, public health and related areas
- Any other invitees, as per request, such as other departments, organisations, university departments

TABLE 1: Departments and their structures in three levels as part of the District Water Quality Platform (Abbreviations in Legend below)

	PHE	Health	ICDS	Education	Others (Forest, Panchayat, MGNREGS), Agriculture, DRDA
Level 1: District	SE, EE, AE	CMHO, additional CMHO, NPPCF Officer	Deputy Director	Chief DEO, 4 DEOs	Forest (DFO, DCF), CEO–ZP
Level 2: Block	JE, Keyman	BCMO, MOIC CHC/PHC	Block CDPO, Sector Supervisor	Block Level Chief BEO	Forest (Ranger), BDO
Level 3: Panchayat	VWSC, Water Operator, Hand Pump Mechanic, SEM	LHV, ANM, ASHA	AWW, ASHA	School Level Per PEEO	Forest (Naka Vanpal, Beat-in-charge), Sarpanch and GP Members

Legend

PHE: SE: Superintendent Engineer, EE: Executive Engineer, AE: Assistant Engineer, JE: Junior Engineer, VWSC: Village Water and Sanitation Committee, SEM: Self Employed Mechanic

Health: CMHO: Chief Medical and Health Officer, NPPCF: National Programme for Prevention and Control of Fluorosis, BCMO: Block Chief Medical Officer, MOIC CHC/PHC: Medical Officer In-charge for Community Health Clinic/Public Health Clinic, LHV: Lady Health Visitor, ANM: Auxiliary Nurse Midwife, ASHA: Accredited Social Health Activist

ICDS: CDPO: Child Development Project Officer, AWW: Anganwadi Worker

Education: DEO: District Education Officer, BEO: Block Education Officer, PEEO: Panchayat Elementary Education Officer

Others: DFO: District Forest Officer, DCF: Deputy Conservator of Forests, ZP: Zila Parishad, BDO: Block Development Officer, GP: Gram Panchayat, MGNREGS: Mahatma Gandhi National Rural Employment Guarantee Scheme, DRDA: District Rural Development Agencies

Components of a Holistic System for Action to Enable Health Impacts

There are three key strands that intertwine to create an effective approach:

1. Looking into the roles and responsibilities of key departments for effective service delivery
2. Focusing on habitation-level capacity building and action
3. Effective monitoring and evaluation with feedback loops

1. Department-Wise Activities Breakdown

The platform plays the key role of ensuring cross-departmental collaboration and

communication, while creating mechanisms for accountability through periodic monitoring. However, it is important to note that connecting directly with a community suffering the side effects of fluoride requires action around water access, nutrition and specific health interventions like diagnosis and rehabilitation. Thus when considered separately, the following activities within each department can be considered to have separate such individual outcomes. The District Platform needs knowledge and support on building capacities of the departments to ensure that the following specific activities (see Table 2) are undertaken on a periodic basis –

TABLE 2: Department wise specific activities to be undertaken for fluorosis mitigation

Public Health Engineering	<ul style="list-style-type: none"> • Comprehensive and regular testing of all drinking water sources and reporting the water quality to the Panchayat. • Ensuring sustained working of all water treatment plants. • Making provisions for supply of safe drinking water from external sources where any local arrangement is difficult. • Identifying and making possible local safe water sources in water-quality affected villages. • Having a continuous stream of communication with Panchayats and communities on water quality issues – ensuring long-term behaviour change on these issues.
Health	<ul style="list-style-type: none"> • Timely detection of water quality related diseases, and their reporting through a referral chain of health systems. • For people affected with water quality related health problems, ensuring rehabilitation processes through treatment, or other means such as nutrition. Through field health workers – having a constant campaign of communication with people to steer them towards better behaviour for improved health for issues caused by water quality problems.
ICDS	<ul style="list-style-type: none"> • Regular testing of water in anganwadis and identifying any water quality issues. • Provision of safe drinking water for drinking and cooking in anganwadis. • Identifying and using existing mechanisms such as village health and nutrition day, Mamta Diwas and others as opportunities for communication with pregnant and lactating mothers on water quality issues.
Education	<ul style="list-style-type: none"> • Regular testing of water in schools and identifying any water quality issues. • Provision of safe drinking water for drinking and cooking in mid-day meals. • Introducing water quality issues in curriculum for long-term education and behaviour change amongst children and their families on water quality issues.
Others	<ul style="list-style-type: none"> • Utilising NREGS as a means to develop a sustainable way of ensuring safe drinking water through water conservation, recharge, etc. • Having agriculture and forestry departments focus on nutrition related interventions by plantations and gardens etc. • Getting Panchayats to have focused planning at the village level for comprehensive action on water quality issues, ensuring convergence on ground.



INREM

Building capacities of women on solutions to water quality issues

2. Capacity Building and Habitation Level Action

Existing village and habitation level governance institutions such as Panchayats and Village Water and Sanitation Committees (VWSC) and frontline workers such as local school teachers, ASHA workers, anganwadi workers, and watermen play a key role in bringing forward the voices of affected communities, and in empowering them with the required information to fight water quality issues and their impact on health.

CSOs and relevant departments also need to build awareness and provide effective training that enhances capacities of these frontline workers and local governance institutions. Panchayats, VWSCs and frontline workers provide an important channel between the departments responsible for service delivery and the affected communities, bringing to the fore the challenges and needs of the

communities, while creating awareness and delivering on the needs around water access, nutrition, and health impacts.

The VWSC and the Panchayat are now better equipped to fulfil their mandates on drinking water and health. Anganwadi and ASHA workers with training based on identifying disease symptoms of fluorosis and arsenicosis provided to them, are aware of the kind of nutritional and health interventions they need to undertake to improve the situation and are better equipped to handle related health challenges.

This helps define the connection that lies between the currently segregated sectors of health, water, and rural development. Hence, by building the capacities of this ground cadre, supported by different government departments, the Platform creates easy approaches for integration of health and water, which allows effective diagnosis of

drinking water related health issues, as well as improved service delivery.

Through such activities on the ground, the final beneficiaries, i.e. the vulnerable, disabled, and affected communities, get a chance to understand the various water quality

challenges that they face. It also enables them to take charge of these challenges and handle them in a systematic and sustainable way, helping them get educated on the avenues and processes available for raising concerns meaningfully.

