Sanitation, Water and Hygiene:
Strengthening Community-Centred and Gender Responsive Provisioning

INSTITUTE FOR
HUMAN DEVELOPMENT

Institute for Human Development (IHD)
New Delhi

Prepared by :
Institute for Human Development (IHD)
Plot No. 84, F.I.E. Patparganj, Delhi -110092
Email: mail@ihdindia.org, Website: http//www.ihdindia.org

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End-term evaluation by
Preet Rustagi, Sunil Kumar Mishra,
Deeksha Tayal, Nandini Mukherjee, Preeti Singh

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www.ihdindia.org

IHD CORE RESEARCH TEAM

Preet Rustagi, Sunil Kumar Mishra, Deeksha Tayal,
Nandini Mukherjee, Preeti Singh

Overall Field Supervision

Mr. Vikas Dubey and Mr. Aidan Singh

Field Supervisors
Mr. Radheshyam Saini, Ms. Aditi Krishna,
Mr. Jaswant Rao and Ms. Anisha Yadav

Data Processing
Mr. Vikas Dubey

List of Investigators

Delhi Team	**Kolkata Team**	**Jaipur Team**
Vikas Dubey	Nandini Mukherjee	Aidan Singh
Pooja Yadav	Rohan Roy	Radheshyam Saini
Ruchika Yadav	Arup Bose	Akanksha Sharma
Veena	Avik Porel	Ayushi Sharma
Neetu Wasan	Maukh Dey	Manju Soni
Manju Priyadarshi	Sayan Das	
Chanchal	Anteek Hazra	
Pardeep Sagrwal	Smita Sinha	
Upasna Kumari	Sneha Sarker	
Aditi Gururani	Sohini Biswas	
BD Bhaskar	Purbani Roy	
Jaswant Rao	Sayana Basu	
Anisha Yadav	Paban Sil	
Abhishek Malhotra	Piyali Roy	

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IHD Research Team

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Executive Summary

Sanitation, Water and Hygiene: Strengthening Community-centred and Gender Responsive Provisioning

Preet Rustagi, Sunil Kumar Mishra, Deeksha Tayal, Nandini Mukherjee, Preeti Singh

This is an end-term evaluation report of the intervention by CFAR, supported by the Bill and Melinda Gates Foundation (BMGF), to identify and address the gaps in awareness relating to sanitation, water and hygiene. The basic intervention was the introduction of sustained sanitation and hygiene behaviors among women by establishing their linkage with health. The intervention was implemented through the formation of forums or groups in the poorest clusters of the three cities of Delhi, Jaipur and Kolkata. While most of the forums had women as members, in a few clusters, male forums, adolescent girls' forums and boys' forums were also formed. Eventually, the programme aimed at empowering vulnerable and poor women to enforce their hygiene and sanitation rights independently or through a group approach. The objective of this report is to evaluate the programme following the Organization for Economic Cooperation and Development (OECD) framework, i.e. relevance, effectiveness, efficiency, sustainability, impact and partnership aspects of the programme.

The evaluation used a mixed method approach that included both qualitative and quantitative methods. Besides this, a detailed primary survey, including a quantitative survey of selected households and a qualitative study, was done in the three cities. The different catalysts interviewed included government personnel, political personnel, social workers, community members (members of women's groups as well as non-members, members and non-members of youth groups, men's group members, community leaders in the clusters) and CFAR members. The study also captured the facility, management and problems relating to community toilet and water sources. The total number of households surveyed in Delhi, Jaipur and Kolkata were 1321, 300 and 608 respectively.

This report is presented in three parts. The first part consists of the introduction, objectives and methodology, including a brief socio-economic profile of the locations in the three cities. The second part provides the findings of the evaluation in different domains such as sanitation, garbage disposal and drainage, water related issues, women's sanitary practices and hygiene; the role of institutions and the partnerships employed as strategy during the intervention; and the changes over time from the baseline to the end term based on the perceptions of the women respondents. The third and last section examines the key findings in terms of achievements, failures and challenges, notes the lessons learnt and discusses the way forward.

End-term Evaluation Findings

The achievements of this intervention programme are visible in the manner in which issues pertaining to water, sanitation and hygiene (WSH) have become central to the lives of the women of the community. They are recognizing these needs, raising their articulate voices where needed, seeking the help of CFAR members or local leaders and actively working towards ensuring that their rights are met. In terms of seeking to contextualize WSH concerns, the CFAR programme has been very successful in demonstrating their relevance and also ensuring participatory involvement of women so that they can exercise their agency in articulating their needs.

Urban poor locations were inhabited largely by Scheduled Castes (more than 50 percent) in Delhi and Jaipur, and by Muslims in Kolkata (80 percent). Nearly one-half of the households were reportedly

below the poverty line. The highest education level among women - graduation and above - in the surveyed households was expectedly low, reported in only seven percent of the households while it was 10 percent for men. Most of the households owned the house they lived in, with only 13% living in rented houses. There were very few kutcha houses; almost 50 percent were pucca and 45 percent were semi pucca.

Improvements have been noted among the households in locations where CFAR has intervened. There are signs of increasing participation by women, and reduction in instances of violence, with women's groups addressing the domestic violence faced in the community. In terms of overall cleanliness and removal of garbage, there has been significant behaviour change among the women: the communities are either doing it themselves, or sharing the tasks amongst themselves by dividing responsibilities. The Delhi Urban Shelter Improvement Board (DUSIB) and other local authorities have taken note of this and are strategizing to involve CFAR in their new venture of Adarsh Bastis (Model Slums). There is increasing recognition that an engineering approach to the problems facing slums in cities cannot solve these issues satisfactorily. Given the fact that the facilities can deteriorate in no time if the communities do not take ownership and feel responsible for them, government officials are attempting to initiate effective and mutually useful collaborations, leading to new partnerships and synergies between government and non-government organizations.

Women and adolescent girls are speaking out on issues such as sexual harassment, violence and discrimination

The CFAR intervention was not only successful in generating awareness regarding the various government programmes, but also with regard to the rights of inhabitants. At the end term, women were aware of the Ladli scheme and Swachh Bharat Abhiyan (SBA Clean India Mission) and were participating in the parent-teacher meetings in their children's schools. More children have been attending school than before the intervention, and some are even going for private tuitions which their parents have invested in.

Another major shift is the increasing confidence of the community that they can address minor issues, such as failure of taps or garbage in the lanes, either individually or collectively. Children within these clusters have begun rebuking persons who throw garbage on the streets rather than at designated places.

With increasing confidence, women and adolescent girls are speaking out on hitherto unspoken or little spoken issues such as; sexual harassment, violence, discrimination and exploitation and menstrual hygiene management. Some of the active members among adolescents are addressing issues of sexual harassment being faced by their friends in their schools, by accompanying them and speaking to the miscreant boys. In one area, the girls even went to meet and complain to a senior official of the National Urban Health Mission (NUHM) regarding subsidized sanitary pads.

On sanitation

The intervention has created an awareness of the problems associated with open defecation and the need for toilet facilities. While less than one-third of all women assigned high priority to the need for

toilet facilities in the baseline survey, by end term more than two-thirds of the women gave high priority to sanitation. These include women who were not members of women's groups.

Several households have now constructed makeshift personal toilets wherever feasible. The toilets are mainly for privacy and security, and are often not connected to any sewerage lines. The lack of space and resources, as well as tenure security, also pose challenges.

In Delhi, DUSIB has been working towards improving public toilets for all those who don't have personal toilets. The women have been making efforts to address their concerns and problems within the community.

The intervention in Rajasthan included the introduction of two-pit dry latrines, which require less water and are easy to manage; has been well received by the community. Exposure to this technology and technical and financial support has helped households with adequate space to build personal toilets in Jaipur. This initiative has been successfully linked to SBA at the state level. It is a replicable model which must be tried out in other areas as well.

On garbage disposal, drainage and street cleaning

Communities are demanding that drains be constructed in their clusters

The urban poor clusters, especially the slums face several difficulties with respect to government provisioning of services. Even where it is the duty of the urban municipality to collect garbage from all localities, the high density and extremely narrow lanes within most slums thwart access. Municipal workers often face social bias, which compounds the problems they face.

Interestingly, while the intervention catalyzed the demand from local communities for such services, it simultaneously encouraged the members to make a beginning by doing it themselves, so that their immediate surroundings remain clean. Consciousness regarding garbage disposal and efforts to keep drains clean were visible in almost all the surveyed areas. Women and adolescents, as revealed from the focus group discussions (FGDs) in the three cities, used different methods to help generate this feeling among the residents within the community.

For instance, when the demand for installing garbage bins was ignored, some women's groups invested in purchasing a large bin for disposing their garbage. Apart from this, the women were also becoming stronger as a collective and were raising issues concerning cleanliness of drains, regular garbage collection and cleaning of streets with the authorities.

On water and related issues

The end-term evaluation survey reveals a growing realization of the need for clean water, appropriate storage, cleaning of containers and using correct methods to prevent contamination. The community now recognizes the health problems that can occur due to use of unclean water. While the circumstances under which the households live often make it difficult to follow the right practice of water use, overall there was a clear improvement in awareness and practice.

Across the three cities, the women members as well as other women made efforts to address the problems in their localities, often with the help of CFAR. They reached out to the authorities whenever water supply was discontinued or any other water-related problems such as contaminated water supply, or inadequate supply occurred. They also sent in requests for water tankers whenever needed. There were more written complaints from Delhi and Kolkata, although Jaipur recorded more oral complaints.

On personal hygiene

A lot more women and girls in the end-term survey reported use of sanitary napkins during menstruation with knowledge regarding their use, disposal and personal hygiene. The easing of socio-religious taboos associated with menstruation has been witnessed in the course of this intervention. The training sessions and open conversations have enabled women, especially adolescent girls, to talk openly about their problems, ask questions and discuss topics relating to personal hygiene, menstruation and similar issues, which were earlier not spoken about in public. Those who still resort to the use of cloth during menstruation, due to economic considerations, are also by and large trying to follow the instructions provided by CFAR members. Fewer women resort to reuse of cloth and if they do, they are aware of the fact that the cloth must be properly washed and dried in the sun before reuse.

The availability of sanitary napkins from various sources at subsidized rates including schools, Integrated Child Development Scheme (ICDS) centres, Gender Resource Centres and so on has proved to be a great support for the women of poor households. When this was discontinued towards the latter period of the intervention, a non-government organization (NGO) entered into a partnership with the project and taught the women to make their own cheaper sanitary pads. This experiment was positive and may help women to move from using cloth to using homemade napkins. As the women and girls are now more articulate and speak up on matters they were earlier shy to broach, health camps can now address issues of personal hygiene and reproduction in a better manner.

On partnership

Some very useful partnerships across the three cities have been an integral part of the intervention. Since CFAR has been working in some of these areas over a long period, they could leverage the leadership and their rapport with local women and community members. Often the different state governments and their various departments used CFAR's help in finding solutions to problems arising within their programmes. For example, in Jaipur, the government officials requested CFAR to help in identifying the beneficiaries for their programmes and also sought their help in convincing the community members to register themselves for schemes and entitlements.

Community leaders interacting with officials

The project also entered into partnerships with Mission Convergence, Gender Resource Centres and other bodies in Delhi; the Ministry of Urban Development in Jaipur and the ICDS in Kolkata. Some newer associations and partnerships are being sought, with the latest achievement being the signing of the Memorandum of Understanding (MoU) with DUSIB in Delhi.

In the course of the intervention programme, CFAR has been able to build capacities and create some efficient community leaders from the localities as well as among themselves; these leaders are now able to interact with officials and political representatives, usually members of the Legislative Assembly (MLAs) whenever any problem arises. The intervention strategy was to enable women to stand on their own and ensure rights and service delivery from different authorities. In many areas it appears that the initial breakthrough has been made; however, continued support will be required from CFAR for some more years before the women are able to independently handle their lives and demands. In that sense, it may be stated that although the programme intervention appears to be sustainable in certain respects, efforts are required in certain others.

Challenges

The reception and acceptance of CFAR members elicited a differential response from people. The experiment to get male members and form groups was not very successful since time was a major constraint and competed with their livelihood pursuits. One of the main reasons why CFAR's interventions could not succeed or even get established in a few locations in Jaipur was due to the migratory nature of the population.

The biggest challenge to the intervention and its success stems from the insecurity of tenure and perpetual fear of relocation or removal of their clusters. This automatically translates into non-involvement, disinterest and demotivation. The sustainability of the programme becomes a challenge since there is constant fear of eviction or displacement. Rumors abound in some clusters and this impacts the intervention and its outcomes. Efforts to contain or dispel that fear were inadequate and often not possible for CFAR members, reducing the effectiveness of the intervention.

The mid-term evaluation report observed that problems stemmed from the fact that particular parts of the clusters were covered while the rest of the community felt alienated. For instance, activities such as mobilization, organization of Jan Sabhas (community meetings), and so on generally tended to occur where the members were active. CFAR therefore paid special attention to address the issues of these uninvolved groups of households. The members of CFAR forums now make conscious efforts to go to other segments within their clusters to mobilize and involve the households there; they even hold some of their activities in these areas. The displeasure, suspicions and doubts harbored among the uninvolved households are now being cleared.

There is also the challenge of going deeper within the same clusters rather than expanding to other clusters, to consolidate the successes rather than spreading thin and losing out on the advantages.

Yet another challenge has been the relocation, changes and short fall among CFAR staff. Because of which the visits and activities required by the strategy could not be carried out in all locations during certain periods.

In terms of effective partnerships, the competition amongst NGOs for the limited resources available for similar programmes can sometimes come in the way of successful collaborations. The effort to do better and get noticed by donors was also noted as a factor that affected partnerships at times.

Recommendations/Way forward

Based on the end-term evaluation, we make the following recommendations:

- While the strategy to use a mix of methods and inputs for the implementation of this intervention has proven to be effective, more rigorous and continuous efforts are perhaps needed in all the areas for it to be successful and to transform to the level where it can be viewed as sustainable.

- There is need to have appropriate support from the government and its programmes for leveraging the intervention efforts effectively. For instance, the early phase of this intervention dovetailed with the Mission Convergence in Delhi and used the Gender Resource Centre platforms. The situation has now changed and the Swachh Bharat Mission which is now a major support can boost any intervention of this kind. There is also the need to enter into closer partnerships with the governments as well as with other NGOS. The efforts by NGOs to partner with the government were often thwarted since the need was not felt. But as governments began to feel the need for involvement by NGOs, the pathways for partnerships opened up. These need to be built upon.
- A national collective consisting of different bodies that can come together with their strengths and weaknesses needs to be formed to build their strong points while helping out in such interventions.
- Given the situation of urban poor localities, there is need to move towards ending open defecation and ensuring toilets for all under the SBA.
- The associated concerns require renewed focus on sanitation, water and hygiene in order to improve the lives of urban poor women and girls.

End-term evaluation Report

Sanitation, Water and Hygiene: Strengthening Community-centred and Gender Responsive Provisioning

Preet Rustagi, Sunil Kumar Mishra, Deeksha Tayal, Nandini Mukherjee, Preeti Singh

1. INTRODUCTION

Sanitation, Water, and Hygiene: Strengthening Community-Centred and Gender Responsive Provisioning is the end-term evaluation report of an awareness building intervention by the Centre for Advocacy and Research (CFAR) for the Bill and Melinda Gates Foundation (BMGF). The eventual goal of the programme being to empower vulnerable poor women to claim their hygiene and sanitation rights independently by themselves or through a group approach. As a first step, the initiatives and interventions have primarily been geared towards identifying gaps in awareness relating to sanitation, water and hygiene and reducing them.

CFAR implemented the three-year programme to facilitate women in deprived urban regions (slums and unauthorized areas) in Delhi, Jaipur and Kolkata to access, actualize and sustain the provision of sanitation, hygiene and health services by the concerned authorities. The basic approach the CFAR adopted was the introduction of sustained sanitation and hygiene behaviour among poor women by forming forums or groups in the poorest clusters. The forums mainly consist of women members but in some clusters men and adolescent boys have also formed such forums. The programme highlighted the linkages between health, hygiene and sanitation behaviour. It also aimed at enhancing budgetary support for sanitation services.

Provision of public facilities like adequate sanitation services, water supply, and hygiene are not only insufficient in the slum clusters but there exists very little recognition of this scarcity among the community. The urban poor accept their deplorable conditions as they do not expect the State to feel accountable to them. The situation is worse in unauthorized slums where there is minimum community awareness about the ways and means of complaining about this insufficiency. Tasks like water collection, storage and use are mainly the responsibility of the women members of the family so they suffer most due to lack of public facilities.