How community voices have enabled change on safe water through a District Platform

A story from Balasore district of Odisha



INREM

Community voices improving safe water access in Balasore

A good example of safe drinking water sharing from a private source is seen in the village Thanagadia of Chasakhanda Gram Panchayat in Remuna block of Balasore district. Through a Remuna block-wide fluoride water survey organised by the District Fluoride Mitigation Centre (DFMC), the hand pump water set up by the government was found to be contaminated with high fluoride, causing dental fluorosis and joint pains. After this initial water testing and communication through the DFMC, the villagers started to think about the possible solutions available locally for safe drinking water. Continuous triggering

by the Balasore district team focused on sharing of safe water sources as the only immediate solution to tackle the fluorosis issue. As a result, Ms Ramani Das (ASHA worker) and Kailash Das (Headman of the Thanagadia village) agreed to share, free-of-cost, their own hand pump water, which has fluoride within the permissible BIS limit, to 40 households of Khandayat Sahi for drinking and cooking purposes. This practice is now helping more than 200 villagers get safe drinking water without any investment of external technology and just through the means of local water sharing.

3. Monitoring and Evaluation

INREM supports periodic monitoring and evaluation (M&E) surveys. These surveys are designed to document the current extent of water quality issues and related health impacts and gauge understanding of solutions within the district. They serve two key purposes, which build more accountability to the working of the District Platform:

1. They help the project management team understand the status of their activities to meet programme objectives and goals.
2. They support the processes of the District Platform by having a mechanism to ensure that ground reality has an impact on concerned processes/programmes/schemes within the government. This pushes for accountability from relevant departments within the District Platform.

With the approval by District Platforms, the resulting data is authenticated and accepted by the respective district governments and bodies. This enables better decision making to improve the health of thousands of young children, women, and those affected with disease.

The M&E surveys are designed to be a replicable process and include tools that can be applied in any district to get a snapshot of the fluorosis situation across that district. In the longer term, they will help understand if the goals, in view of the original indicators, are being met.

Conclusion

Most development issues require an integrated approach so that the solutions benefit the affected. The District Platform, in that sense, is an enabler for exchange of solutions, and a mechanism to spread best practices. The purpose of this case study has been to document this approach at a particular point in its evolution, as well as the learning from the experience thus far.

Evolution and Growth through Collaboration and Partnership

This is a concept that has been shaped by the partners taking it on. With every new partner who comes onboard, the concept is evolving and getting sharper. A good example is UNICEF who came on board to formalise the platform and processes in Rajasthan, expanded its purview across more districts, and got support at the state level. The key is that as the District Platform idea grows, in going from one place to another through contextualisation and replication with partners, it shows that there is room for improvement and for making it more meaningful in its impact.

Wider Impact at the State Level

There is potential for wider impact as the District Water Quality Platform and process becomes a means through which integrated work on mitigation against contaminants can possibly support action at the state or national level.

Channel and Platform for Tackling Other Contaminants

Lastly, the setting up of a platform and its constituent processes allows for a robust scaffolding, through which one can address issues related to contaminants beyond fluoride and arsenic, with issues like salinity, biological contaminants, uranium and selenium coming to the fore.

Learnings

Government officials hesitate to get going

Getting all the departments on board with this idea is a challenge in the beginning. Government officials are hesitant to be part of such a process where their actions are subject to accountability by senior officers like ZP CEO or the district collector. Hence, an influencer (could be a person or an organisation) who is within or works with the government, needs to be identified, who may help kick-start the process and build confidence.

Keeping things simple is essential

It is critical not to overburden the departments with complex agendas and activities. It is important to identify channels within the systemic process where specific inputs can help achieve the objectives, so that best practices become part of the agenda within each department or CSO. A strategy that is bearing fruit given this learning is seeing how requirements for platform activities can be aligned with, or subsumed within, existing policies or running programmes. For example, to ensure that affected communities grow

plants and trees whose output is necessary for the required nutrients, the platform used existing horticulture mandates around distribution of seeds and saplings, directing them to distribute amla and moringa plants to farmers and families in affected districts in Dungarpur, Rajasthan.

Monitoring of ground actions

Developing a strong monitoring framework is crucial to the functioning of the District Water Quality Platforms. It helps to serve as a milestone-marker for both the government and platform representatives. The key, though, is to make sure that these processes are accessible by communities on the ground; both in the way information and data is collected, and in the way, the analysis of that data leads to iteration and outcomes.

Strengthening capacities and institutions is critical

In the water sector, especially related to health impacts, there is no specific frontline staff as it falls and overlaps in the purview of many individuals and institutions. Thus, policy decisions made at any level sometimes fall through the cracks as they fail to create an impact on the ground. It has thus been an important learning that it is essential to support community members themselves, frontline workers, and local governance bodies in taking action. District platforms amplify and ensure action through the connect they establish across relevant departments and the community.

Authors: (From INREM) Dr. Sunderrajan Krishnan, Kiran Kumar Sen, Akshay Roongta, Vikas Ratanjee, Dr. Rajnarayan Indu and Sachin Vani





Better Access to Community WASH Services through the use of Social Accountability Mechanisms

Introduction

Nepal is among the least developed countries in the world, with about one-quarter of its population living below the poverty line.¹ The rural areas of Nepal have extremely low socio-economic and human development conditions as indicated by the Human Development Index (HDI). The Karnali province of Nepal is far behind the development matrix with respect to access to safe water, improved sanitation facilities, and good hygiene practices. The Hima and Palata rural municipalities (RMs) of Jumla and Kalikot districts respectively of this province are among the most deprived rural areas of Nepal where the lives of the marginalised people and those in vulnerable situations are even worse.^{2,3}

The Constitution of Nepal 2015 in Article 35, Sub-article 4, clearly protects the right to drinking water and sanitation for all, but the status of water, sanitation, and hygiene (WASH) is in a very fragile condition in this

area. Only 29 per cent of the total water supply schemes are fully functional (47 per cent in Hima RM, and 11 per cent in Palata RM).⁴ The budget allocation for WASH in both RMs was inadequate for the services required. Information gaps on WASH-related rights and the required roles and responsibilities of the communities led to limited engagement in managing the existing systems and holding duty bearers accountable. In addition, the duty bearers themselves had limited capacity to deliver quality services and meet the service gaps. The WASH governance mechanism therefore had to be strengthened in order to make the right holders responsible and the duty bearers accountable.