The end-term evaluation report focuses on the components of behavioral transformation and perception of change with respect to water, health, sanitation, hygiene, sewerage, and garbage disposal. Section 1.1 presents the programme strategy by CFAR, section 1.2 provides the objectives of the end-term evaluation, and the methodology is discussed in section 1.3. Section 1.4 provides a brief socio-economic profile of surveyed areas and section 1.5 discusses the problems with comparisons between baseline and end term findings. Section II focuses on the end term findings in different domains sanitation (2.1), garbage disposal, drainage and street cleaning (2.2), water related issues (2.3), women's sanitary practices and hygiene (2.4); role of institutions and partnerships employed as strategy during the intervention (2.5) and changes over time from baseline to end term based on the perceptions of women respondents (2.6). Section III concludes with highlighting the successes and failures of the intervention, the challenges that need to be addressed and the way forward.

1.1 Programme Strategy by CFAR

The locations where the interventions have occurred are urban poor slum clusters and unauthorized settlements which tend to remain underserved in terms of public provisioning. CFAR's intervention focused on a wide array of issues and concerns that affect the community including those pertaining to

sanitation, water and hygiene. The entry point of the intervention was through multiple mechanisms, such as talking to the women and other community members to understand their problems and priorities. Often, addressing some of the concerns of the community served as an ice breaker and helped in building rapport between the CFAR members and the community. CFAR's efforts were directed towards ensuring gender responsive and community-centered provisioning. Community engagement was facilitated by forming women's groups and having regular meetings, conducting other activities, such as camps, the distribution of IEC (information, education and communication) material, public meetings, and so on, to communicate the core messages on WSH (Water Sanitation Hygiene)

The initiative focused on ensuring gender responsive and community centered provisioning

As the CFAR training module clearly states, the key elements of community engagement are:

- To enable change agents and leaders to translate the information they gather on WSH to strengthen informed demand generation;
- To facilitate exchange to shape and advance norms of partnership with government and various agencies;
- To raise consciousness and awareness on hygiene and sanitation;
- To collaborate with likeminded organizations, networks and related institutions to scale up efforts; and
- To capacitate change agents to spearhead change.

The end-term evaluation revealed that CFAR's first step was always an attempt to understand people and their experiences, comprehend their priority issues and concerns, recognize the efforts being made to address them, and try to build on them.

It is only after gaining the confidence and trust of the community people, that CFAR could begin its intervention to raise consciousness and awareness on WSH. The intervention also sought to Identify change agents or leaders who could strengthen the collective understanding and lead to informed demand generation.

1.2 Objectives of End-term evaluation

This report analyses the findings of the end-term evaluation of the programme by the Institute for Human Development (IHD), New Delhi. The purpose of the evaluation is to find out the impact of the programme over time on the clusters in general and on women in particular by using the OECD framework of relevance, effectiveness, efficiency, sustainability, impact and partnership. The end-term evaluation assesses the achievements, challenges and possible elements of the intervention which are amenable to the sustainability of the programme so that the objective can be achieved. Since IHD had also undertaken the mid-term evaluation for Delhi, the end-term evaluation takes into account the elements of course correction or design modification introduced in the intervention.

The basic objectives of the study are given below:

1. Shift in terms of behaviour change and adoption of safe sanitation practices by the community.
2. Evaluating the increase in the community's collective stake in sanitation over the years.
3. Evaluating the role played by the forums in translating the stake into behaviour change or adoption of new technology.
4. Evaluating the extent of ownership among community members and stakeholders.
5. Evaluating the strength, growth, progress of the various women's' forums and their role in catalyzing and sustaining behaviour change.
6. Evaluating how far the community is empowered for the future.
7. Evaluating the change in the technical competence of the community resource persons in the real sense of the term.
8. Assessing the ability of forums to make decisions, be part of the decision making process, voice their concerns, and advocate on their right to safe sanitation.
9. Evaluating the extent to which sanitation has become integral for people.
10. Assessing the extent of behaviour change that has been consistent.
11. Assessing the impact on the quality of life and aspirations of the people of the community.
12. Evaluating the status of community-government partnership. Is the partnership a response to or supported by some other commitments?
13. Evaluating the extent to which the SBA helped in spreading the awareness of and access to sanitation and hygiene among the community. What is the change before and after SBA in both community response and that of the implementers with special focus on administration and bureaucracy?
14. Exploring future possibilities of action within the community after the programme.

1.3 Evaluation Methodology

Given the purpose and objectives, in addition to the OECD framework, the evaluation also included the partnership model adopted in planning and monitoring the programme.

The evaluation used a mixed method approach that included both qualitative and quantitative methods. A detailed primary survey was conducted in the cities of Kolkata, Jaipur and Delhi. This included a quantitative household survey in selected clusters and a qualitative study to capture the detailed process of the different activities relating to the programme. The different catalysts interviewed included government personnel, political personnel, social workers, community members (members of women's groups as well as non-members, members and non-members of youth groups, men's group members and community leaders in the clusters) and CFAR members. The study also captured the status of community toilets and water sources, their management and problems relating to them. A schedule was devised for cluster information and known people from the cluster like the caretaker of the community toilet, *pradhan*/ward members of the community were interviewed.

The tools used for the qualitative interview were focus group discussions, in depth interviews, case studies, and stories of success and failure in the studied clusters.

1.3.1 Survey methodology

The clusters in all the three cities were categorized into three groups i.e. intensive (highly effective), extensive (medium effective) and comprehensive (low effective). The quantitative information was collected at two levels, i.e. at the household level (the respondents were group members) and at the community level (the caretaker of the community toilet and other persons who were knowledgeable about the cluster). The requisite number of households to be interviewed from each town was captured from two set of clusters- intensive and extensive, though all the areas were covered in the qualitative survey and for capturing community information. The total number of households surveyed in the three cities of Delhi, Jaipur and Kolkata were 1321, 300 and 608 respectively (for cluster-wise numbers, see Annexure Table 1.1). The number of households to be surveyed was arrived at following intensive discussions at IHD on methodology and surveys and was finally decided upon on the basis of the population ranges of selected slums or clusters. The higher proportion of households was taken from the intensive clusters as compared to extensive clusters. The ratio of extensive clusters to intensive clusters is 35:65. The population range for each city is separate as there is a difference in the total number of households in different slums or clusters. However, all the areas were covered in the qualitative survey. The settlement level information was also captured from the selected slums.

The survey collected information at the household and community level

The end-term survey did not identify the baseline households as most of the addresses were not complete and locating these would have been very time consuming. Hence it was decided that the overall results of the baseline and the end-term surveys for the selected clusters would be compared. The detailed procedure of selecting sample households is given in Table 1.1.

The community schedule was tested for all the studied clusters - 27 in Delhi, seven in Jaipur and six intensive and 27 extensive in Kolkata. Beside the quantitative information about 50 qualitative interviews in Delhi and 25 each in Jaipur and Kolkata were also conducted (details in Annexure Tables 1.2 to 1.7).

The qualitative interviews were expected to provide insights into how the intervention helped women. The process of change as well as areas where the behaviour change has been relatively easier compared to other areas where the transition has been marginal or insignificant were ascertained through the interviews to understand the challenges posed during the intervention.

1.3.2 Purpose, objective and scope of this evaluation study

The evaluation was based on the OECD criteria of analysis of the project objectives in terms of results achieved against objectives, change relating to sanitation behaviour, their ownership of the changed behaviour, as well as the financial and organizational sustainability of the action. It was also done to examine the nature and scope of partnerships among different stakeholders that helped in achieving the goal. The evaluation also analyses the efficacy of the partnership model.

Table 1.1: Procedure of selection of households in extensive and intensive slums

Cities	Extensive/Intensive	Household Range	HH to be Selected	Number of Clusters covered
Delhi	Extensive	Below 500	35	3
		500-1000	45	1
		1000 to 2000	55	4
		Above 2000	85	1
	Intensive	Below 500	75	5
		500-1000	105	2
		Above 1000	130	2
	Total HH to be covered		**1300**	**18**
Jaipur*		Below 250	40	3
		250-500	70	1
		Above 500	110	1
	Total HH to be covered		300	5
Kolkata	Extensive	Below 250	20	2
		250-500	30	3
		500-1000	50	1
	Intensive	Below 500	60	4
		500-1000	80	2
	Total HH to be covered Grand Total (3 cities)		600 2200	12 35

*Note: *The household range is the same for both intensive and extensive clusters in Jaipur as there are only seven clusters and in five of them the household size is below 250.*

Table 1.2: The list of catalysts covered for qualitative interviews

	Delhi	Jaipur	Kolkata
FGD with women's groups, women non-group, adolescent group and non-group, men non-group, Youth group, local club	29	13	19
Community leaders	0	2	1
Government officials, political leaders, other NGO members, ICDS worker (anganwadi sevika or sahayeka), ASHA workers	14	13	12
Cluster level advisory committee/organizer	0	0	1
Community interview (Each slum or clusters)*	27	5	13

* *The community interviews are both qualitative and quantitative in nature, and include information on community toilets, water sources, problems faced by the community, etc.*

1.3.3 Evaluation framework, questions and methods

Given the purpose and objectives, in addition to following the OECD framework, the study also evaluated the partnership model adopted in planning and monitoring the programme. Each parameter of evaluation consisted of a specific question given in Table 1.3

Table 1.3: Evaluation framework and questions

Evaluation Criteria	Evaluation Questions
Relevance Are the objectives and strategy adopted in the programme relevant to the specific issues of water sanitation and hygiene behaviour in the programme areas (selected slums and unauthorized clusters)?	- Has the programme changed the hygiene behaviour among women in particular and of society in general? Do the women in the area prioritize water, sanitation and hygiene issues due to the programme and to what extent? - How well were the problems relating to water, sanitation and hygiene understood, analyzed and strategized and whether an action plan was made to change the behaviour through awareness among women? - Is there any dimension or strategy to enhance knowledge and awareness in CFAR's intervention area and to extend the area of intervention to other slums or clusters? Was the strategy of the programme modified due to the recently launched SBA programme and how?
Effectiveness Has the programme been able to ensure sanitation and hygiene behaviour within the urban poorest clusters? To what extent do community members ```exercise their right and negotiate with the duty bearers or with institutions (like Jal boards, urban local bodies, etc.)? Has the programme percolated to bring about behavioral change in families or households? To what extent has the programme addressed gender equality and reduced patriarchal influence on society?	- How effective is the approach adopted by CFAR in changing sanitation behaviour? - Is there any example of such changed behaviour? - How effectively did the women leadership model within society help in changing sanitation behaviour and in exercising the community's right to sanitation, hygiene and safe water? Has the leadership also helped in exercising the rights of women in other gender dimensions like patriarchy, gender violence, gender discrimination in education, health, etc? - Was the programme helpful in strengthening the capacity of the duty bearers involved in water-sanitation-hygiene? - How appropriate were the training and awareness programmes in contributing to the project goal? Did the training programmes contribute to strengthen groups (women's groups, adolescents' groups, men's groups) and women leaders within the community?
Efficiency To what extent have the objectives of the programme been achieved as per schedule? Is the strategy adopted to fulfill the objectives the most efficient as compared to other strategies?	- What was the different strategies adopted under the programme? Is there any inconsistency among different strategies? - What is the role of the duty bearer? Has the capacity of the duty bearer been enhanced over the programme period? - To what extent have the training programmes helped in achieving the goals?

Sustainability How has the leadership and group activity on the one hand and the enhanced capability of the duty bearer on the other hand been helpful for women in exercising their right to sanitation and hygiene? Have they enhanced the overall empowerment of women?	- Have the women developed capacities to continue the programme in the absence of CFAR (after the project period)? Is the leadership efficient and self-sufficient enough to carry forward the project and help the women to exercise their rights? - Are adolescents responding to the cause? Is there an example? What are their thoughts to carry forward the project? How supportive are the men (within the household and in society) for the sustainability of the programme?
Impact What impact has the programme had on women? Is there any change in the status of women within the household and the community? Has the programme had any impact on the capacity of duty bearers? If yes, in what way?	- To what extent have objectives of the programme been achieved? - What has been the major impact of the programme and what are the gaps in terms of behaviour change at the individual level and group level? What are the gaps? - Have sanitation and hygiene issues of women become a part of the group activity and in what ways does the group tackle them at the household level and at the community level? - Has the group (women, men, adolescents) effectively convinced the non-group members as well as the duty bearers about their right and duties? - What is the reaction of the men within the household and the community?
Partnership How effective was the partnership model of CFAR with different agencies in empowering women?	- How well has the partnership of CFAR with different government and non-government agencies helped in achieving the goal? Will the partnership be carried forward in future beyond the project period? - Has the existing partnership of CFAR been leveraged to help build further partnerships during the project period? Has it moved from strength to strength? What are the learnings from this?

The secondary data was generated from baseline reports, midline reports and the database of all the previous surveys done under the programme. All the progress reports, case studies as well as reports of different CFAR activities were consulted to get an idea of the different activities done during the last three years.

To assess the change and progress, baseline and midline data were the reference points against which the programme output and outcome were assessed. Otherwise the focus was on the process adopted and identification of those which were most effective in bringing about change.

A structured household schedule was made to evaluate the programme. It not only reflected the questions mentioned in the evaluation framework, but also highlighted different issues like demographic profile of members and households, uses, sources, problems and solutions to water, water-borne diseases, garbage disposal and street cleaning, overall cleanliness and hygiene practices and women's issues relating to sanitation, health and hygiene.

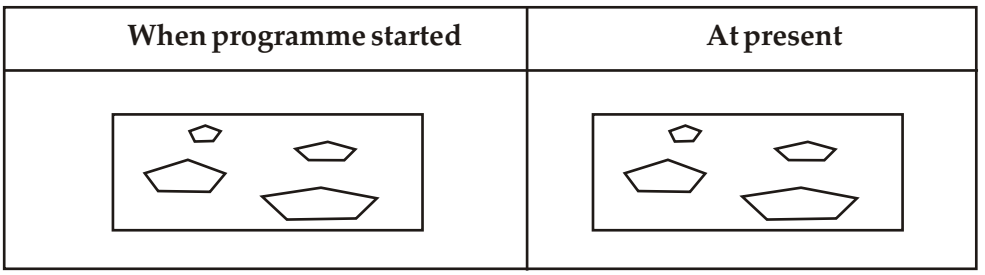
FGDs and in depth interviews were guided by the checklist prepared. This targeted the women's group members, women's non-group members, adolescent's group, community leaders, CFAR staff and different official members as well as political members.

The different catalysts for qualitative interviews are listed below:

1. Jal Board officials/members
2. Urban Boards (DUSIB in Delhi)
3. National Health Mission (Jaipur)
4. Caretaker of the community toilet
5. Delhi/Jaipur/Kolkata Development Authority
6. ICDS centres (Anganwadi *sevika* and *sahayika*)
7. NRHM officials
8. *Pradhan*/ward members
9. CFAR Staff

The evaluation also used pictorial tools to analyze the perception of women on different indicators relating to water, sanitation, hygiene and also the change in the agency of women over the period of three years. This question was asked of both group members and non-group members for both the time periods, i.e. before and after the programme. Four options were given to the respondent, i.e. very low, low, medium and high for boh the periods as shown in the pictorial sample (Graph 1.1).

Graph 1.1 : Pictorial Sample



Main Questions/statements

- Clean water is necessary.
- Toilet is necessary.
- Washing hands with soap and detergent is necessary.
- I can complain about non-provision or non-accessability of facilities relating to water and sanitation.
- I can talk to anybody about any issue.
- Boys and girls are equal in all spheres.
- I used to help or join others in addressing common issues (complain or raise voice).
- My health was given importance.
- I can discuss my health concerns with the doctor and with other members of the household.
- I can complain to the police when violence or any misbehavior takes place.
- Do I have the freedom to move outside the house?
- Am I facing any objection from the household in participating in any public meeting?
- Do men share the responsibility of household work?
- The stakeholders are more responsive (Anganwadi worker, ASHA (Accredited Social Health Activist) workers, Pradhan, etc.).
- The stakeholders are more responsive (ICDS workers, Jal Board, Municipalities/ corporation, caretaker of the community toilet, sanitation workers etc.).
- Is there any discrimination between boys and girls in different spheres of life like education and health and in receiving different facilities?

1.4 Brief Socio-Economic Profile of the Survey Areas (Delhi, Jaipur and Kolkata):

According to the 2011 Census of India, in Delhi, Jaipur and Kolkata there are 3.68 lakh, 0.62 lakhs and 3.0 lakhs slum households respectively. The proportion of slum households in NCT Delhi, Jaipur town and Kolkata town is 11 percent, 40 percent and 29 percent of the town's total population. With growing urbanization and population pressure, the burden on civic amenities and services provisioning is tremendous.