Human Rights-Based Approach (HRBA)

Realising the need for intervention in the area, a Human Rights-Based Approach (HRBA)⁵ was adopted as shown in Figure 1. The specific intervention or Sustainable WASH Project

¹ Nepal Economy 2019, available at: https://theodora.com/wfbcurrent/nepal/nepal_economy.html

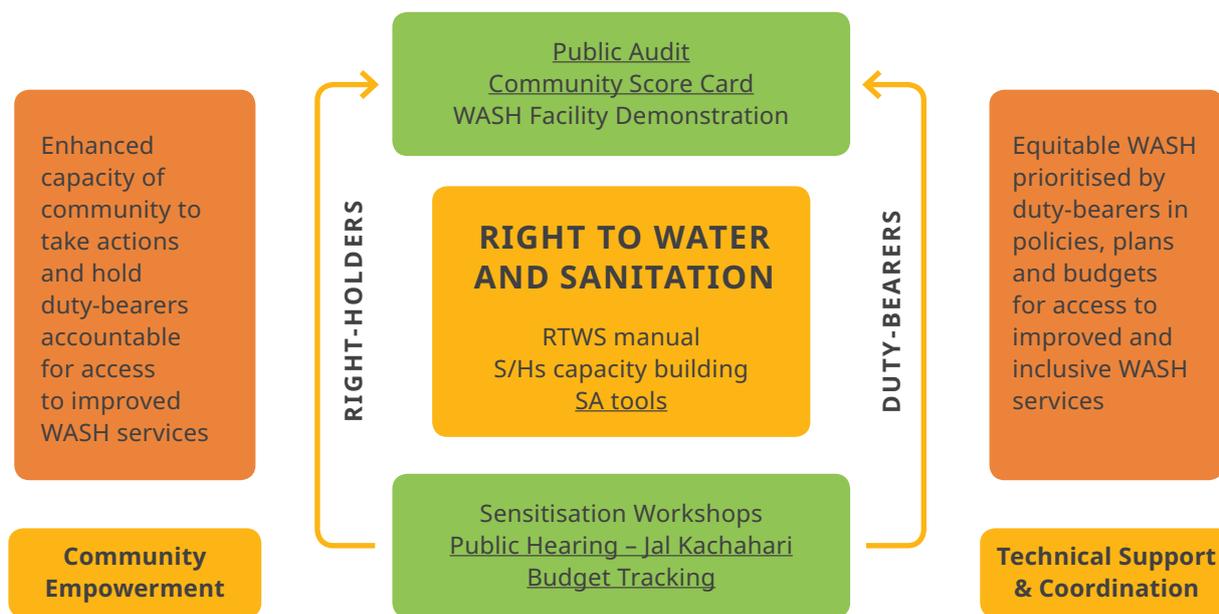
² National Planning Commission (Government of Nepal) (2018) Nepal's Multidimensional Poverty Index: Analysis Towards Action 2018. Oxford Poverty and Human Development Initiative (OPHI), Government of Nepal, available at: https://www.npc.gov.np/images/category/Nepal_MPI.pdf

³ Nepal Human Development Report (2014) Beyond Geography Unlocking Human Potential, available at: http://www.hdr.undp.org/sites/default/files/nepal_nhdr_2014-final.pdf

⁴ WaterAid Nepal, KIRDARC (2017) Baseline report, Sustainable WASH project

⁵ WaterAid Guidelines Embedding and integrating a human rights-based approach into WaterAid programmes. Available at: <https://washmatters.wateraid.org/sites/g/files/jkxoof256/files/Guidelines%20on%20embedding%20and%20integrating%20a%20human%20rights-based%20approach.pdf> (A human rights-based approach to development is rooted in the central idea of empowerment. It seeks to change the relationship between development actors and poor or vulnerable people from one of charity and powerlessness to one of obligation and rights.)

FIGURE 1: Schematic diagram showing how HRBA is embedded in the Sustainable WASH Project design



aimed to strengthen the WASH-related rights of the marginalised communities and people in vulnerable situations by empowering them through capacity building. On the other hand, in order to make the duty bearers accountable, the capacities of the supply side were also built up through technical support, so that the right holders receive quality services. A manual on ‘Right to Water and Sanitation’ (RTWS) was prepared and capacity building of both right holders and duty bearers was undertaken. This manual contains an introduction to the rights, human rights and responsibilities, along with the different elements of the Right to Water and Sanitation, roles and responsibilities of stakeholders, sector performance monitoring on RTWS, social accountability, etc. Attempting to undertake a broader influencing of the stakeholders and institutional setups at both ends of the spectrum, the intervention conducted capacity building exercises for elected representatives from the local bodies,

media persons, WASH stakeholders, Water and Sanitation Users Committees (WSUCs) and the community people.

Social accountability tools such as public hearings, public audits and community scorecards were promoted and used as major tools. Jal Kachahari, a public hearing platform with face-to-face dialogue and interaction between the right holders and duty bearers, organised at the RM and ward levels helped to establish a strong platform to promote RTWS, for communities to share their issues, and for duty bearers to respond. This initiative triggered right holders to claim their right and duty bearers committed to deliver the services. The local municipalities have owned such Kachahari platforms and have now taken the initiative to organise it themselves.

Based on the commitment by local authorities, budget allocation in delivering WASH services increased in 2019 to 20 per cent in Palata and 10 per cent in Hima RMs from 6 per cent

and 5.6 per cent respectively in 2017.⁶ Use of the community scorecard as a tool has been highly appreciated by the community as it led to the preparation of an action plan to improve the existing WASH situation. The action plan included use of safely managed water supply, payment of water tariffs for the functionality of the system, construction and improvement of existing latrines, and non-discrimination while delivering WASH services. Use of the public audit at the community level has not only informed community people about the budget plan and expenditure, it has also increased their understanding of programme quality and monitoring. The public audit has increased financial transparency and the quality of delivery among the service providers and right holders; and ensured completion of targets on time. Overall, the project has established a meaningful participatory mechanism to ensure accountability of the duty bearers, defined the roles and responsibilities of the right holders, and ensured the right to water and sanitation for all.