The clusters which were part of the intervention in the three cities were selected in a phased manner. The intensive clusters were the ones where the intervention was initiated from the first phase and is continuing, while the extensive areas were those where the intervention began later and in some cases did not meet with success. As a result the total areas and households covered during the baseline and later mid-term as well as end term does not match for comparisons. The evaluation study in Delhi was based on 27 clusters of which nine were intensive, nine were extensive and nine comprehensive, In Kolkata it was 13 clusters of which six were intensive and seven were extensive and in Jaipur it was seven clusters of which four were intensive, one was extensive and two were comprehensive. The total number of households covered in the survey in all of these clusters was 1321 in Delhi, 608 in Kolkata and 300 in Jaipur. Moreover, several FGDs were also conducted among the forum and the non-forum members consisting of women, adolescent girls and boys; in-depth interviews of service providers were also conducted.

The urban poor locations are inhabited largely by Scheduled Castes (more than 50 percent) in Delhi and Jaipur, and by Muslims in Kolkata (80 percent). Nearly one half of the households were reportedly above the poverty line. Seven percent of the households reported the highest education level among women as graduation and above, while it was 10 percent for men. A bulk of the households owned the house they lived in, with only 13 percent living in rented houses. There were very few kutcha houses;

almost 50 percent were pucca and 45 percent were semi pucca. Only 65-70 percent of children of school going age were enrolled and attending school. There was the usual gender gap with more boys attending school than girls, except in Kolkata where there were more girls going to school than boys.

Income and occupational profile

In Delhi, in 13 percent of the total households the major part of the income was coming from regular government or private jobs. About 16 percent earned their livelihood from wage labor, of which a substantial part was construction labor. Six percent were factory workers. The major occupation of nine percent of the households was driving. About four percent were sanitation workers. In Jaipur about one-third of the total households depended on wage labor of which 22 percent were engaged in construction work. About 15 percent were drivers and 14 percent were self-employed as masons and painters. About four percent of the total households had their own shops. In Kolkata more than one-fifth of the total households depended on driving as an occupation and another one-fifth on general/construction labor. Domestic work was the major occupation for about seven percent of the total households. About eight percent of the total households depended on government or private jobs for their livelihood. Nine percent of the households were engaged in small businesses.

Households in Delhi did not have as many high income families as in Jaipur, where both men and women worked in construction related activities in a larger proportion of households. Almost two-fifth of the women respondents in Jaipur were engaged in construction work, while others reported tailoring, handicraft making and so on as sources of livelihood. In Delhi the jobs available for women tended to be largely domestic work, with only a few of them (eight percent) having private sector jobs. In Kolkata one-fourth of the working women were engaged as construction labor, 12 percent worked as anganwadi sevikas or sahayikas. Domestic work accounted for the livelihood of one-fifth of total women workers (21.1 percent). Eight percent of the women were engaged in small businesses.

1.5 Issues relating to Baseline and End-Term Comparisons

CFAR had done the baseline survey in the three cities before they started the programme. In Delhi, nine intensive clusters - Indra Camp, Kalyanpuri; Old and New Priyanka Camp; Rajeev Camp, Jhilmil Colony; Saboli Khadda, Jain Mandir; Indra Camp, Khichripur; J.J Camp, Anand Vihar; Rajasthani Camp and Subhash Camp, NTPC - were covered and the total sample size was 685. The minimum sample size in baseline was 50 in Indira camp, Khichripur and the highest was 160 in Jain Mandir. In Jaipur a total of 236 households were covered in seven clusters (details provided in Annexure Tables 1.8-1.10). The lowest was in Brajlal Pura with 10 and the highest was 105 in Jhalana Kunda. In Kolkata, a total of 270 households in five clusters were covered. The households ranged from 50 to 60. In the end line survey, we covered 18 clusters in Delhi including the nine that had been covered in the baseline survey. The clusters included in the baseline were mostly intensive in all the three cities. The results of the comparison between the baseline survey and the end line survey may appear counter intuitive due to the following reasons:

1. Slums or clusters are not exactly the same.
2. Households surveyed are not exactly the same.
3. IHD's sample selection followed a systematic sampling where the samples for the baseline survey were picked from different parts of the clusters.
4. In Kolkata we covered 13 clusters that included the five clusters taken in the baseline survey.
5. The intensity of work in non-baseline slums and clusters was lower as compared to the baseline clusters and slums.

Therefore, while the report does use some comparisons from baseline to end term, the figures are not always comparable. Therefore the questionnaire adopted a pictorial set of questions to capture the change over time of the various critical dimensions which has been discussed in section 2.6 as end-term evaluation findings.

2. END-TERM EVALUATION FINDINGS

The end-term evaluation reflects the big and small changes as well as the challenges confronting both the group of NGOs working with the communities as well as the communities where the intervention occurred. It reveals the experiments and strategies which worked and where modifications or mid-term changes were required. The effectiveness of some of these strategies is appreciable. Working on bringing about behaviour change is extremely challenging and difficult but CFAR's intervention has in fact managed to substantially improve the behaviour of women and communities towards WSH and overall social responsibility.

In terms of relevance, the intervention has by and large been quite effective in ensuring that the women and their communities are prioritizing clean water, sanitation and hygiene related issues. The importance attached to these issues has increased substantially with some variations across cities and locations, depending on the situation prevalent when CFAR began working and support from the institutions responsible for providing the required facilities or services. The analysis of both quantitative and qualitative findings reveals a high level of awareness among the women on WSH issues and problems as a result of CFAR's intervention strategy. Even before the SBA was announced, CFAR was working at modifying its intervention strategy as per the recommendations of the mid-term evaluation.

Efforts were made to spread the intervention outreach to other clusters and locations, and to focus more on influencing the non-forum segments of the cluster. The effectiveness criterion too shows positive results, since the intervention has helped to create knowledge about the institutions and agencies to reach out to for addressing problems associated with WSH. Women are gradually becoming more confident, although there are still several who do not feel confident enough to file complaints individually. A sense of collective strength is witnessed among the women. There are several instances of how women complained to the Jal Boards, urban bodies and municipal authorities for addressing sanitation and water related issues, garbage disposal and cleanliness of streets and so on. Illustrations of these are provided under the relevant subsection from each of the three cities. The end-term evaluation reveals the efficiency of CFAR's trainings and interactions in empowering poor and marginalized women to aspire for and place demands for the provision of basic services.

The support of men and boys in the interventions has proved to be another positive sign

DUSIB's takeover of the rehabilitation of slums from MCD was a major change which also signifies the enhanced capacity of duty bearers. Several CTCs which were being managed by either the community or DUSIB were renovated or reconstructed. Often this was done as a result of the demands placed by groups of women from the community.

In terms of sustainability, it may be stated that the women leaders of the forums and some of the women have displayed the ability and capacity to continue the programme even after CFAR's withdrawal. In several ways, the leadership appears to have become self-sufficient, with adequate information and knowledge about institutions which they have to approach or deal with in order to

address their problems. However, in many cases it appears that support from CFAR is critical for the women to pursue the objectives.

Among adolescent girls who had been mobilized into groups, some displayed substantial ability to stay with the group, there were others who tended to withdraw or drop out. The turn-over of the CFAR team members, in Delhi, also posed problems as noted during the mid-term evaluation. Some of these issues continued to present themselves. The support of men in the interventions has proved to be another positive sign. Wherever the group of women managed to successfully address any problem of the community and families benefitted, the acceptance of the group and its activities within the community as well as families increased. On an experimental basis, CFAR initiated the formation of men's groups; however, this faced the usual problems due to their time constraints. This meant that ensuring that all male members participate in the regular weekly or fortnightly meetings proved to be a challenge. However, this helped in enhancing the men's cooperation and understanding of women's forums and groups to some extent.

Some very useful partnerships across the three cities have been an integral part of the intervention throughout the period, beginning with the partnership between Mission Convergence, Gender Resource Centres and other bodies in Delhi, Ministry of Urban Development in Jaipur and the Women and Child Development (ICDS) Department in Kolkata. Newer associations and partnerships are being constantly sought; the latest achievement is the signing of the MoU with DUSIB in Delhi.

The following section will present the end-term evaluation findings thematically from the three cities, beginning with sanitation in section 2.1; clean surroundings in terms of garbage disposal, drainage and street cleaning in section 2.2; water in section 2.3; women's sanitary practices and hygiene in section 2.4 and role of institutions and partnerships in section 2.5. The overall behaviour change as perceived by the surveyed women in the course of the period of this intervention is assessed using a pictorial survey tool and these findings are provided in section 2.6.

Nukkad Nataks are regularly used to create awareness in communities

2.1. Sanitation

Sanitation facilities are critically lacking in urban poor localities, with the Census of India 2011 recording only half of all slum households in Delhi as having latrine facilities within the premises. Jaipur and Kolkata recorded relatively better facilities with 81 percent and 92 percent households respectively having latrine facilities within the premises. In the context of Delhi, where the proportion of households with toilets is lowest, the dependence on public toilets and latrines is high – 37 percent. However, the provisioning of common toilets to unauthorized localities and their maintenance usually poses several problems. Also, the capacity of the public toilets tends to be quite limited and inadequate as was witnessed during the mid-term and end-term evaluation.

Although the situation of provisioning has substantially improved in several locations with both personal toilets as well as CTCs which were renovated and newly constructed, it must be noted that the personal arrangements are at best makeshift toilets in most cases since they are not linked to any sewerage lines. In that sense, the facilities provided as common toilet complexes (CTCs) are better. In Delhi, the efforts of women's groups and communities in making demands for better provisioning by MCD and DUSIB have borne fruit in several cases. The complaints of the providers that any facility tends to be misused or destroyed due to poor maintenance, was also addressed through the intervention since CFAR evolved a participatory approach for keeping the CTCs clean and ensuring the proper maintenance of the facilities. The use of community-centered approaches resulted in growing awareness regarding the relevance and importance of these facilities; women's interaction with the authorities as well as Jan Sabhas and public meetings in which officials of MCD and DUSIB also participated. This enabled both sides to appreciate the concerns and apprehensions of each other better.

The capacity of public toilets tends to be quite limited and inadequate

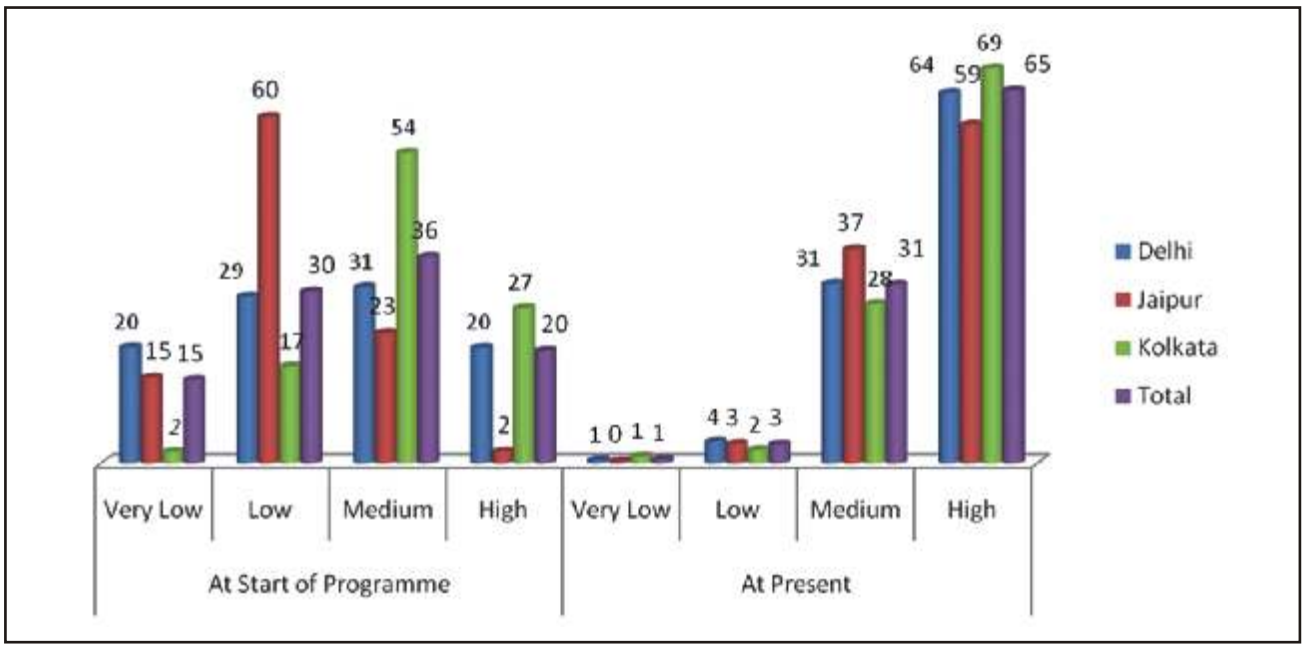
This section deals with the access of the households in the clusters across the three cities to toilet facilities and issues relating to them. In the context of the country-wide focus on sanitation through the SBA to ensure elimination of open defecation, this becomes extremely important since lack of facilities in urban poor locations often leave no option for the communities but to resort to open defecation. In Delhi, in clusters where the households do not have personal toilets, provisioning of public toilets is crucial, given the absence of open spaces and high density in urban slums. Safety of women and girls is another critical factor in these locations even among those who very often use public toilets. The maintenance and cleanliness of the CTCs are also important for proper utilization. The capacity of the CTCs is another factor constraining its utilization. The long queues and waiting time in the CTCs become a deterrent for some of the residents. However, over time, there has been an easing of these pressures with additional public and private capacities. Apart from the lack of adequate space to build toilets within their premises, the lack of sewerage connections and well-laid pipelines for waste disposal constrain the residents in several locations from constructing personal toilets. Interactions with the authorities wherever feasible have resulted in some success stories in a few areas.

2.1.1 Relevance and recognition

More respondents reported high priority for toilets by the end term compared to when the programme started. Nearly 45 percent of the women surveyed attributed very low or low priority to toilets being necessary at the beginning of the programme (see Graph 2.1). Post intervention, a very negligible share of women, less than five percent gave it low priority, with most women attributing it medium or high priority. The change over time even in the perception of those women who reported very low priority to toilets at baseline is significant with more than 80 percent now reporting it to be a medium or high priority (see Graph 2.2).

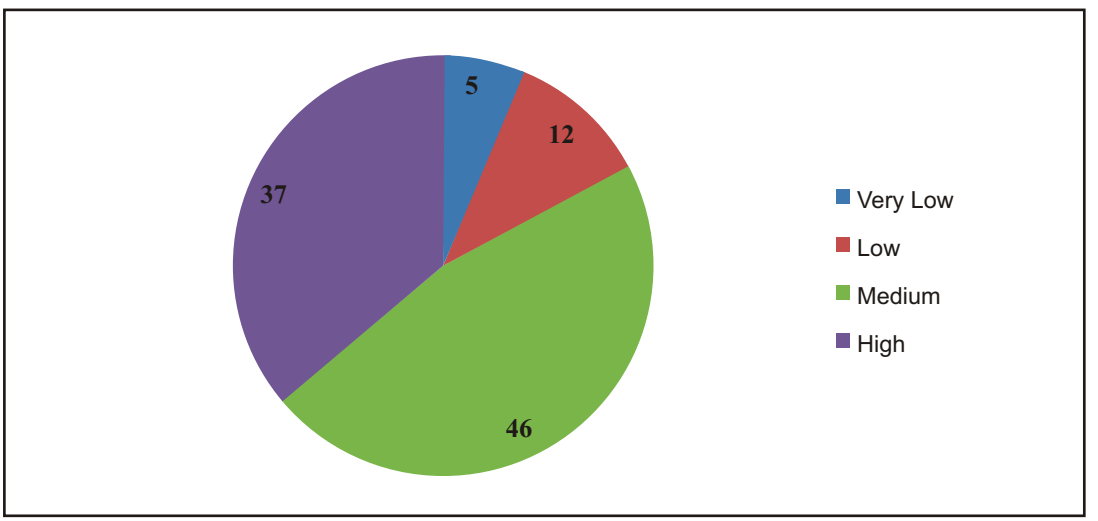
Other changes that have occurred by end term in Delhi include the construction of personal toilets and involvement of several community members in filing complaints and writing petitions to DUSIB for up gradation of CTCs and renovations and construction of new complexes where the earlier MCD public toilets were in a pathetic condition due to poor maintenance. In Delhi the capacity of CTCs has improved and in most places they are functioning well.

Graph 2.1: Priority attributed to the need for toilets – before and after intervention (% of households)



Source: IHD End-term survey 2015-16

Graph 2.2: Percentage change in the perception of women reporting very low priority to toilets being necessary at baseline



Source: IHD End-term survey 2015-16

Issues around user fees, ensuring security for women, constant maintenance and provision of basic facilities such as soap, water, etc., thefts, miscreants defacing or using the space for drugs and alcohol consumption and sexual harassment have all been reported to a greater extent in some areas compared to others. The closure of CTCs during night hours, which emerged as a safeguard against such actions, is now being sought to be addressed by ensuring that one seat is available for use all 24 hours in the new complexes, which is a welcome move. It is hoped that the efforts to instill a feeling of ownership among the residents will pave the way to preventing the misuse or abuse of the public facilities meant for them.

2.1.2 Access to toilet facilities

In the 2016 end-term survey, 56 percent of the total surveyed households had access to personal toilets (including shared toilets). Seventy five percent of the households associated with groups and 51 percent non-group households said that they had this basic facility within their houses (Table 2.1). More importantly, 76 percent of the households said that they were self-motivated to construct a toilet within their homes and 83 percent felt that their social status had improved after constructing a toilet (Graph 2.3). Two primary reasons for construction of personal toilets at home have been privacy (nearly 50 percent) and security (32 percent) and this holds true for all households irrespective of their income levels.

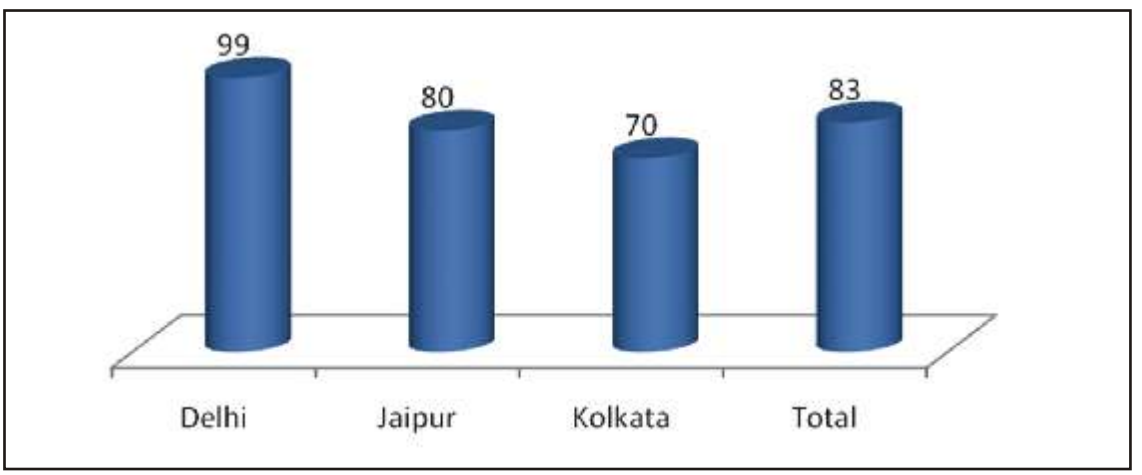
Table 2.1: Percentage of households having access to personal toilet facility

Respondent	Delhi	Jaipur	Kolkata	Total
Total	38	69	92	56
Group member	56	80	97	75
Non-group member	35	60	91	51

Source: IHD End-term survey 2015-16

In the absence of access to a toilet at home, 33 percent of the total households, irrespective of gender, depended on community or public toilets in their cluster and eight percent opted for open defecation. The share of households which have constructed personal toilets has increased over the intervention period. To have the resources to build a personal toilet and not having to depend on either public toilet facilities or resort to open defecation is increasingly being associated with improvement in social status by most of the community.

Graph 2.3: Percentage of households who feel their social status has improved after constructing a toilet



Source: IHD End-term survey 2015-16

Almost all of the surveyed households said that they faced several problems due to open defecation. Lack of privacy, safety issues, misbehavior by others and filthy surroundings were the major discomforts associated with open defecation. But diseases and health problems which may result from this unhygienic practice seems to be less commonly known because just nine percent of the total surveyed households considered them to be related to open defecation (Table 2.2).

Table 2.2: Problems faced due to open defecation (% of households) – multiple responses

	Delhi	Jaipur	Kolkata	Total	Total number of households
Too far	5.2	32.1	50.0	19.4	31
Inconvenient	18.2	56.8	100.0	38.8	62
Water problem	15.6	1.2	0.0	8.1	13
Dirty	37.7	50.6	0.0	43.8	70
Objection by others	10.4	6.2	50.0	8.8	14
Misbehaviour by others	45.5	33.3	0.0	38.8	62
Unsafe	48.1	38.3	50.0	43.1	69
No privacy	40.3	43.2	0.0	41.3	66
Health problems	9.1	2.5	0.0	5.6	9
Others	0.0	1.2	0.0	0.6	1
Total	100.0	100.0	100.0	100.0	160

Source: IHD End-term survey 2015-16

Despite problems faced in using CTCs and open defecation, lack of space (69 percent) and funds (57 percent) for construction of toilets prevented households from creating their own facilities at home (Table 2.3). Table 2.3: Reasons for not having a toilet/latrine at home (% of households) - multiple responses

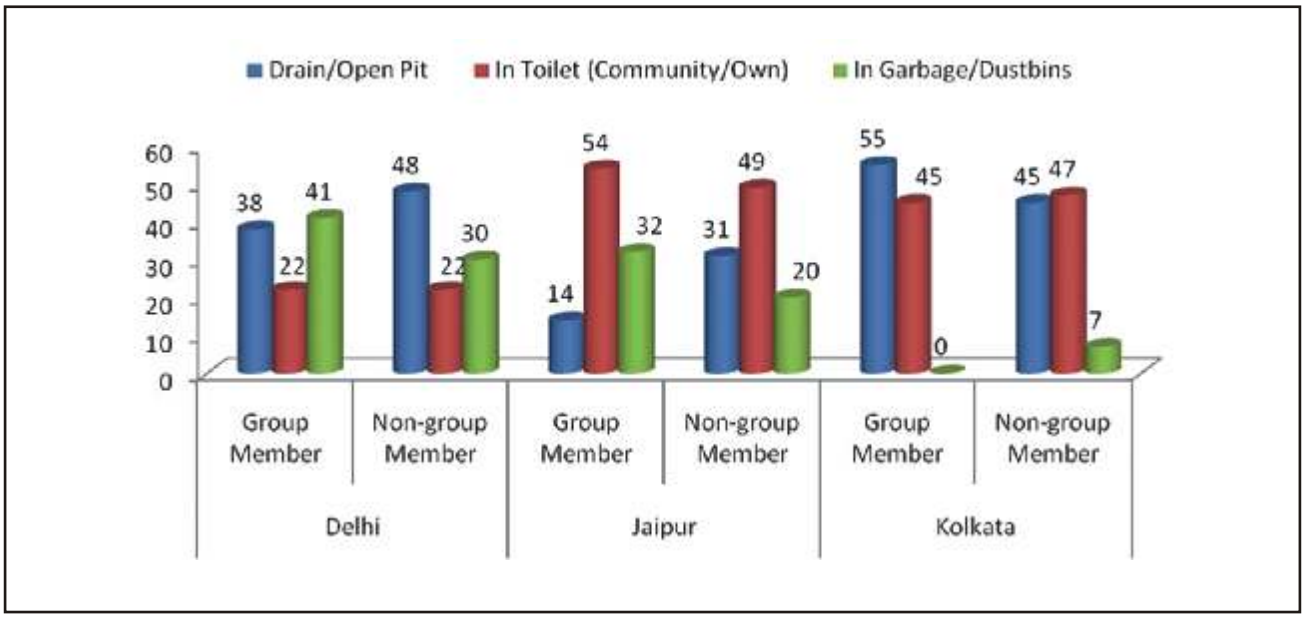
Table 2.3: Reasons for not having a toilet/latrine at home (% of households) - multiple responses

City	% households by reason for not constructing toilet								Total number of households
	No Space	No funds	Do not feel Necessity	Feel uncom-Fortable	Others	No sewer-age Line	As they are rented do not Construct	Water problem	
Delhi	73	55	1	2	1	1	0	1	802
Jaipur	41	72	6	2	0	1	4	2	83
Kolkata	50	50	0	0	0	0	0	0	6
Total	69	57	1	2	1	1	1	1	891

Source: IHD End-term survey 2015-16

Another important finding relates to the disposal of children's excreta. The quantitative data indicates that 44 percent of the surveyed households disposed the excreta of their children in drains or open pits, 32 percent in toilets (community or personal) and another 24 percent in garbage/dustbins. Even among the section of households having their personal toilet, 26 percent threw it in the drains outside their houses and 14 percent in open pits. A state level analysis indicates a stark difference in practices followed by group and non-group members. In Delhi, 41 percent group members use garbage bins for this purpose while 48 percent non-group members simply throw it in drains and open pits. Similarly in Jaipur, 32 percent group members and 20 percent non-group members use dustbins for the same (Graph 2.4). The difference can be attributed the greater level of awareness among the group members as well as the availability of facilities such as community toilets or dustbins and garbage dumps, which have in several cases been fought for or demanded from appropriate authorities.

Graph 2.4: Prevalent practice of disposal of children's excreta (% of group ad non-group members)



Source: IHD End-term survey 2015-16

Each of the cities displayed substantial variations and therefore the discussion for each city is separately provided here. Delhi, as mentioned above, had comparatively fewer households with personal toilets, and a substantial proportion of those without toilets within their premises depend on the community toilet complexes. The practice of open defecation tends to become higher at locations where the facilities are inadequate compared to the population. In Jaipur, the intervention was able to initiate construction of innovative two-pit dry latrines, which subsequently received the appreciation of the Department of Urban Development. CFAR is examining the prospect of utilizing the SBA programme to boost this initiative. As in Delhi, in some locations in Kolkata, there are shared toilets with very low capacity among a large segment of the inhabitants, leading to overcrowding and extremely poor conditions. Most of the inhabitants reported that they did not or were unable to use soap due to economic constraints and that they use mud to wash their hands after defecation. In several cases they admitted that they were aware that they should wash their hands with soap after defecation, but were not able to do so.

2.1.2a Delhi

In Delhi, 38 percent of the households have their personal toilet and the variation is significant between group and non-group members. Also, the income of the households seems to be an important factor governing the building of a toilet within the home. The education level of the woman in a household is also a factor: 50 percent of the households where women hold a graduate degree or a higher qualification have a toilet. Irrespective of the group or non group status of the household, privacy

(60 percent) and security (30 percent) of family members were the primary reasons for constructing a toilet within homes. Across income groups, privacy has a higher weightage among high income households and security is more important among lower income households. Besides, government awareness campaigns, the shrinking of open spaces and provision of government subsidy also seem to be important reasons, particularly among group members and medium income category of households (Table 2.4).

Table 2.4: Reasons for construction of toilet in Delhi (% of households)

Reasons for construction of toilet in Delhi (% of households)	Respondent is a		Income quintile					
	Group member	Non-group member	Very low	Low	Medium	High	Very High	Total
To maintain privacy	54.3	59.7	47.7	52.1	60	61.5	66.3	58.6
Govt. awareness campaign	3.8	1.8	0	4.1	3.3	2.2	0	2.3
Shrinking of open spaces	3.8	3.9	2.3	3.3	5.6	5.2	2.1	3.9
Government provided subsidy	3.8	2.1	2.3	2.5	3.3	2.2	2.1	2.5
Security concern of family Members	30.5	31.6	47.7	37.2	25.6	25.9	29.5	31.3
CFAR's or other NGO awareness Campaign	1.9	0.8	0	0.8	1.1	2.2	0	1.0
Other	1.9	0	0	0	1.1	0.7	0	0.4
Total	100	100	100	100	100	100	100	100

Source: IHD End-term survey 2015-16

Another question relating to the motivating factor provides a better insight into reasons for construction of personal toilets. Seventy three percent said that they were self-motivated and 23 percent said that relatives and friends encouraged them to do so. Thus, improvement in social status after the construction of a toilet within the house has been indicated by all the households as a motivating factor. Irrespective of their income category, 94 percent of the households have used their own funds to build the facility within their home. Dependence on loan facility is very low (five percent) and government schemes do not seem to have played any role in facilitating people to construct personal toilets in urban areas.

Among them, 62 percent of the households did not have personal toilet due to lack of space and funds for construction, 54 percent depended on community toilets and eight percent opted for open defecation. Women who are dependent on community toilets reported several incidents of eve teasing, molestation, road accidents and raising concerns for safety and security of young girls, women and children.

A few incidents from focused group discussions are cited here:

Incidents from Delhi:

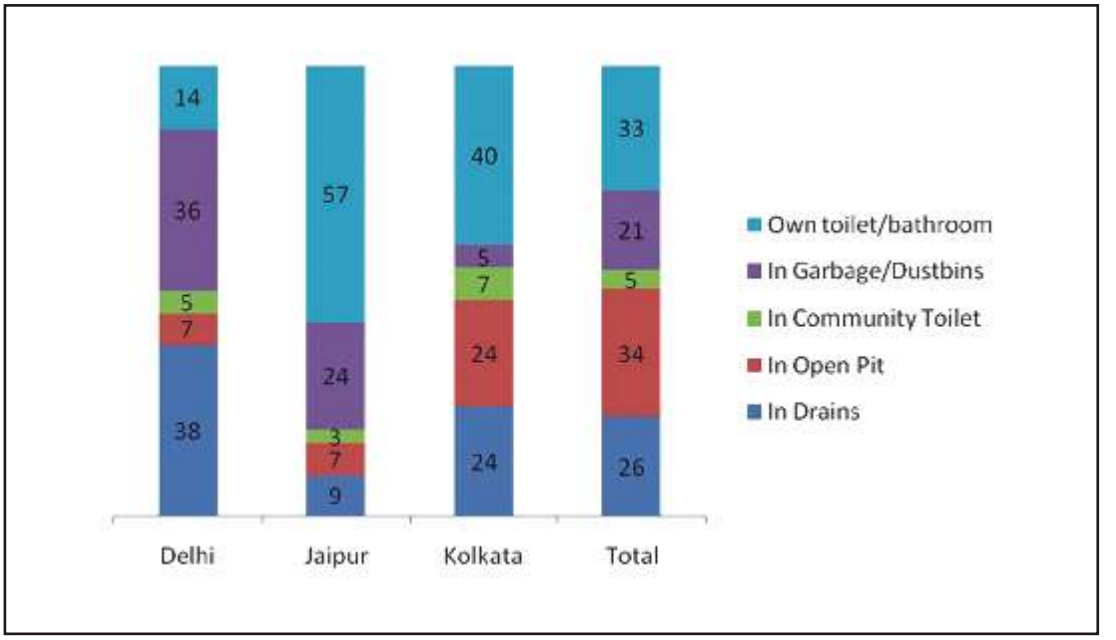
In the Jain Mandir cluster, antisocial elements and drug addicts are often found roaming around near the community toilet complex (CTC). They harass, tease and pass comments on women and girls who come to use the facility. This is a common problem reported by women from several areas where women depend on public toilets.

In the Shastri Mohalla cluster, a man was reported to have hidden in the female CTC and tried to rape a female who went to use the toilet. A woman from Kalyanpuri cluster narrated her problem saying "Shaamko 7- 8 baje ko hum shochalaya nahi jaa sakte hai kyuki wahan aadmi ghus jaate hain."

Moreover, since the community toilet is closed during night, several people said that they have no option but to defecate in the open, even though they were aware of the harmful impacts of open defecation.

As far as open defecation is concerned, insecurity, lack of privacy, misbehavior by anti social elements, foul smell and dirt were the commonly quoted problems. Just nine percent felt that open defecation may result in several diseases and health issues. The manner of disposal of children's' excreta is also an indication of the extent of awareness of health problems which may arise due to lack of adequate sanitation facilities. Among the households having personal toilets at home, 38 percent simply threw it in open drains near their house and seven percent put it in open pits (Graph 2.5).

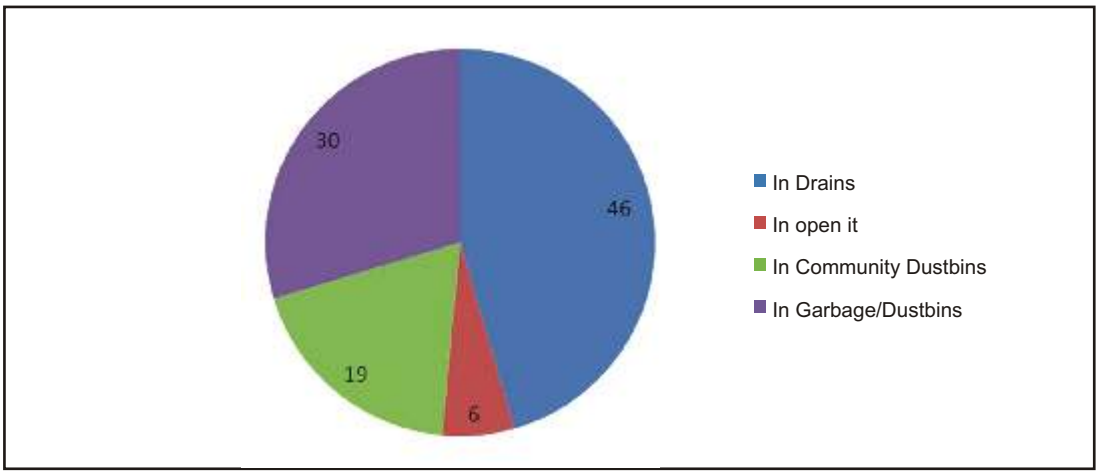
Graph 2.5: Place of disposal of children's excreta among the households having own/shared toilet



Source: IHD End-term survey 2015-16

In addition, among the 54 percent of the surveyed households that depended on community toilets, 46 percent disposed their children's excreta in drains and six percent in open pits (Graph 2.6).