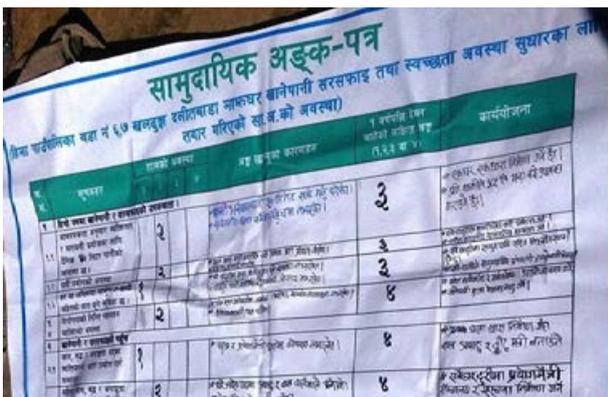
Empowerment of the Marginalised Groups

The rights-based approach has focussed on empowering marginalised groups of the community. Women, people with disabilities, adolescent girls, and Dalits are the key beneficiaries. The formation of a 'woman's group' for conducting hygiene sessions as well as an orientation on the Right to Water and Sanitation (RTWS) led to the rising of the collective voices of the unheard and the unserved. As **Ratna Prasad Upadhyya, a local woman from Thulo Chiudi, Hima RM**

said during the orientation on RTWS, *"We have high water scarcity in Patharkhola. We are happy to know that our right to water has been ensured in the Constitution."* This initiative served as an information-receiving platform for the beneficiaries. Community members shared existing practices and took leadership for self-initiative processes for WASH improvement. *"During menstruation, women and adolescent girls were not allowed to touch the water tap. Now, we are aware of our right to water and sanitation,"* said **Sabina Bam, a local woman from Palata RM** sharing her enhanced awareness after attending an orientation on RTWS. Formation of the 'woman's group' triggered the community to represent themselves in the vital positions of the committee. The evidence can be observed where women are leading as key members of the WSUCs, are key members of WASH Coordination Committees (WASH-CCs) at various levels and are playing leading roles in different advocacy initiatives such as rallies, interaction and triggering. At least 33 per cent women have participated in any committee formed in the project area.

The community voice of women during public audits and public hearings, especially Jal Kachaharis has been a tremendous step towards women empowerment. *"A Jal Kachahari had been facilitated by KIRDARC Nepal and will be soon implemented by Palata RM. For this, I would like to thank KIRDARC Nepal. I would like to assure that the RM will learn and conduct such Jal Kachaharis in the coming days,"* said **Laxman Bahadur Bam, Chairperson, Palata RM, Kalikot district**, showing his commitment during the close of the Jal Kachahari.

⁶ Programme and Budget, Hima and Palata RM, 2019



Community gathering and their engagement during social accountability tools like Public audit and Community Scorecard

Likewise, the representation of people from the Dalit community as key members of the water supply system wherever present has been mandatorily implemented. The representation of Dalits on such a platform has contributed to raise the collective voice of the marginalised Dalit community. The community people are continuously engaged in consultation and feedback collection. They are involved in the decision-making process and are able to access information from various sources. To ensure process sustainability, the duty bearers have been directed to serve the on-ground interest of the citizens.

While conducting the public audit, all the community people and concerned stakeholders are invited prior to the event. The major communication means include notices at public places, mobilisation of

human resources, telephone conversations and announcement of the event while conducting other events like hygiene sessions, RTWS, triggering and advocacy-related events, promotional events and so on. The public audit has been conducted at least thrice in each scheme and the project practices disclosure of the financial budget plan versus expenditure after the completion of each event. Such practices have built trust between the community people, implementing agency, and the local level agencies. *“In our community, we have got access to improved water service in the yard of each household and we are glad to know the budget allocated for the construction of water supply. Everyone in the community knows the amount that the labourers received and how much has been saved. The public audit has made everything clear,”* reflected **Narendra Nath Yogi, Secretary, Jogibada WSUC, Hima RM** during one of the public audit events.



Community people raising their unheard voices on WASH during a public hearing – Jal Kachahari

Similar events conducted in the project area, especially RTWS sessions, public audits, Jal Kachaharis, demand for water supply from the community and WASH related rights-based promotional events were covered by the local and national media in both digital and print formats.

Strengthening the System and the Service Providers

Water and Sanitation Users Committees (WSUCs) and local level representatives are the ultimate accountable duty bearers and the frontline agencies engaged in delivering WASH services in the project areas at present. In order to engage them to provide services, they were trained on the Right to Water and Sanitation (RTWS). This helped all the duty bearers internalise RTWS as a constitutional mandate. As the project area is highly remote and the existing WASH services are very poor, the duty bearers linked the water scarcity with the Right and have been motivated to be engaged.

Likewise, the conducting of the Jal Kachahari became the key event to enable duty bearers to respond. Here the demands for WASH services were raised, and the duty bearers committed by making declarations of taking

actions and accordingly allocated budgets for WASH services in both RMs in the coming fiscal years. The demand for construction of the water supply system is being addressed by the local government. Meanwhile, the duty bearers have realized Right to Water as a basic human right. This has been a key political agenda during the local level elections, and addressing this issue was their election mandate. Besides budget allocation, Palata RM has also prepared procedural documents related to overall WASH in the RM, Disaster Risk Reduction (DRR) and WASH in schools. Technical assistance was provided by the Project to the Palata RM to overcome and improve the policy and implementation-related hurdles in WASH. This has added value to their WASH procedural documents and to their organisation of WASH activities.

Since the area is very remote, there is a huge gap in technical and skilled human resource availability. In this context, the transfer of such skills from the project into the RM has enabled duty bearers to respond. The process has been established at the local level as the smallest unit of delivering WASH services and has been recognised as WSUC, which will be monitored by the ward WASH-CC and RM WASH-CCs. WSUCs are further capacitated on

book keeping, operations and maintenance, system management and strengthening. This has enabled them to manage the financial portion of the system effectively. The recognition of the WSUC as a WASH governing body at the local level has triggered the committee to deliver effective services.

Conclusion

1. Social accountability tools (public hearings, budget tracking and community scorecards) were found to be participatory, user-friendly and locally adaptable during project implementation.

The tools improved the capacity of the right holders and duty bearers to perform effectively. This has improved accountability in the project area as demand for WASH has increased and parallel to that, the government has been addressing these issues as reflected in their budget plan. A 'one house, one tap' strategy has been adapted by both RMs. Jal Kachaharis have been owned by the local government as they have supported the RM in reaching the community.

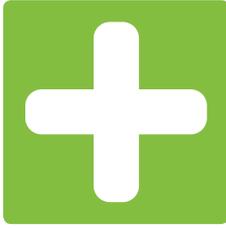
2. The public audit tool has been very effective in ensuring transparency.

During the discussions, the community people demanded clarity on the expenditure, including the original bills. In addition, people filed a complaint if they

were not satisfied and the public audit was conducted again. Public audits at each water supply scheme level with maximum participation from the community people are necessary to strengthen the transparency mechanism. User-friendly community scorecards are used as indicators and can be revised as per the local need and context.

3. The role of the local government and WSUC is crucial to sustain social accountability.

The sustainability of the existing local system of duty bearers such as WSUC and WASH-CCs plays a key role in improving accountability. They serve as the first touch-point from the perspective of the right holders but the mechanisms are not fitted with any kind of tangible benefits. Therefore, the stakeholder's performance needs to be linked with awards and recognition as motivation. Technical support enhanced the local capacity of the RM to address the WASH demand from the community. Financial gaps in the existing system are a major hindrance in sustaining the accountability mechanism, as the existing system could be non-functional at any time. Hence, establishment of a continued local level monitoring mechanism is required to monitor and track the progress on a regular basis.



WASH Facilities Help Improve Health Services

Experiences from Community Clinics in Gangni, Bangladesh

Introduction

The 'Alma-Ata Declaration' in 1978, with its focus on primary health care (PHC) and health for all by 2000 set the goal based on equity, community participation and health as a Right. However, by 1996, Bangladesh was far behind the goal as per the set indicators. To address those shortfalls, the then Government of Bangladesh envisaged establishing Community Clinics (CCs), one-stop health centres, for every 6,000 people across the country. The CCs aimed to meet community health needs such as family planning, nutrition services, childcare, overall antenatal and postnatal care, free medicine and referral under one roof and within a half-hour walking distance from their homes, even in remote areas. CCs are situated at the ward (smallest local government administrative unit in Bangladesh) level under the Union Parishad (lowest tier of local government). The CCs are managed by Community Groups (CGs) and Community Support Groups (CSGs), with representation from local communities and Local Government Institutions (LGIs). Bangladesh has 14,000 Community Clinics¹ across the country.

Key Findings from the World Bank Assessment

- Approximately **31 per cent** CCs had limited services as per SDG standards.
- **14 per cent** CCs did not have any facility for handwashing.
- **~19 per cent** CCs did not have any functional water, sanitation or handwashing facility.
- **~64.8 per cent** of CCs had inadequate or dysfunctional water supply.
- **99 per cent** of the CCs had at least one latrine, yet 28 per cent of these lacked functional latrines.

A recent World Bank assessment² of CCs in Bangladesh highlights the dysfunctionality of WASH facilities as a widespread problem across the country. The paper also identifies priority areas for action when considering the prevalence of poverty and chronic

¹ World Health Organization Community clinics in Bangladesh: Bringing health care to the doorsteps of rural people. WHO South-East Asia, available at: <http://www.searo.who.int/mediacentre/events/community-clinics-bangladesh-story/en/>

² Joseph, George; Alam, Bushra Binte; Shrestha, Anne; Islam, Khairul; Lahiri, Santanu; Ayling, Sophie Charlotte Emi. (2019) An Assessment of Water, Sanitation and Hygiene Access in Bangladesh's Community Health Clinics (English). Policy Research working paper; no. WPS 8924. Washington, D.C. : World Bank Group, available at: <http://documents.worldbank.org/curated/en/540641561662684672/An-Assessment-of-Water-Sanitation-and-Hygiene-Access-in-Bangladeshs-Community-Health-Clinics>

undernutrition at the 'upazilla' level. Poor WASH has implications on long-term poverty reduction and overall human development. The poor, usually the bottom 40% (B40) of the income distribution, are the ones who use CCs as their first line of health care. They also carry the added burden of disease and inadequate nutrition. Together, in the short term, this puts pressure on resources of the poor and in the long term, has the potential to compromise their capabilities that push them back into the cycle of poverty. Most often, this is manifested in chronic undernutrition.

There is growing evidence that inadequate WASH adds to the disease causal pathway of stunting through increased burden of diarrhoeal diseases and environmental enteric dysfunction (EED). Since about 35 per cent of all children under five in Bangladesh are stunted, it is important to prioritise WASH in community clinics when we consider the far-reaching impacts it can have on human development.³

The potential of CCs to improve the health of the local community (especially the poor, children, girls, women and the elderly) is marred by limited participation of CG and CSG members, poor quality WASH facilities, improper maintenance of existing facilities, inadequate capacity of LGIs, lack of knowledge on management, and demotivation of service providers.

System Strengthening and Enhancing Accountability for WASH in Community Clinics

Community Clinics (CCs) are a unique Public-Private Partnership initiative in Bangladesh, where the community provides the land, the government constructs the infrastructure, provides medicines and operational costs, and the local community manages it. An interface of community ownership and supervision is inbuilt along with the role of the state to provide the infrastructure and support in running the PHC at the local level. But often, CGs and CSGs at the local level are not very organised or even adequately informed. At times, the infrastructure is at a very dismal level, in that it neither inspires the community to seek services and neither do the service providers, especially the health care workers, provide health care in such dismal premises.

In order to fill this gap, WaterAid Bangladesh (WAB) along with local partner SKS facilitated the capacity and skill development of the CGs on one hand and the duty bearers responsible for the CCs on the other hand. The subsequent intervention 'Local Government Institution (LGI)-led WASH in Health' has aimed to strengthen the overall system of primary health care at Gangni upazilla, Meherpur district since September 2017.

Since then, CG and CSG members of CCs in Gangni have been oriented regarding their roles, responsibilities, basic financial management, reporting, organisation of monthly meetings and ensuring follow ups for managing the community clinic. This has

³ Joseph, George; Alam, Bushra Binte; Shrestha, Anne; Islam, Khairul; Lahiri, Santanu; Ayling, Sophie Charlotte Emi. (2019) An Assessment of Water, Sanitation and Hygiene Access in Bangladesh's Community Health Clinics (English). Policy Research working paper; no. WPS 8924. Washington, D.C. : World Bank Group, available at: <http://documents.worldbank.org/curated/en/540641561662684672/An-Assessment-of-Water-Sanitation-and-Hygiene-Access-in-Bangladeshs-Community-Health-Clinics>

resulted in motivating and empowering the CGs to start monitoring the work schedule, service quality, medicine disbursement, patient flow, infrastructural and repair issues, monthly meetings, and community participation.

Communities at large have also been oriented on health, hygiene, and water security issues as safe water is one of the conditions necessary for health. Specific training was provided through community volunteers and WASH promoters on water safety plan (WSP), safe sanitation and hygiene practices, including menstrual hygiene management (MHM). These sessions at the village level have enhanced people's knowledge about the linkages of WASH with health and also the necessary behavioural change required for personal hygiene.

The Citizen Charter, which has been mandated by the Bangladesh government for public services, to ensure transparency and accountability at the required institutional settings, was reinforced at the CC level. The Citizen Charter has been displayed on walls to showcase the available services, processes, and patient's rights, along with the phone numbers of the service providers. To enhance transparency and trust in the system, a chart displays the list of available medicines and stocks and also the cost for toilet and WASH renovations by a WaterAid supported project.