Graph 2.6: Place of disposal of children's excreta among the households using CTC



Source: IHD End-term survey 2015-16

2.1.2b Jaipur

In Jaipur, 69 percent of the surveyed households, comprising of 80 percent of the group members and 60 percent of the non-group members, had personal toilets. There was significant variation across the income categories of the households. Women's education appeared to play an important role. Nearly 90 percent of the households with women educated to graduate degree and higher levels had constructed a toilet within their house.

Irrespective of the group or non group status of the household, privacy (60 percent) and security (20 percent) of family members were the primary reasons for constructing toilets within homes. The government's campaign among non-group members (eight percent) and CFAR's awareness generation programme among group members (8.6 percent) were also important motivating factors in the city. The reasons for the construction of a toilet varied across income groups. Among very low income households, privacy (80 percent), security of family (10 percent) and CFAR's awareness programme (10 percent) figured as the prime reasons (Table 2.5). As the level of income increased, government awareness campaigns, shrinking of open spaces and provision of government subsidy also gained importance.

Table 2.5: Reasons for construction of toilet in Jaipur (% of households)

Reasons for construction of toilet in Jaipur	Respondent is a		Income quintile					
	Group member	Non-group member	Very low	Low	Medium	High	Very High	Total
To maintain privacy	58.1	59	80	58.3	57.7	61	54.8	58.5
Govt. awareness campaign	5.7	8	0	5.6	3.8	6.8	9.6	6.8
Shrinking of open spaces	1	3	0	0	3.8	3.4	1.4	2.0
Government provided subsidy	4.8	3	0	5.6	7.7	0	5.5	3.9
Security concern of family Members	21.9	22	10	30.6	19.2	20.3	20.5	22.0
CFAR's or other NGO awareness campaigns	8.6	5	10	0	7.7	8.5	8.2	6.8
Other	0	0	0	0	0	0	0	0.0
Total	100	100	100	100	100	100	100	100

Source: IHD End-term survey 2015-16

In the city, besides self-motivation (75 percent), 17 percent of the households said that they were motivated by the campaigns run by CFAR and other NGOs to build toilets in their premises, and five percent were encouraged to do so by members of the sanitation department. Eighty percent said that their social status improved after they built their own facility (Table 2.6).

Table 2.6: Motivating factor for construction of toilet (% of households)

Factors	Delhi	Jaipur	Kolkata	Total
Self	73.0	75.2	79.3	75.7
Relatives/friends	22.9	1.0	11.9	11.3
MLA	0.2	0.0	3.7	1.4
NGOs other than	0.8	7.6	0.7	3.2
CFAR	0.8	9.5	2.2	4.1
Sanitation department members	1.2	4.8	0.7	2.6
Owner of the house	1.0	1.9	1.5	1.7
Total	100.0	100.0	100.0	100.0

Source: IHD End-term survey 2015-16

Eighty six percent of the households used their own funds and 13 percent availed government schemes for construction of the facility (Table 2.7). In Jaipur, CFAR helped people residing in clusters to gain access to a personal toilet under Swachh Bharat Mission (SBM). They worked with the government functionaries in identifying the beneficiaries and encouraged and helped the residents of the slums (in both the intervention and non-intervention areas) to fill the form for construction of toilets under SBM. As per the SBM norm, in urban areas the government gives Rs. 8000 as subsidy and the Urban Local Body contributes Rs 4000. Hence on the whole, the households got Rs. 12000 for construction of an individual toilet. As households started getting subsidy and some households completed the construction of toilets, other households were encouraged to apply for the same facility. According to the CFAR representative, they have till now helped 2000 households to fill the required forms in Jaipur. At the time of the end-term evaluation, 320 households in CFAR intervention areas had already completed construction of toilets under the SBM programme. Of these, 250 were from Jhalana Kunda slum, 40 from Soothmill Colony and 30 from other CFAR intervention areas.

Table 2.7: Source of funding for construction of toilet by income group

	Income group	% household by source of funding			Number of households
		Own funds	Under government Scheme	Loan	
Jaipur	Very low	90	10	0	10
	Low	92	8	0	36
	Medium	85	12	4	26
	High	90	8	2	59
	Very high	79	19	1	73
	Total	86	13	1	204

Source: IHD End-term survey 2015-16

The quantitative survey revealed that all the households (31 percent) that did not have a personal toilet due to lack of space and funds for construction had to opt for open defecation. Non-availability of community toilets or poor conditions of the few available CTCs was the main reason.

Box 1.1: Condition of Community Toilets in Jaipur

In Soothmill Colony, there was a community toilet near the cluster, which was provided by the owner of a mill for the benefit of the workers. After the mill closed down, the condition of the community toilet started to deteriorate and neither any government authority nor the owner of mill took any action to revive the condition of the community toilet. So the condition of the CTC continues to remain unchanged.

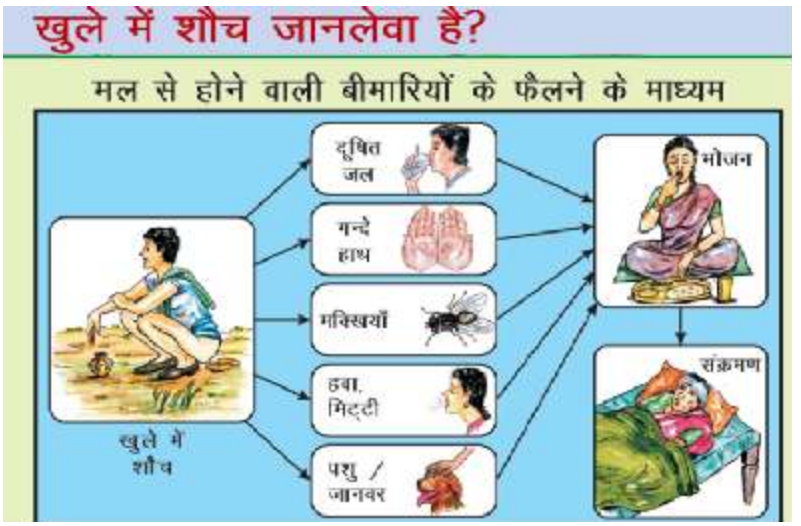
The Jhalana Kunda cluster has a community toilet constructed in the lower part of the terrain, as a result of which it remains water logged and garbage collects in it. This renders it unusable by the people of the cluster. In the Ambedkar Nagar cluster, one community toilet has been constructed, but due to high usage charges (Rs. 5) people are unable to use it. So they use the toilet only during emergencies.

Eighty percent of the households informed that open defecation resulted in several problems including inconvenience (56.8 percent), filthy environment (50.6 percent), lack of privacy (43 percent) safety (38 percent) of family members, and misbehavior by others (33 percent). The distance to the place of open defecation was also a problem for 32 percent of the households, with nearly 45 percent of them saying that they had to go to a place that was 500 meters away. However, just 2.5 percent of the households felt that open defecation may have resulted in health problems for their family members.

In addition, among 69 percent of the surveyed households that had their own toilets, 16 percent disposed their children's excreta in drains and open pits. The rest of them - more than 80 percent - disposed it in dustbins, toilets or bathrooms.

2.1.2c Kolkata

In Kolkata, 92 percent of the surveyed households have personal toilets and there is not much variation in this percentage across group and non-group members, across income category of the household and highest education level of the female. Privacy (35 to 38 percent) and security (36 to 43 percent) of family members were the primary reasons for constructing toilets within homes. In addition, government campaigns (15 percent), shrinking of open spaces (four to five percent), and government subsidy (four percent) were some additional motivational factors (Table 2.8). There were some variations in the reasons across income quintiles. Government campaigns were important among households with low, medium and high incomes. CFAR seemed to have played a important role among very high and very low income groups.



Government campaigns were important among households with low, medium and high incomes

Table 2.8: Reasons for construction of toilet in Kolkata (% of households)

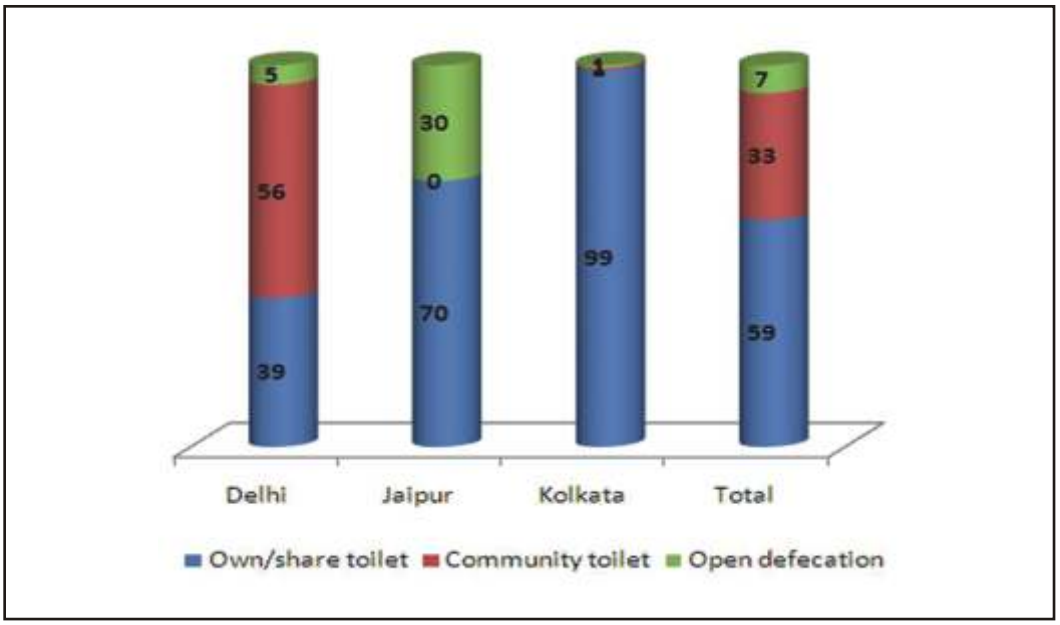
Reasons for construction of toilet	Respondent is a		Income quintile					
	Group member	Non-group member	Very low	Low	Medium	High	Very High	Total
To maintain privacy	34.3	38.1	43.9	38.6	28.6	37.6	29	37.1
Govt. awareness campaign	14.2	14.9	9.3	16.3	15.9	17.8	12.9	14.7
Shrinking of open spaces	3.7	4.7	1.9	5.4	7.9	4	3.2	4.4
Government provided subsidy	3	3.9	2.8	2.7	3.2	6.9	3.2	3.7
Security concern of family members	43.3	35.8	41.1	34.2	44.4	30.7	46.8	37.7
CFAR's or other NGO awareness Campaigns	1.5	2.6	0.9	2.7	0	3	4.8	2.3
Other	0	0	0	0	0	0	0	0.0
Total	100	100	100	100	100	100	100	100

Source: IHD End-term survey 2015-16

Self-motivation (79 percent), encouragement by relatives and friends (12 percent), the MLA (3.7 percent), and CFAR and other NGOs (three percent) were the factors motivating the households to construct their own toilets. Among them, 70 percent also said that their social status had improved after the construction. The households which used their own funds were 77 percent and 21 percent availed of government schemes for the construction of toilets.

Despite having a personal toilet, 24 percent of the households threw their children's excreta in drains and another 24 percent disposed it in open pits. When members of the women's group, Alor Disha, were asked whether any of them had a septic tank, they informed that the government authorities (Pouroshobha) had earlier sanctioned just 30 septic tanks over a huge area (Ukhila Majher Para, Ukhila Loskar Para, Dhalai Para, Mandal Para), while the Baruipur Stadium Para was only allocated 10 septic tanks. CFAR has been spreading awareness regarding the necessity for a septic tank in every household. But this has not happened due to lack of financial support. In the case of houses having the necessary documents, the municipality has helped financially in constructing septic tanks. Every household also took on the responsibility of cleaning their respective shared toilets. In Kolkata, the practice of open defecation and existence of community toilet is almost nil. Those who do not have toilet facilities at home use shared toilets; this practice is most common in Pirottapally. In almost all other clusters people have their own toilet (Graph 2.7).

Graph 2.7: Percentage distribution of households by use of toilet



Source: IHD End-term survey 2015-16

2.1.3 Transformation from baseline to end term

A comparison of end term with baseline clearly indicates a change in terms of increased construction and usage of personal and shared toilets, accompanied by a decline in the extent of open defecation in the two cities of Jaipur and Delhi. While the primary reason for this is having access to a personal toilet across all cities, it is only in Delhi that CTCs have provided toilet facilities to community members. Women's demands and complaints filed for improvements, renovations and construction of CTCs are also resulting in some improvements. While DUSIB provided toilet facilities together with inputs for maintenance from the community, some of the older MCD toilets are yet to improve (Table 2.9).

Table 2.9: Change in access to toilet facility from baseline (BL) to end term (ET) (% of households)

	Delhi			Jaipur			Kolkata		
	Personal/ shared toilet	CT	OD	Personal/ shared toilet	CT	OD	Personal/ shared toilet	CT	OD
BL	27	53	20	51	0	47	100	0	0
ET	39	56	5	70	0	30	99	0	1

Note: CT- Community Toilet; OD – Open Defecation
Source: IHD End-term survey 2015-16 and CFAR Baseline data

A comparison of the prevalent practice of disposal of children's excreta indicates a substantial change from baseline to end term. There has been a reduction in the proportion of households disposing the excreta in open pits and drains. Also, random disposal of excreta seems to have been eradicated. People have started using garbage dumps and dustbins and toilets for this purpose. A change in perception of the women regarding the importance of access to personal toilets seems to have played a crucial role in bringing about a change from the baseline to end term as indicated above. The change is more evident among the group members than the non-group members. The proportion of women, who in the baseline perceived access to toilets as virtually unimportant, had reduced to near insignificance in the end term (Table 2.10).

Table 2.10: Change in the perception of women on the need for toilet facilities

		Before (Baseline)		After (End term)	
		Very low	High	Very low	High
Delhi	Group member	19	27	0	77
	Non-group member	20	19	1	62
	Total				
	20	20	1	64	
Jaipur	Group member	15	3	0	67
	Non-group member	15	1	1	52
	Total	15	2	0	59
Kolkata	Group member	1	31	0	77
	Non-group member	2	26	2	66
	Total	2	27	1	69

Source: IHD End-term survey 2015-16

2.1.3a Delhi

In Delhi, there has been an increase in the proportion of households having access to personal or shared toilets from 27 percent in baseline to 38 percent in end term. This seems to be the primary reason for the reduction in the proportion of households opting for open defecation.

However, there does not seem to be any change in the availability of community toilet facilities. In the city, the distance of community toilets from the cluster continues to be a major problem in both the baseline (71 percent) and the end term (44 percent). However, the proportion reporting this has declined. Households located at a distance from the CTCs do not find it convenient to use them and resorting to open defecation can be a very insecure option given the number of cases of women being abused or facing violence under these circumstances. Thus, several households constructed personal or shared toilets for ensuring safety and security of the family members, subject to availability of space and access to funds.

CFAR too has played a significant role in bringing about a change in the perception of the people.

New CTC after registration of complaint: *In Kalyanpuri block- 18 cluster of Delhi, people had to go 2-3 kilometers from their cluster to defecate. After forming the group, and joining the "Mahila Pragati Manch" (MPM) women members of the group made various formal complaints and applications for a CTC to DUSIB after discussions among themselves in their group meetings as well as with CFAR members. As a result with the help of DUSIB and constant pressure from MPM, a CTC was constructed in the cluster. The earlier CTC of 80-odd seats was in poor condition and not usable. This new CTC has 52 seats and is being used by the inhabitants with a sense of ownership among them.*

Motivation for construction of personal toilets: *In another example, CFAR's intervention and the resulting increase in awareness have made it possible for residents to have personal toilets in almost every household of the Sunlight Colony cluster. The Mahila Pragati Manch in this cluster is very active and has encouraged almost every household to construct its personal toilet. The motivation and intervention measures of the Mahila Pragati Manch could work since the CTC of the cluster was almost dysfunctional.*

Community hall demanded instead of CTCs: *Having achieved this positive outcome of constructing personal toilets in Sunlight Colony, the group no longer felt the need for renovation of the toilet complex. Women of the community expressed the need for a community hall wherein cultural and religious functions could be held.*

Along with CFAR members, cluster people wrote several applications for conversion of the community toilet into a community hall. After several applications, the MLA passed the proposal. Now the CTC is functioning as a community hall and people are enjoying the benefits of it.

Renovation of CTC: *Rajasthan camp is a Jhuggi Jhopri cluster having 600 households. Approximately 3000-3500 people reside here. The primary concern of the community was repairing the community toilet complex. The condition of the CTC was bad; out of 20 seats, seven were working (four for women and three for men). There was no exit for human excreta. All the human waste went into an open drain behind the toilet. The women's group with support from the CFAR team approached DUSIB and the MLA of the area. They discussed the problem with them. After many visits and discussions with the authorities, the MLA passed the budget for renovation. Renovation work started in January 2013 and finished in March. Now the CTC is working properly and benefiting 600 odd households. (CFAR's process report also documented this case). During the end-term evaluation, it was noted that this CTC constructed by DUSIB is functioning well with 24 seats (12 each for men and women).*

Complaint filing

CFAR members assisted the people in its intervention areas in filing complaints with the concerned authorities if the community toilets, were not being maintained.

Baseline and end term comparison indicates that during baseline, four percent of women respondents filed complaints, 20 percent did not file any complaint thought they knew whom to complain to, and 76 percent gave no response. Among those who filed a complaint, 61 percent approached local leaders and the rest went to the government officials or councilors. Most complaints were in the form of oral communication.

People in CFAR's intervention areas were assisted in filing complaints if the community toilets were not being maintained properly

The end-term survey indicated that 26 percent of the households knew who to complain to if the community toilet was not in a useable condition. Among them, almost 80 percent had filed a complaint; 61 percent had approached local leaders, 24 percent went to the municipal office and eight percent went to CFAR members for help. Just 16 percent of the complaints were written complaints and the rest were oral.

Further, unlike the baseline survey, when all the complaints reported, though few, were filed by people from Rajasthani camp, in the end term, people from other camps also came forward to get their grievances addressed.

Another notable feature of end term relates to the fact that not only did the number of complaints that were filed increase but after the intervention, many more issues were being addressed. During the baseline, problems relating to 19 out of a total of 26 complaints were solved. In the end term, as the Table 2.11 indicates, 64 complaints out of a total 172 were resolved, either partially or fully.

Table 2.11: Filing of complaints and their solutions in Delhi slums (% of women)

Slum/cluster	% distribution Yes fully resolved	Yes partially resolved	Not solved	Total number of women who complained
Indira camp Kalyanpuri	12	42	45	33
Indira camp Khichripur	30	40	30	11
Indira camp Trilok Puri	25	0	75	4
J.J. Camp Anand Vihar	29	43	29	7
Jain Mandir	22	44	33	18
Jhilmil Industrial Area	8	50	42	12
Navjeevan Camp	17	17	67	6
NTPC Subhash Camp	13	63	25	16
Old & New Priyanka Camp	50	25	25	4
Priyanka Camp	20	20	60	5
Rajasthani Camp	64	14	21	28
Rajeev Camp Jhilmil Colony	0	75	25	4
Rajiv Camp Chitra Vihar	0	77	23	13
Shashtri Mohalla	0	33	67	3
Subhash Camp Dakshin Puri	25	25	50	8
Total	24	40	36	172

Source: IHD End-term survey 2015-16

2.1.3b: Jaipur

There has been an increase in the proportion of households having access to personal or shared toilet facilities in Jaipur, from 51 percent at baseline to 69 percent at end term. However, the level of open defecation continues to be high at 36 percent of the households, declining marginally from 47 percent at baseline. Slum clusters in the city continue to face problems due to lack of usable community toilet facilities. In some clusters, households have constructed their own personal toilets wherever feasible.

For instance in Jhalana Kunda, three years ago most people used to go for open defecation where they faced several difficulties. CFAR members discussed the importance of constructing toilets with them and the problems arising from lack of access to sanitation facilities. Since then, several households have constructed personal toilets.

In order to generate awareness of the Swachata Abhiyan (cleanliness campaign), CFAR had organized camps where people registered their name for the construction of a toilet. Under this scheme, the Jaipur Nagar Nigam gave Rs. 8000 as grant for the construction of a toilet to each household. As a result of this exercise, most of the cluster people do not go for open defecation anymore. People are paying more attention to sanitation because of the constant meetings and discussions by the cluster group with CFAR members, where the harmful effects of open defecation are discussed.

CFAR staff took group members to Delhi and Bikaner, where they were exposed to two-pit toilets and other types of toilets. A two-pit toilet consists of 2 deep pits, which are used one after the other, and can be constructed at little cost with local materials. It has a working life of three years. On returning, the group members themselves constructed a few two-pit toilets. That night it rained. Next morning, when they went to the pit, they saw that all the water was absorbed within the pit. They showed it to other households and explained the relevance of this kind of toilet in dry areas like Jaipur. This encouraged other households to construct similar toilets, which are cost effective and require minimum water and space. It is user friendly due to high soaking capacity, which is relevant given the climate of Rajasthan.

Community representatives were taken to Delhi and Bikaner to observe how two-pit and other types of toilets were constructed

There has been a steep reduction in the proportion of households disposing excreta in open pits and drains. The random disposal of excreta has also declined and in place of it, community members are using garbage dumps or dustbins. A change in the perception of women regarding the necessity of a toilet is clearly visible among both group and non-group members. The proportion of women who lacked awareness on the importance of a toilet reduced to nil at end term (Table 2.10).

2.1.3c Kolkata

In the surveyed clusters, men, women and children of 73 percent of households used a toilet at home. In the intensive clusters this increased to 81 percent at end term as compared to only 51 percent during the baseline survey. The percent of households using shared toilets was 26 for men, women and children. In the intensive cluster this percent reduced to 17 as compared to 49 percent during the baseline survey. At Pirottopally there is a lack of adjacent bathrooms in households. Because of the immense pressure, the majority of the community use shared toilets, which are filthy and unhygienic especially for the women . However, the necessity for toilet facilities is now recognized by several group and non-group women members.

Concluding remarks

CFAR's intervention generated a significant change in women's perception of the need for a toilet in the house, as well as the problems associated with open defecation. The number of women ascribing high priority to this increased from less than one-third during the baseline to over two-thirds at end term. These women included both group and non-group members. Thus, it is hardly surprising that several households have now constructed personal toilets wherever feasible. It is primarily for privacy and security reasons that the households opted for constructing their own toilets. However, lack of space and resources, as well as tenure security pose hurdles and challenges. The introduction of two-pit dry latrines which require less water and are easy to manage in states like Rajasthan is an innovative venture which has been well received by the community in Jaipur. Exposure and support, both technical and financial, helped households with access to space to build personal toilets.

2.2. Clean Surroundings

The lack of clean and sanitized surroundings in locations where the poor live is as much an outcome of inadequate facilities and services as the unhygienic practices among the inhabitants due to lack of awareness. The CFAR intervention aimed to address both these concerns to the extent possible with help from relevant agencies and institutions responsible for public provisioning of infrastructure and services and through partnerships with other agencies that were involved in similar work in some of the clusters.

Slums are generally located near sewerage drains, garbage dumps, and unused waste land. Locational disadvantages and unhygienic practices related to disposal of garbage by people have negative health consequences. In some clusters people were well aware of the need for cleanliness in their houses but ironically they did not pay much heed to cleanliness of their surroundings and, as a result, they dispose their garbage randomly anywhere in the locality. Garbage disposal in urban areas, particularly in slums, is a major concern when it comes to planning for urban development. It is important to generate awareness among the slum dwellers and inform them about hygienic ways to dispose the garbage as well as providing them with essential services for this. Before the intervention, services for disposal, collection were lacking and garbage was often strewn all over the cluster. However, since the intervention, the public bodies collect the garbage from the premises of households or from some fixed designated place in the slums. In some areas the residents themselves make arrangements for carrying the garbage to the dumping place.

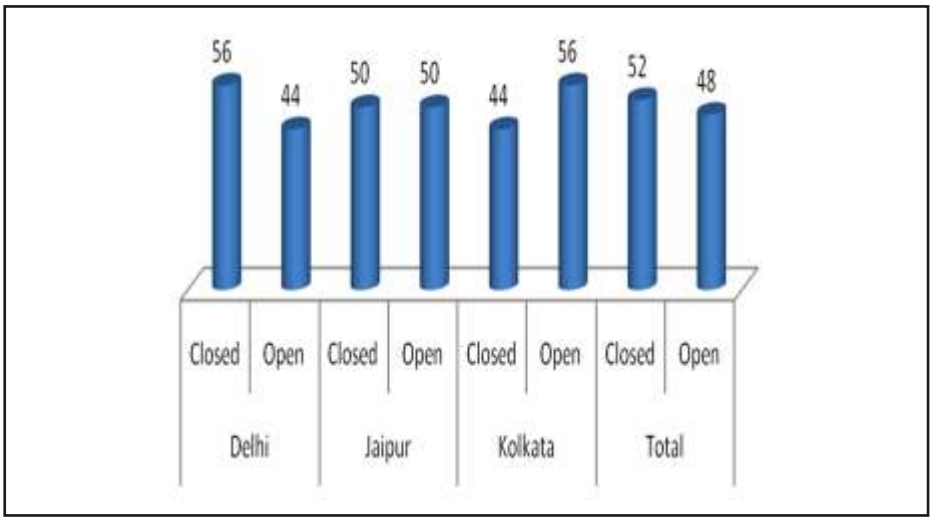
In some clusters people started cleaning the drains themselves

This section analyses the status of garbage disposal and street cleaning in slums clusters in Delhi, Jaipur and Kolkata at the end of the four-year intervention by CFAR. The first subsection deals with the availability of dustbins in selected slums; the second subsection is an analysis of the places where household garbage is disposed of; the third subsection depicts the arrangement of removing garbage from the clusters; the fourth subsection explains the complaint mechanism relating to garbage disposal; the fifth subsection discusses the transformation of these slums over the period of four years with respect to garbage disposal and street cleaning.

2.2.1 Garbage disposal, drainage and street cleaning

The manner in which the slum residents keep their daily waste material within their houses is very important for understanding the extent of their awareness regarding basic hygiene and sanitation. Garbage should be kept separately in closed dustbins so as to prevent the spread of foul smell and germs in the house. Findings from the end-term survey show that 52 percent of total households are now keeping their garbage in closed dustbins, while the remaining 48 percent keep it in open containers (Graph 2.8).

Graph 2.8: Percentage of households by type of dustbin used for disposing garbage



Source: IHD End-term survey 2015-16

The waste material collected at home should be disposed in a proper manner so as to prevent spread of diseases within the cluster. Putting it in the MCD van, the community dustbin or giving it to the paid sanitation worker may be considered as some of the best community practices. However, the end-term evaluation revealed that just half of the total surveyed households followed such practices, mainly due to lack of access to garbage disposal facilities. Twenty six percent of the households put the garbage in community dustbin, 16 percent in the MCD van and nine percent give it to the sanitation worker. Among the rest, half, or 33 percent, just threw their garbage in open grounds or lanes outside their houses, 13 percent threw it in empty plots, while eight percent dumped it in open drains (Table 2.12).

Table 2.12: Percentage of households by manner of garbage disposal

	Delhi	Jaipur	Kolkata	Total
In open drain	10	15	2	8
MCD van	9	3	37	16
In community dustbin regularly	38	22	1	26
In community dustbin occasionally	3	0	1	2
Outside on lane in non designated area	3	1	1	2
Open grounds/road side	30	49	23	31
Empty plots	9	16	19	13
Sweeper collects it from the house	1	11	26	9
Others	5	2	5	5
Total	100	100	100	100

Source: IHD End-term survey 2015-16

Even if the slum households follow the necessary practice of collecting their garbage in a proper place and manner, the lack of regular services by MCD vans and municipal workers prevents cleanliness in the slums. The end-term survey showed some improvement in the availability of such facilities, with garbage being collected by the MCD in 64 percent of households. Another 32 percent said that it is not

collected by anyone (Table 2.13). The FGDs revealed that sanitation workers would rarely visit the cluster; if they did, they would avoid entering the interiors of the cluster to clean the drains and streets. After the CFAR intervention, the slum residents began to form groups and take the responsibility of keeping their clusters clean and safe.

Table 2.13: Collection of garbage from the cluster (% of households)

	Delhi	Jaipur	Kolkata	Total
Contractor	5	0	0	3
Municipal corporation	60	75	67	64
Not collected	35	22	32	32
Others	1	3	0	1
Total	100	100	100	100

Source: IHD End-term survey 2015-16

2.2.1a Delhi

The quantitative survey in Delhi showed that 56 percent of the households keep their waste material in closed dustbins and the remaining 44 percent in open dustbins. Again, nearly half the surveyed households — 38 percent — put their collected garbage in the community dustbin; nine percent put it in the MCD van and one percent gave it to a paid sanitation worker. Among the rest, 10 percent threw it in open drains, 33 percent in open grounds, road sides and lanes outside the house, and nine percent in empty plots.

The collected garbage was picked up by the municipal corporation in the case of 60 percent of the households. Thirty five percent said that the garbage was not collected by anyone and five percent said that the contractor got this job done. After the CFAR intervention, the dependence on sweepers for cleaning the streets and drains declined and now people of the cluster at several places do it themselves.

The FGDs in Delhi clearly supported the quantitative findings discussed earlier. Some such instances are cited below.

In clusters of Sunlight Colony there is a dumping pit made by the MCD and residents throw their daily garbage into the pit. The waste is carried away from the dumping pit, on a weekly basis by MCD.

In some clusters like Priyanka Camp and Kalyanpuri, due to absence of community dustbins or any other public arrangement for garbage disposal, people throw their garbage on streets, open spaces or drains.

In the clusters of Shastri Mohalla, garbage is usually disposed of in the community dustbin or a nearby dumping yard. MCD comes with a crane to clean the dumping yard. However, people complained that the MCD's cranes do not visit the area on a regular basis.

2.2.1b Jaipur

The end-term survey indicates that presently half of the surveyed households use closed dustbins within their households for disposal of their garbage. Garbage was dumped in the community dustbins by 22 percent of households, 11 percent gave it to a paid sanitation worker and three percent put it in the MCD van. Almost half the surveyed households had the habit of throwing their garbage in open grounds, the road side or outside lanes, 16 percent threw it in empty plots and 15 percent in open drains. Seventy five percent of the surveyed households said that the municipal corporation got the garbage collected from their cluster, and 22 percent said that the garbage was not being collected. The

contractor did not seem to play a role in the city. However, lack of frequent visits by the MCD may be the reason for the unhygienic garbage disposal practices in the slums.

CFAR members helped the people of the clusters in lodging complaints with the authorities for garbage disposal and drainage related problems. At several places the people themselves formed groups to undertake these tasks.

The following are some Instances from FGDs in Jaipur:

In many areas youth groups and women groups alternately clean the streets every fifteen days

Earlier, people in Soothmill cluster used to dispose their garbage in open plots or on the railway track. The women visited the municipal officer several times for getting the garbage disposal problem solved. When no action was taken, the women's group went to the municipal zone office and submitted a written complaint, following which the Nagar Palika placed a community dustbin in the cluster. Once the dustbin was placed, it was regularly used by the people of the cluster but was never cleaned by the municipal workers. So the women's group had to again lodge a complaint. Now municipal workers regularly clean the community dustbin. As no sanitation worker visits the cluster for cleaning the streets and drains, every household cleans the road in front of the house and disposes the garbage in the community dustbin. Members of the youth group and women's group alternately clean the drains every fifteen days.

In the Jhalana Kunda cluster, people residing near the big drain would throw their garbage directly into the drain. Post CFAR intervention, the people of the people of the cluster stopped this practice and the drain was also cleaned to prevent the spread of diseases.

In the Ambedkar Nagar people of the cluster disposed their garbage in a dustbin kept outside every house. The garbage was then thrown into a big dustbin kept outside the cluster between 10 am and 4 pm. This was made possible after the filing of several complaints by the community with the help of CFAR members.

2.2.1c Kolkata

Quantitative findings from Kolkata showed that 44 percent of the total households used closed dustbins in their home, while 56 percent used open dustbins. There was not very much variation between the intensive cluster and the group members. But it was strikingly high for the non-group members and in the extensive cluster: 71 percent of households used an open dustbin and only 29 percent used a closed dustbin in the extensive cluster.

Garbage collected in the house was disposed of in the municipal corporation van by 37 percent of the households, while 26 percent gave it to the paid sanitation worker and one percent put it in community dustbins.

Thus 64 percent of the households have developed a practice of disposing their waste material in a proper manner. Among the rest, eight percent throw it in open drains, 33 percent in open grounds, road sides, or lanes outside their house and 13 percent in empty plots. Lack of community dustbins in the city seems to be a major hurdle in developing proper garbage disposal practices in the clusters.