The Union Parishad (UP) is the key government agency for influencing change, as it has relative autonomy over its annual development budget. For this reason, WaterAid Bangladesh (WAB) has been working at the union level as opposed to lower (ward) or higher (upazilla) administrative levels. As the Local Government Institutions

Water and sanitation infrastructure provide a healthy start to a new life

By mid-2019, 21 out of 35 CCs were renovated with running water, handwashing stations, separate gender-sensitive toilets, and toilets for persons with disability. In CCs of the first level design from 1998 with one toilet, WaterAid Bangladesh (WAB) supported the building of a new one that can be accessed by persons with disability. For the water supply, WAB has supported building of overhead water tanks, provided electric motors to pump water and ensure running water supply. WAB also supported building of handwashing stations near the toilets and one specifically in the family welfare visitor (FWV) room. Ministry of Health (MoH) has furnished this room with a delivery couch for normal vaginal deliveries, which are safely possible only when there is good WASH support and Skilled Birth Attendants (SBAs) are present.

Both LGI and CG representatives have mobilised contributory funds (20–30%) for renovation and other facility-level improvements (e.g. boundary wall, garden or main gate); and allocated funds for operation and maintenance (O&M) costs for future maintenance of facilities.

(LGIs) have a role in ensuring the working of the community clinics as well as in allocating resources, the capacity of the local government has been also enhanced

by engaging them in various training sessions. They were trained through needs assessment, planning and implementation, financial coordination of the project fund, generation of matching fund (10–20%) for operation and maintenance (O&M) mainly from the communities, overall monitoring and reporting processes, project human resource management, advocating for additional funds, and coordination with other local bodies of health, education, family planning, press, women’s organisations, etc.

The Union Parishads have not only led the repair and construction works in the CCs, but they have also driven the reactivation of the community groups (CGs) that manage each of the clinics. The Union Parishad has refreshed their roles and responsibilities as duty bearers in community level health services. The CGs, which are headed by the Union Councillor, are all being governed by the same method. CGs are a 17-member group made up of the Councillor as President, the landowner (the person who donated the land for the clinic), the staff, and representatives from the local community. A separate Community Support Group (CSG) also exists for each clinic. From the outset, the committees were required to raise a contribution for general improvements

and the O&M fund. The committees are also responsible for clinic time keeping, ensuring the presence of the staff, paying the cleaners, the electricity bills and accessory expenses.

Following these interventions, the average flow of patients to the CCs has increased by 30 per cent. The government has committed to supplying adequate quantities of medicines to meet people’s demands from the Upazilla Health Complexes through the Central Directorate. Most importantly, the service provider and the community health care provider (CHCP) at the CC are now more enthusiastic to provide better health care services to recipients. They are also more likely to stay in CCs for their entire workday unlike earlier. Almost all CHCPs have now completed their basic training organised by the Ministry of Health (MoH), which has made them more confident. The availability of primary support like WASH within the CC premises has also boosted their work and performance. Earlier, they were compelled to leave the clinic if they needed to drink water or visit the toilet, which interrupted or caused closure of CC services. Patients are also more satisfied using these toilet facilities. LGIs have played a vital role by being the watchdogs as well as the gatekeepers for the community.

FIGURE 1: Roles and responsibilities



How Change Happens

Saharbati is a village in Bangladesh's Meherpur district. Nahida Akter, a Community Health Care Provider (CHCP), organised sessions to educate and create awareness in the community on the water safety plan, handwashing at five critical times, and training in menstrual hygiene management (MHM) for women and adolescent girls to bring about behavioural change in maintaining personal hygiene. SKS also activated and trained CG and CSG members. As CHCP, Nahida Akter received WASH Promotion training within the project, which enabled her to counsel patients on healthy hygiene practices. WASH information has enabled the community to

avail health care services at the CC and also participate meaningfully in discussions with LGI bodies in pre-budget sessions and with health care providers for ensuring services or increasing their demands for medicine.

Active citizenship of the people has increased accountability of the CCs. Additionally, WASH infrastructure was strengthened. This resulted in renovation of the building, improved sanitation facilities, installation of handwashing stations, safe running water points, ramp for persons with disability, and construction of a waiting area at the CC.

Nahida Akter states that the daily patient flow has doubled—from an average of 25/30 to 55/60—because of better facilities such as the waiting area, water and sanitation options, and better health care. *"Previously I worked for a few hours irregularly. Now I work for the full day, but I am satisfied to serve them. The newly added facilities and environment at the CC has enhanced my dignity in the community which is more encouraging for me than any other personal benefit,"* said Nahida.

Md. Golam Faruque, Chairman of the Saharbati UP, states that engaging with this project has demonstrated how the Union Parishad can implement pro-people interventions. Saharbati UP has implemented 4 CCs in its constituency. *"Initially I didn't take this activity seriously, but SKS helped me understand it. It was a really good learning*

experience for all UP Chairmen when we visited SKS's development intervention in the WASH sector in northern Bangladesh. When we returned, our UP signed a Memorandum of Understanding (MoU) with the project for renovation of CCs and committed its support. Gradually, the UP body also received training on financial management and project management, which has built our capacity to undertake similar interventions. After SKS transferred funds to the UP for renovations, our effective management of the funds increased our transparency and institutional capability. This is the first time that UPs, local community groups such as CGs and CSGs, local people and NGOs have implemented activities which are planned, designed and conducted together by ensuring good quality with highest integrity in a timely manner," Mr Faruque added.

Encouraged by the approach and consequent improvements, Saharbati UP has contributed to the operations and maintenance (O&M) fund and towards construction and repair of the boundary walls, gate, and connecting roads. They have also allocated funds for distribution of sanitary pads among school girls for MHM. Mr Faruque also said that involvement with the intervention has not only increased their image in the community but has cemented their commitment to continue this support from the UP's annual development plan involving local institutions.

Conclusion

The key learnings from strengthening the Community Clinics are:

1. Coordination and contribution of all relevant stakeholders helped in strengthening accountability and ownership of key actors and built confidence among them, which was imperative for making this difference. Capacity building at both ends; strengthening communities as well as duty bearers; helped in overall coordination.
2. This pilot project has created evidence that this system has worked to adopt and improve WASH facilities and thus can be applied to other components and further improvement interventions; i.e., immunisation, maternal and child health (MCH), or diarrhoeal disease control for which WAB has been consulting with the MoH.
3. Making information available in the public domain, transparency regarding expenditures and medicine stocks helps in checking corruption, building trust, and making communities contribute from their end and be responsible for operations and management.



Citizen Report Card

Enabled Community Voices Inform the Swachh Bharat Mission in Chhattisgarh

Introduction

India has a rich history of sanitation movements starting with the Central Rural Sanitation Programme in 1986, moving to the Total Sanitation Campaign (1999–2012), the Nirmal Bharat Abhiyan (2012–2014), and to the current Swachh Bharat Mission (SBM) (2014–2019). Prior to SBM, sanitation programmes built several million toilets, yet faced significant issues related to the quality of toilet construction and regular usage, consistent financing and capacity for large-scale implementation. With SBM, India saw significant investments in sanitation, in terms of political will and drive, financial resources, trained and motivated human resources, and technical support. Consequently, over 11 crore (110 million) toilets have been constructed between October 2014 and September 2019, providing nearly 60 crore (600 million) Indians with access to toilets in their homes.

SBM's unparalleled success in rural India is not without issues. From the initial phases of SBM, concerns related to reaching the last mile, appropriateness of toilet infrastructure, availability of water, usage of toilets by all at all times, toilet repairs (retrofitting), and faecal sludge management have emerged as important to address to confer the long-term benefits of sanitation. These concerns highlight the role of people's participation or citizen's feedback to monitor progress

and provide real time feedback to improve implementation and strengthen sanitation policy.

Community feedback is an important mechanism for tracking the impact of various government programmes. Such feedback highlights gaps in implementation and can suggest ways for improvement. Citizen Report Cards (CRCs) work by generating feedback from the community on processes and implementation of government schemes or initiatives—in terms of awareness of schemes, access to and usage of schemes, use of technologies, and user satisfaction. The process further elicits key constraints faced by the community in availing government services. Finally, the CRC tool engages the community to recommend ways in which government policies, strategies, and programmes can be strengthened to address constraints and improve service delivery. The CRC tool further helps in collating and sharing this feedback with decision makers, thus serving to inform course correction or changes in the programme and to address critical gaps.

In Chhattisgarh, India, the Citizen's WASH Forum, an informal conglomeration of individuals, civil society organisations, and experts have used the CRC to facilitate a positive and productive discourse to improve the accountability of duty bearers for drinking

water and sanitation. The Citizen WASH Forum comprises of community members, community leaders and NGO representatives from 13 districts. This was started as a subset of the Janshakti Sangathan (JS), which was established in 2006 as a people’s collective for the Forest Rights movement in Chhattisgarh. The Citizen’s WASH forum was initiated in 2014 in Rajnandgaon as a WaterAid India community-based sanitation intervention, and now operates on a larger scale at the State level.

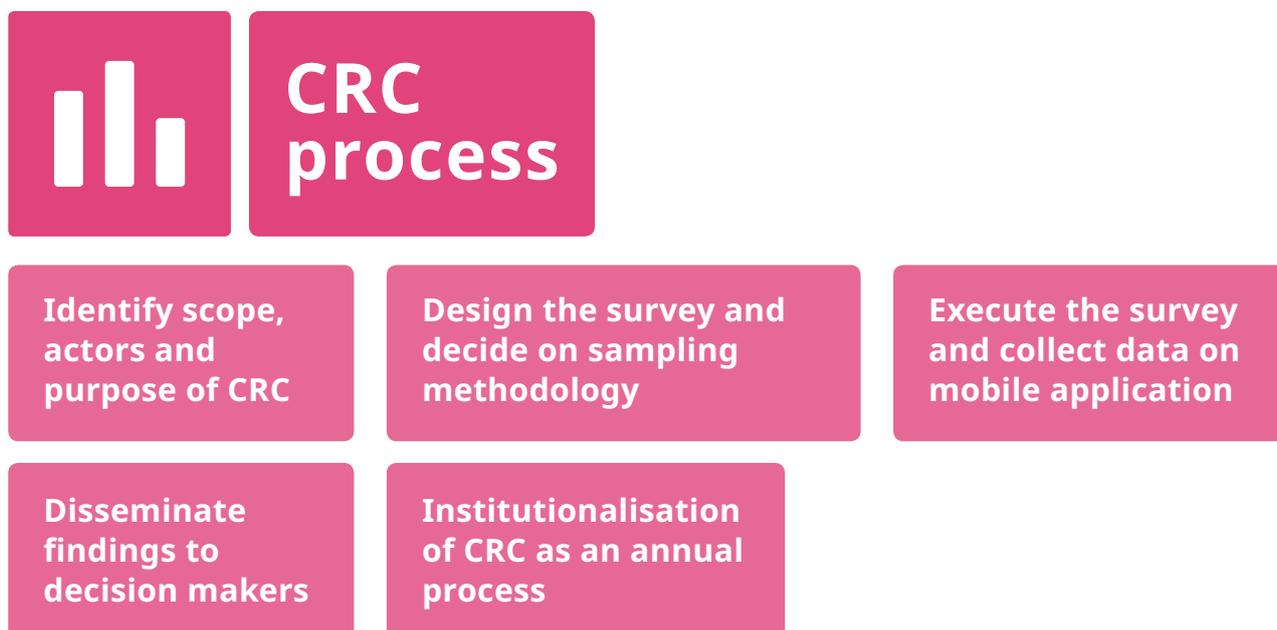
Implementation of the Community Scorecard Approach

The Chhattisgarh Citizen’s WASH Forum manages and drives the CRC process, as depicted in Figure 1 below.

Since 2015 (a year after SBM was launched), the Citizen’s WASH Forum has taken a nuanced and real-time approach to identifying focus areas and developing simple yet comprehensive questionnaires to delve into the issues. This has led to them recognising

various issues affecting the community through the different phases of SBM. For instance, in 2015, the Citizen’s Forum identified SBM’s Information Education Communication (IEC) Strategy, functionality of toilets, usage, and the application process to get government support for toilet construction as critical issues to elicit community feedback. In 2016, the report card added a more nuanced focus on the quality of construction, appropriateness of the toilet infrastructure, factors that determine preference for a particular toilet technology, and the open defecation free (ODF) verification process. By 2017, some districts of Chhattisgarh had achieved their targets, and the report card turned its attention to addressing the ODF verification process in three districts. The last CRC in 2018 zeroed in on ODF sustainability as the main issue and examined community monitoring systems, toilet functionality, inclusion of marginalised groups for coverage, and solid and liquid waste management efforts. The Citizen’s WASH Forum facilitated data collection through a mobile application

FIGURE 1: The CRC Process



that enabled faster and more reliable data collection, entry, and analysis. This, in turn, ensured that the Citizen's WASH Forum shared the findings with decision makers and other stakeholders in a timely manner, is based on an evidence and feedback process at the community level, and influenced course correction measures.