At Pirottopally, some of the members were aware of the need for using dustbins in their homes but the majority of them still followed the practice of throwing the garbage in open grounds, ponds or drains. With respect to collection of garbage from the cluster, 79 percent of households in the intensive cluster reported that the municipal corporation performs the job whereas 20 percent of the households

reported that the waste was not collected. In the extensive cluster the picture is somewhat different: 43 percent of households had the garbage collected by the municipal corporation and almost 57 percent of households reported that the waste was not collected. The corporation started sending a garbage truck to collect garbage in several clusters after repeated complaints submitted by the communities with the help of CFAR.

2.2.2 Transition from baseline to end term - household practices and service availability

The transition in terms of awareness about the proper manner of garbage disposal, and availability of garbage collection and drain cleaning facilities from the baseline to end term was clearly visible in the end-term evaluation. Now, a larger section of households are able to make collective or individual efforts to approach the concerned authorities by filing complaints against non-availability of such basic facilities. In several clusters, households have even taken the initiative of forming groups and taking upon themselves the responsibility of keeping the slum clean.

Over the period of four years between the baseline and end term, the proportion of households disposing their garbage in closed dustbins rather than open dustbins has increased (Table 2.14). The manner of disposing the collected garbage outside the house has also changed with MCD vans being visible in slum areas.

Table 2.14: Percentage of households in Delhi, Jaipur and Kolkata by manner of garbage disposal

	Baseline		End term	
	Closed bins	Open bins	Closed bins	Open bins
Delhi	67	33	56	44
Jaipur	28	72	50	50
Kolkata	1	99	44	56

Source: IHD End-term survey 2015-16

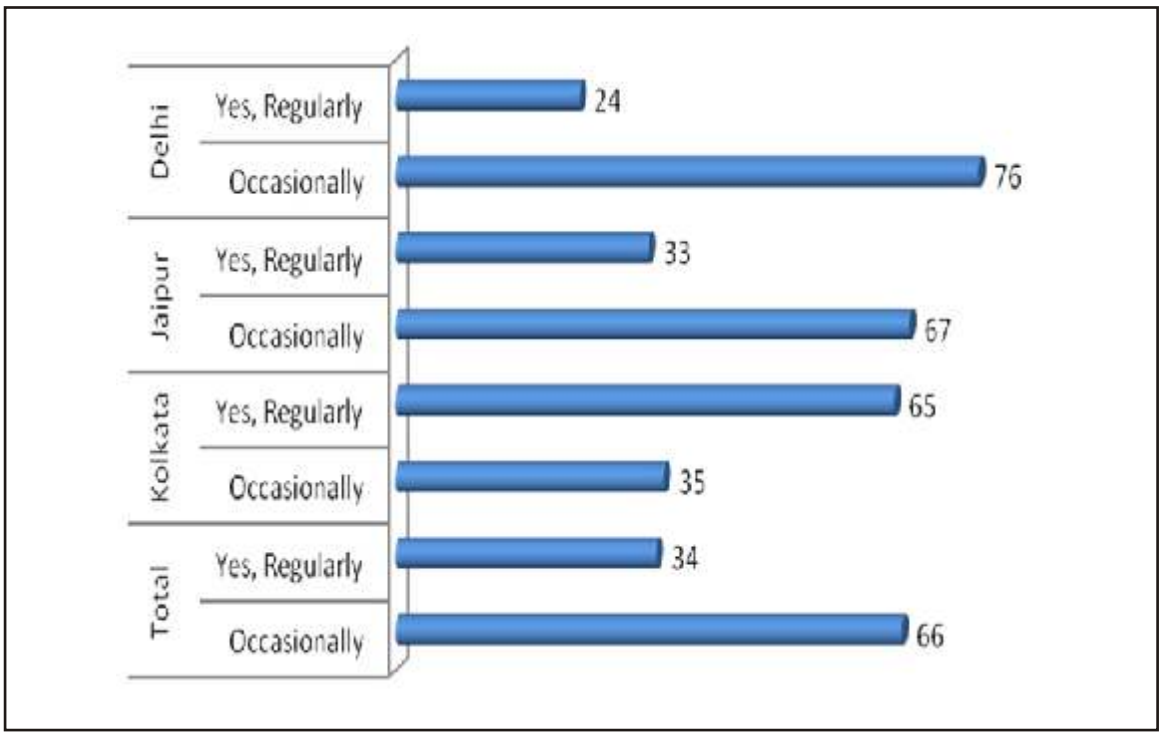
In the surveyed slum clusters, there was some improvement in the availability and usage of community dustbins for garbage disposal by the time of the end-term survey (Table 2.15). However, just 34 percent of the households during end term said that garbage from the community dustbin is removed on a regular basis by the concerned authorities (Graph 2.9).

Table 2.15: Availability of Community Dustbins

	Baseline	End line
Delhi	67	44
Jaipur	19	35
Kolkata	4	8

Source: IHD End-term survey 2015-16

Graph 2.9: Is garbage from the community dustbin removed on a daily basis (% of households)



Source: IHD End-term survey 2015-16

Cleanliness of drains and the availability of sanitation workers in the slum clusters are generally ensured by the municipal authorities.

A baseline to end term comparison indicated that the sanitation workers role had been declining and was being replaced by self-cleaning initiatives of the communities. The main reasons for such a change has been the non-availability or infrequency of the worker , refusal of the worker to clean the interiors of the slums, overflowing drains, non-cooperation by municipal authorities, etc. Awareness generated by CFAR regarding the necessity of keeping the surroundings clean has motivated and facilitated the communities to rely on itself (Table 2.16).

Table 2.16: Cleaning the drains and streets (% of households)

	Baseline			End term		
	Sweeper	Self	Other	Sweeper	Self	Other
Delhi	64	34	2	56	44	-
Jaipur	20	79	1	20	80	-
Kolkata	65	34	1	11	89	-

Source: IHD End-term survey 2015-16

2.2.2.1a Delhi

In Delhi, the percentage of households disposing garbage in open grounds, road sides and open lanes decreased from 34 percent to 28 percent; nine percent of households used MCD vans for this purpose. Dependence on sanitation workers for cleaning the drains and streets declined from 64 percent to 56 percent and self-cleaning increased from 34 percent to 44 percent.

Several instances from FGDs clearly indicate the change.

In the cluster of Kalyanpuri block, people throw their garbage in a community dustbin from where the MCD van regularly collects the garbage. One women said "सुबह का कूड़ा शाम को फेंक देते हैं और शाम का कूड़ा अगले दिन फेंकते हैं" (We throw the garbage in the morning and in the evening. The garbage thrown in the evening is collected the next morning.)

In the Nandnagari cluster, women told us that the kudewaali (sanitation worker) comes regularly and collects the garbage from their homes or from the community dustbin near the CTC. Each household pays Rs.30 per month for this.

In the NTPC Subhash Camp, people said that earlier they were not so keen on keeping their surroundings or the slum clean. They used to keep their houses clean but cared little about cleanliness outside the house. CFAR members created awareness among the people and organized several health camps. Since then, people of the cluster have started making an effort to keep their area clean.

In the same cluster, 21 households in a particular gali (lane), filed several complaints with the concerned department for getting the drains cleaned. Even the sanitation worker would just clean the main road, leaving the interior as it is. Thereafter, all the 21 households decided to clean the drains collectively. They divided the households into seven groups with three members in each group. The groups were responsible for cleaning the drains on a rotational basis. CFAR members recounted this story in other hamlets of the cluster so that they could also replicate this practice in their areas. In the cluster of Shastri Mohalla, drainage was a major problem three years back. Broken and overflowing drains used to fill the surrounding area with slush, making it difficult to even walk. It became a breeding ground for flies and mosquitoes. Small children would often fall into the drain. The problem was raised in one of the community meetings. A letter on behalf of the community was then written to the MCD requesting them to get the drain cleaned. But no action was taken by them. Finally, four community women along with CFAR team members followed it up with the MCD sanitation department. As a result MCD sanitation inspector assured the residents of immediate action.

In the cluster of Rajeev Nagar, 20 women and adolescent girls participated in drain and street cleaning activities on the occasion of Swachh Bharat Mission. Seven officials including sanitation workers cleaned the drains in two lanes and reached out to 60- 70 households.

In Rajasthani camp, the adolescent group has played a significant role in ensuring proper garbage disposal practices in the cluster. The group started this from their own homes by making sure that garbage is always thrown in closed dustbins. They also requested MCD people to pick up the garbage from different places in the locality. They started sticking posters at different places that said, "Yaha kuda phekna mana hai (Dumping of Garbage is not allowed here)". They implemented this initiative under the guidance of CFAR members.

In the Anand Vihar slum, the households used to throw garbage in front of the CTC. Despite many requests, the practice could not be stopped. The CFAR members discussed the problem with the caretaker of the CTC. It was then decided to use the space outside the CTC to plant flowers. At present people do not throw garbage in this space. One household member remarked 'जहां फूल खिल रहे हैं वहां कैसे कूड़ा फेंके' *(How can we throw garbage where flowers are blooming?)*

2.2.2.1b Jaipur

The baseline-end term comparison in Jaipur indicates that among the surveyed slums, there has been a 20 percent increase in the proportion of households using closed dustbins and a consequent decline in the usage of open dustbins. At the same time, the proportion of households disposing their garbage in open drains has declined from 20 percent to 15 per cent and in open grounds and outside lanes from 59 percent in baseline to 46 percent in end term. The proportion of households using community dustbins has also increased and 2.3 percent now use municipal corporation vans as well. Although, the availability of community dustbins for garbage disposal has increased from 19 percent to 35 percent, 67 percent of the households said that garbage from these dustbins was not removed on a regular basis.

Dependence on sanitation workers does not seem to have shown much decline, but self-cleaning has shown a marginal increase from 78.6 percent to 80 percent.

Several instances from our FGDs indicate a change which has been facilitated by CFAR members.

Persistent demands leading to results:

Earlier, the people in the cluster of Ambedkar Nagar did not have a dustbin inside their house or a community dustbin. People used to throw their garbage outside the house in open spaces or on the road. Post CFAR intervention, the situation has changed. People have understood the importance of keeping their garbage separately in closed spaces. Now they use a dustbin for collecting their daily waste material. In order to keep the cluster clean a community dustbin has been placed in the cluster as well, where all the people throw their garbage from 10 am in the morning to 4 pm in the evening. This was made possible by the efforts of CFAR members who helped the people of the cluster in filing repeated complaints with the Nagar Nigam, till the problem was finally addressed by the authorities.

Self-cleaning of drains:

The intervention enabled people to get small drains constructed in front of their houses which are linked to the big drain

In the cluster of Jhalana Kunda, there were no drains three years back. Water from the houses used to flow directly on to the road. Water-logged roads made life difficult for the slum residents, particularly for the children and the elderly. There is a big drain located in the slum cluster, which has not been cleaned in the last 8-9 years. The intervention by CFAR led to several improvements: the drain was cleaned; a "pucca" road was constructed in the cluster; and people also managed to get small drains constructed in front of their houses. These small drains were then connected to the big drain, solving the water- logging problem. The people of the cluster themselves clean these drains.

In the Soothmill cluster, there is no sanitation worker to clean the streets and drains. So every household cleans the roads in front of their house and disposes the garbage in the community dustbin. In the case of drains and pits, the members of the youth group and the women's group take the responsibility of alternately cleaning them every fifteen days.

In the J P colony cluster, there is an open space (near the community centre of Gurjar Chowk), where people of the cluster dispose all their garbage. This garbage has never been picked up by anyone so the place had become a breeding ground for mosquitoes, insects and worms, seriously affecting the health of the people residing around it. The people of the cluster filed complaints with the Nagar Nigam several times. However, nothing was done. As a last resort, the women's group decided to sit near the open space in order to stop people from throwing their garbage there. Their efforts were successful and raised awareness among the people about the importance of keeping the surroundings clean. Now the roads in the cluster are also cleaned by the sanitation worker on a daily basis. Every household pays him Rs 20 per month.

2.2.2.1c Kolkata

Garbage disposal practices in the selected slums of Kolkata have shown a clear transition from the baseline to the end term: All the households used open dustbins at the time of the baseline survey; by the time of the end-term survey, 44 percent were using closed dustbins and 36 percent of the

households were disposing of their garbage in municipal corporation vans. However, community dustbins were absent both during the baseline and the end-term surveys.

The survey result shows that CFAR intervened more actively in the intensive clusters in spreading awareness on using closed dustbins as compared to the extensive sector. Though CFAR has been instrumental in motivating the group members to use closed dustbins they are yet to do the same with the non-group members. In the city, there is not much increase in the availability of community dustbins (four percent in the baseline to eight percent in the end term). Dependence on sanitation workers for cleaning the drains and streets has declined from 65 percent to 11 percent and self-cleaning has increased from 34 percent to 89 percent.

Several instances from the FGDs indicate a change which has been facilitated by CFAR members.

Earlier, in the Uttarkumrokhali cluster, women used to throw their garbage outside the house in nearby ponds, or streets, making the surroundings dirty. After the intervention by CFAR, women are aware of the importance of cleanliness. Within their houses, they throw waste material in proper dustbins and outside their house; they dispose it in the dustbins placed within the locality or in the corporation vehicle that is collecting wastes. Since the area has open drains, the water tends to overflow and pollute the water in the ponds. The women continue to use this contaminated water for daily purposes, thus exposing themselves and their families to health risks. However, following CFAR's visit to the area, women from the cluster have started cleaning the drains and streets to prevent water-logging.

In the cluster, drains are open and never cleaned. During rainy season, water from them overflows and fills the street. Being connected to the pond, it pollutes it as well. In addition, there is no community dustbin in the cluster. People dispose their garbage in the MCD van whenever it comes to the slum, which is occasionally. Hence, the garbage is often thrown into drains and ponds, making the situation pathetic. CFAR organized several awareness-raising camps to motivate people to keep their surroundings clean and stop throwing garbage in drains and ponds. Thereafter, people of the cluster contributed money to set up a community dustbin for throwing household waste material.

In the Purbopara cluster, the main problem was the lack of drainage facilities. Post CFAR involvement a proper drainage system has been constructed in the area. But drainage of individual houses is still a major concern. CFAR is spreading awareness regarding the installation of a septic tank in every household but this has not been successful due to lack of financial support. In the case of houses having proper paperwork, the municipality has helped financially in constructing septic tanks. There are also multiple complaints regarding the negligence of the municipality in cleaning the main drainage which causes blockages in the other drains. Further, a proper garbage disposal facility has also been put in place following the intervention. Members of the cluster group arranged a rally in order to spread awareness about proper garbage disposal and hygiene practices. They also drew graffiti on the walls of the locality to indicate the importance of the issue.

When asked about the cleaning of the street 88.5 percent of the total households reported that this was done by the sanitation worker while the rest cleaned them on their own. Only two percent of the households reported that they paid the workers for collecting garbage from the home or cleaning the street. The women themselves took the responsibility for keeping the streets clean.

2.2.3 Complaint filing

Knowledge of the concerned authorities

An important dimension of awareness generation is the knowledge of which authority to complain to in the case of non-availability of services. The end term findings indicated that CFAR members were successful in their efforts in this direction (Table 2.17).