In addition to the government, the CRC findings were shared with the media, who in turn highlighted the glaring gaps in newspaper articles, spurring the government into action. Table 1 below outlines the various focus areas of the CRC in Chhattisgarh from 2015–2018, as well as the key findings shared with stakeholders, including the Government of Chhattisgarh, and the media.

TABLE 1: Areas of inquiry and findings from CRCs (2015 - 2018)

Year	CRC focus area	Key findings disseminated to decision makers
2015	<ul style="list-style-type: none"> • SBM's Information, Education, Communication (IEC) Strategy (main sources of information on SBM). • Status of toilets – functionality and usage. • Application process for government support in toilet construction. • Perceptions of the importance of toilets. • Preference for toilet technologies. • Arrangements for construction of toilets including masons, material. • Household's satisfaction with toilets. 	<ul style="list-style-type: none"> • The main source of information on SBM and the related incentives for construction of toilets for households was the local government (Gram Panchayat members and officials). • Communities faced impediments in constructing toilets, mainly delays in getting incentives. More than half of the households surveyed stopped construction because of delays in receiving the incentive amount. • A majority of the households were not aware of the existence of Grameen Swachhta Marts, where they could purchase the raw materials needed for toilet construction. • Satisfaction with provision of toilets was generally high, except when incentives were not received in a timely manner, and the quality and design of toilet construction was poor.
2016	<ul style="list-style-type: none"> • Shift in IEC priority to a focus on twin leach pit toilets. • Quality of toilet construction. • Appropriateness and preference for toilet model. • Use of newly constructed toilets. • ODF verification process. 	<ul style="list-style-type: none"> • Awareness creation on toilet technology was weak; only two out of five toilets were twin leach pit toilets. • About 6% of newly constructed toilets were not in use in ODF declared Gram Panchayats; about 7% people in ODF villages were practicing open defecation. • One out of five (about 18%) toilets did not have doors, alluding to poor super structures. • More toilets were constructed by the local government (Gram Panchayats); with a consequent reduction in the percentage of toilets constructed by families themselves. • Local government representatives from many ODF Gram Panchayats shared that they were comfortable in mobilising people for toilet construction work. However, promoting and ensuring 100% use was challenging. • People's satisfaction with the local government's cooperation for toilet construction had reduced from the previous year.

<p>2017</p>	<p>Independent ODF verification in three districts.</p>	<ul style="list-style-type: none"> • Gram Panchayats were declared ODF without ensuring 100% toilet coverage. • Surveys revealed huge variations amongst districts in terms of toilet usage. In Korba, only 53% of toilets were found to be used. Durg and Kanker showed higher rates of usage at 91% and 99% respectively. This reflected gaps in the sanitation drive where focus seemed mainly on toilet coverage in Korba and not on supporting usage. • Safe disposal of child faeces was an issue with wide variation in the proportion of families in all three ODF districts discarding child faeces in the open (49% in Korba, 17% in Durg, and 2% in Kanker). • Surveys also provided insights into the prevalence of appropriate toilet technology in communities. For instance, Durg had a high prevalence of septic tanks (30%) and single leach pit toilets (40%).
<p>2018</p>	<p>ODF sustainability:</p> <ul style="list-style-type: none"> • Community monitoring system. • Functionality of toilets. • Inclusion of marginalised groups in toilet construction drive. • Status of functionality of toilets in institutions (schools, health care facilities, anganwadis). • Solid liquid waste management efforts. 	<ul style="list-style-type: none"> • Few families (less than 1%) were still without toilets and over 5% of toilets constructed under SBM were defunct. • Little attention was paid to constructing toilets accessible to persons with disabilities. • Only 23% households had access to water storage near the toilet, potentially affecting usage. • About 18% anganwadis (nutrition and early childcare centres) had defunct toilets. None of the anganwadis had handwashing facilities for children. • About 35% of schools had separate toilets for children with special needs, but none were functional during the survey. • None of the surveyed districts had resource recovery centres (for household waste) and door-to-door waste collection services in rural areas.

Impact of CRC

The CRCs in Chhattisgarh have catalysed government action on sanitation, particularly in addressing gaps and taking course correction measures in a timely manner. Notable achievements of CRCs that have implications for scale and sustainability are as follows:

1. State Swachh Bharat Mission-Gramin (SBM-G) turned their attention to the quality of toilet construction (and not just toilet coverage), building the capacities of masons, engineers and SBM-G teams across districts. They also sought technical support from development partners (e.g., WaterAid

India) to ensure that quality trainings were conducted and appropriate technologies were implemented in the field.

2. Disbursement of incentive was streamlined, ensuring that families received incentives on time to complete toilet construction.
3. Volunteers were engaged and trained to enable community-monitoring systems to provide regular feedback to the local government, and to support and sustain government programmes.
4. State Swachh Bharat Mission-Gramin developed guidelines for solid and liquid waste management.

5. State Swachh Bharat Mission-Gramin also initiated a pilot intervention on 'inclusion' in sanitation, with a focus on toilets for persons with disability at the household and community level. They have now included accessible community toilets for transgender persons.

Conclusion – Considerations for Initiating and Sustaining Effective CRC Processes

- CRCs are successful in contexts where policy makers and service agencies are open to civil society/citizen engagement and advocacy for bringing reforms. Chhattisgarh has a history of citizen engagement (e.g., for health), and this may have provided the space for such action on sanitation.
- Conducting large scale surveys are resource (human and financial) intensive. Sustainability of CRCs may require alternative, low-cost ways to conduct such inquires.
- The public (i.e., the community) needs to be regularly informed and cautioned against expecting too much too soon from the CRC process, as it can lead to citizen disillusionment if there is no improvement in the quality of services.
- For CRCs to be effective, meetings between citizens and public officials must remain constructive and focussed, and not serve as a forum for political agendas.
- CRCs require sustained and constructive follow-up to circumvent any institutional resistance or lack of political will among public service authorities to act on the findings.





WaterAid/ Dhiraj Singh

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October 2019

Report compiled by Vanita Suneja (WaterAid) and Arundati Muralidharan (WaterAid India)

Wateraid India Country Office

2nd floor, RK Khanna Tennis Stadium, 1, Africa Avenue,
Safdarjung Enclave, New Delhi 110029

Tel +91 11 6612 4400

Email waindia@wateraid.org



WWW.WATERAIDINDIA.IN