Table 2.17: Knowledge of whom to complain to (% of households)

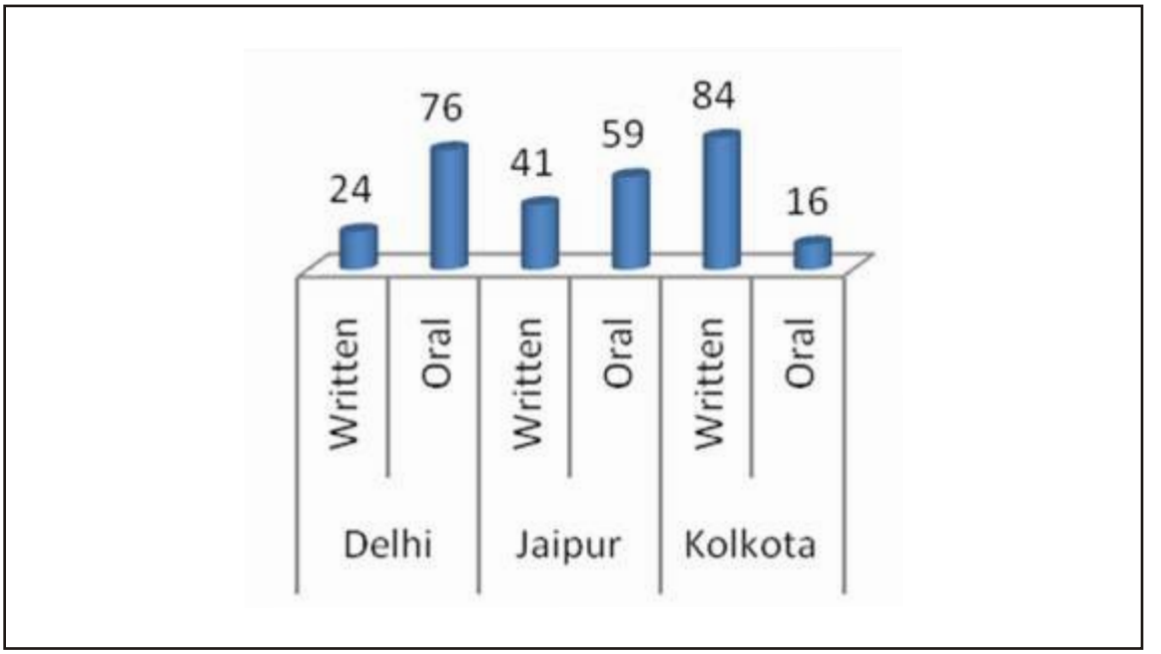
	Delhi	Jaipur	Kolkata
Intensive	24.4	55.9	60.3
Extensive	14.3	37.5	33.8
Group member	60.3	69.2	72.1
Non-group member	14.1	41.1	44.7
Total	20.9	53.5	51.3

Source: IHD End-term survey 2015-16

Approaching the concerned authorities :

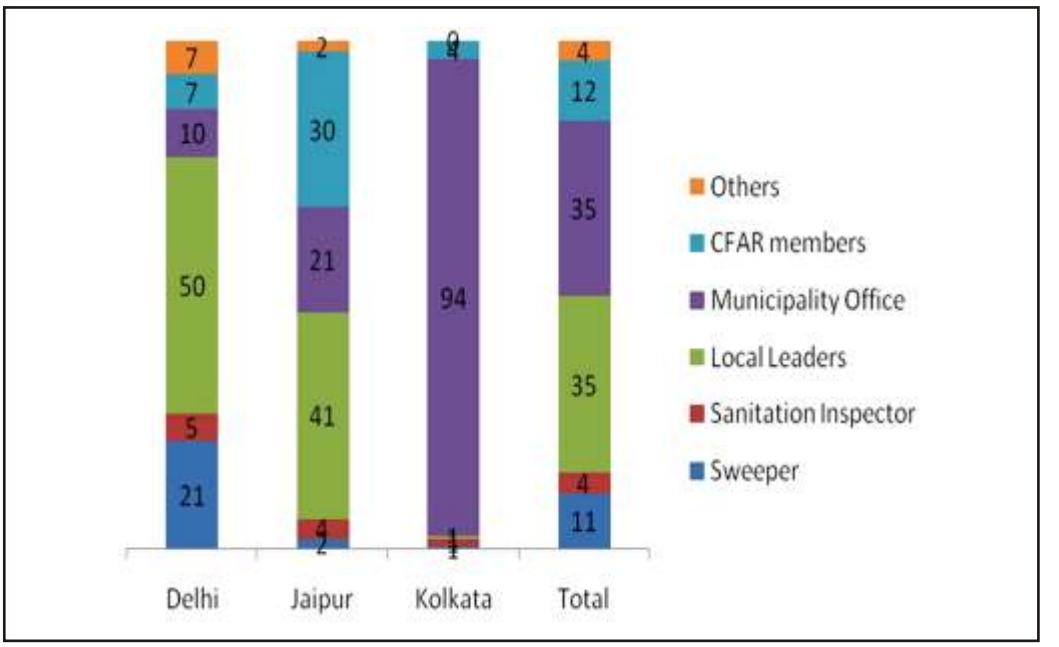
Raising their concern by filing complaints with the concerned authorities is extremely important. Among the section of women who were found to be aware of the concerned authorities, 43 percent actually made the effort of filing the complaint. Also, 88 percent of those filing complaints took the initiative in collaboration with their group and/or CFAR members. The manner in which the complaint is filed partly determines its effectiveness. For instance, a written application or complaint is more effective than an oral interaction (Graph 2.10 and 2.11).

Graph 2.10: Mode of complaint for issues (% of households)



Source: IHD End-term survey 2015-16

Graph 2.11: Respondents' perception regarding solutions to the complaints made (%)

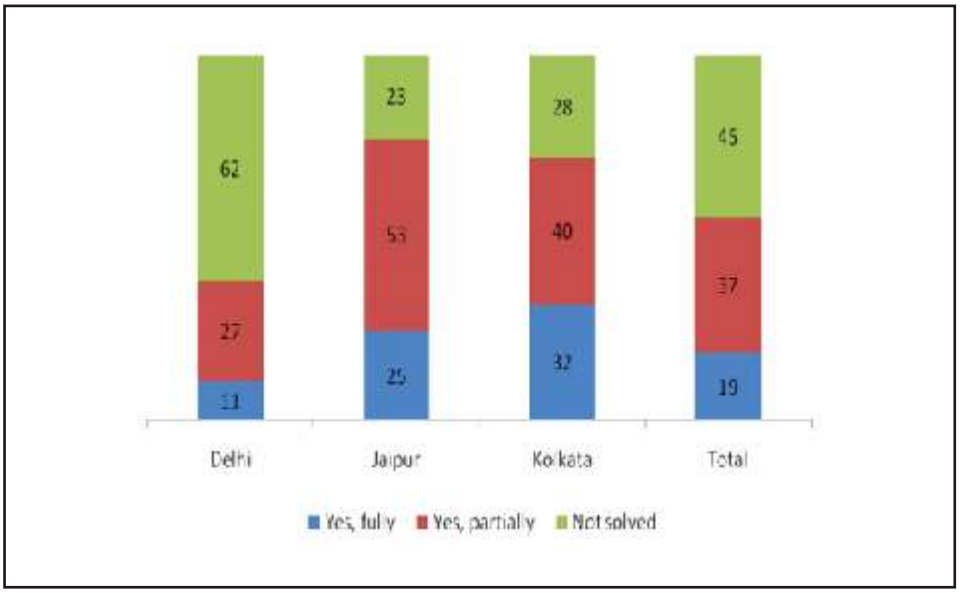


Source: IHD End-term survey 2015-16

Most approachable by the community for problems solving :

In the case of drainage, garbage disposal and street cleaning problems, 35 percent of the total surveyed households said that local leaders were most approachable, and another 35 percent named the municipality office. Twelve percent felt that CFAR members were easy to approach and communicate with (Graph 2.12).

Graph 2.12: Percentage distribution of women by the person most approachable



Source: IHD End-term survey 2015-16

2.2.3a Delhi

In Delhi, about one-fifth of the total surveyed households said that they knew whom to complain to. Among the group members the proportion was higher at 60 percent. Sixty two percent of the aware women said that they had filed a complaint and 90 percent of these said that they had made a collective

effort in this direction. The end-term survey showed that women from intensive and extensive clusters were equally active in approaching the concerned authorities regarding non-availability of basic services.

Twenty four percent of the women, who had filed a complaint, did so in a written format and group members were more informed in this regard. However, more than 60 percent of those who had filed a complaint said that their problem was not solved. Verbal communication of the problem may be a reason for it.

Almost half the slum dwellers found local leaders to be the most approachable, while 21 percent felt that talking directly to the sanitation workers was easier.

2.2.3b Jaipur

More than 50 percent of the households said that they knew whom to complain to with regard to garbage and drainage related problems. Sixty percent of the women said that they had filed a complaint and 16 percent of them made such efforts at an individual level. Women from intensive clusters were more active (62 percent) than those from extensive clusters (33 percent), clearly indicating the important role played by CFAR. Also, 41 percent of the women filed a written complaint and among group members this percentage was higher at 47 percent. A fourth (25 percent) of the women said that their problem was fully solved and 53 percent said that it was partially solved. As in Delhi, in Jaipur 41 percent felt that local leaders were easiest to approach with regard to their problems; 30 percent found CFAR members and 21 percent felt the municipality office were the most approachable.

2.2.3c Kolkata

In Kolkata, more than half of the total households said that they were aware of the concerned authorities. Eight percent of the women said that they had filed a complaint and 11 percent of them had made individual efforts. Further, 22 percent of the women who were taking such initiatives were from intensive clusters and three percent from extensive clusters. The greater participation of women from intensive clusters may be due to training by CFAR members.

As far as manner of complaining is concerned, 84 percent of the women filed a written complaint; the proportion was higher among the group members (97 percent) than among non-group members (69 percent). Further, 32 percent said that their problem was fully solved and 40 percent said that it was partially solved.

Almost all (94 percent) of the surveyed households felt that the municipality office was the most approachable authority during crisis situations arising from the lack of proper garbage disposal and drainage facilities.

Concluding remarks

There is far greater self-motivation to take initiatives and also undertake cleaning by oneself wherever feasible at the end term as compared to the start of the project. Consciousness regarding garbage disposal and efforts to keep drains clean were visible in almost all the surveyed areas. Women and adolescents in the three cities used different methods to help generate this feeling among the residents within the community. Demands for installing of garbage bins were made to the authorities from time to time; when these were not met, some women's groups discussed amongst themselves and invested in purchasing a large bin for their garbage disposal. Apart from this, the women were also beginning to become stronger as a collective group and raise the issues concerning cleanliness of the drains, regular garbage collection and street cleaning with the authorities whenever required.

2.3 Water

This intervention focused on improving access to water and creating better awareness and knowledge about clean drinking water among urban slum dwellers. In locations where water supply was inadequate, the programme aimed to generate voice and agency among the inhabitants to register complaints and demand that the supply be restored. Access to water is critical for day-to-day existence, life and living.

The Census of India 2011 provides information on the main sources of drinking water among the slum households. Availability of water sources and access to clean drinking water tends to become a challenge for urban poor settlements since a substantial proportion of these households do not have any drinking water source within the premises. In Delhi's slums only 51 percent have access to drinking water sources within their premises, while the share is 66 percent in both Jaipur and Kolkata.

In Delhi's slums only 51 percent have access to drinking water within their premises

Two-fifths of all the slum households access water from nearby sources in Delhi, while the share is one-fourth in the other two cities of Jaipur (24 percent) and Kolkata (27 percent). Close to 10 percent of slum households in Delhi and Jaipur have to collect drinking water from sources that are some distance from their premises. As per the Census reports, Kolkata has relatively better access to tap water from treated sources even for households that use sources near or away from their premises, while slum households in Jaipur and Delhi depend on untreated sources.

This section provides the details on sources of drinking water, its adequacy and utilization as per the end-term survey; problems if any relating to water supply, adequacy, and how women in these localities sought to address their problems to change the situation over the years of the intervention, are also discussed. Several changes have been witnessed, although many of the challenges also remain.

The CFAR intervention provided inputs in terms of sharing information with the inhabitants regarding who to complain to and how, the process of following up depending on the response and whether the problem has been addressed or not. These are also covered here through the qualitative and quantitative survey information.

2.3.1 Primary source, adequacy and manner of utilization of drinking water

Access to clean drinking water is the most basic of human needs which seems unfulfilled in several of the cluster households. A quantitative survey during end term showed that in Delhi, half of the slum households depended on government sources, mainly Jal Board stand post, for obtaining drinking water. Just 20 percent of them had a Jal Board water connection at home. Another 20 percent were dependent on private sources like water tankers, hand pump/motor and bore wells, which have been individually or collectively installed by the people of the cluster to meet their water needs (Table 2.18).

Table 2.18: Primary sources of drinking water (% of households)

City	% household by source				
	Connection at home	Government Sources	Private sources	Take water from other Sources	Total households
Delhi	28	43	19	11	1321
Jaipur	19	79	1	2	300
Kolkata	3	56	37	3	608
Total	20	51	21	7	2229

Source: IHD End-term survey 2015-16

In addition to access to drinking water, adequacy of the available water sources, both in terms of quantity and quality are equally important issues. In the end-term survey, 60 percent of the households said that the existing water sources are adequate for meeting their daily drinking water requirements. Among the rest, 23 percent felt it was highly inadequate and 18 percent feel its inadequacy during certain time periods (Table 2.19).

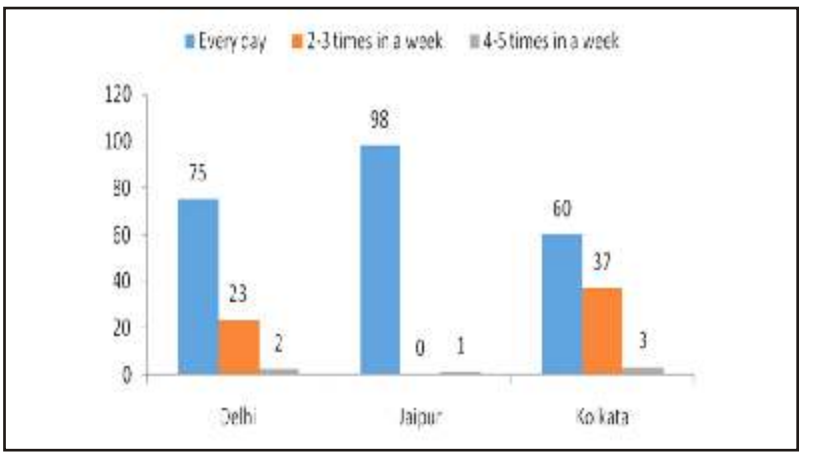
Table 2.19: Adequacy (quantity) of drinking water for daily needs (% of households)

Water source	Delhi	Jaipur	Kolkata	Total
Yes	42.2	70.3	91.0	59.3
Highly inadequate	29.8	21.7	8.2	22.8
Inadequate for some period	28.1	8.0	0.8	17.9
Total	100.0	100.0	100.0	100.0
Total household	1321	300	608	2229

Source: IHD End-term survey 2015-16

The utilization of collected water in a proper manner is very important in order to prevent the spread of mosquitoes and the occurrence of water borne diseases. Some of the concerns that can be addressed by increased awareness and behaviour change include the type of container used for storing water; covering and cleaning the container regularly; purifying water before use; and method(s) used for taking water from the container.

Graph 2.13: Frequency of cleaning the vessel used for storing drinking water (% of households)

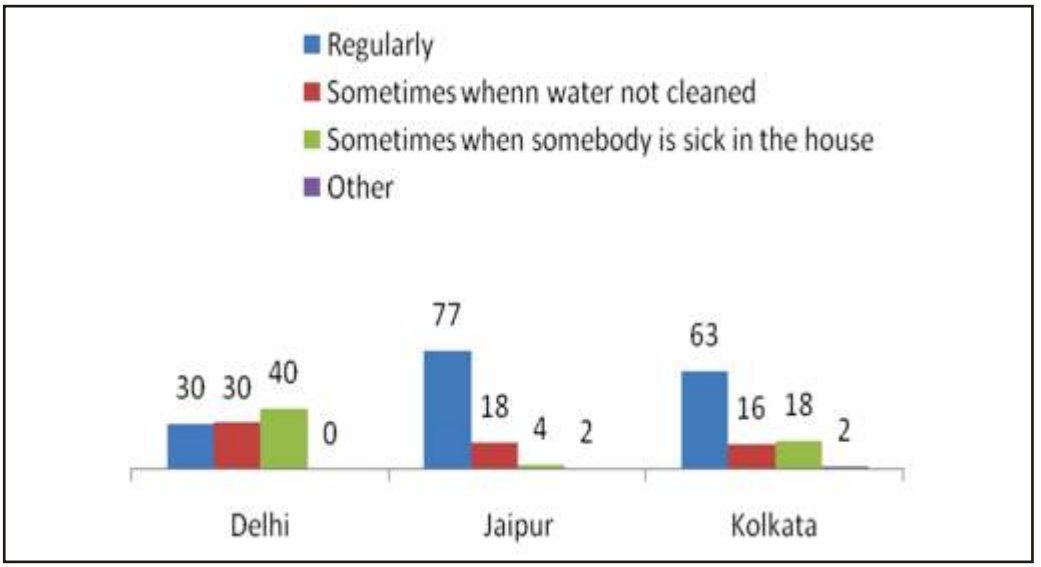


Source: IHD End-term survey 2015-16

The quantitative survey revealed that buckets (49 percent) and plastic bottles (40 percent) were the most commonly used containers for storing drinking water. Cans and steel and mud pots were the other kinds of vessels being used by 15 to 20 percent of the households. More than 99 percent of the total households said that they were aware of the fact that stored water should be kept covered and that they also practiced it. The vessels used for storing drinking and cooking water were cleaned everyday by 75 percent of households; while 24 percent cleaned it 2-3 times in a week and the remaining two percent cleaned it 4-5 times in a week (Graph 2.13).

As far as the mechanism for taking out water from the stored container was concerned, 37 percent used a mug, 21 percent poured water directly from the container, 15 to 16 percent used the tap of the container or ladle pot, while nine to 10 percent put their hand directly into the pot.

Graph 2.14: Frequency of purifying water (% of households)



Source: IHD End-term survey 2015-16

Since all the clusters are not receiving water supply from treated sources, purification of water for consumption is extremely important. Purifying water before use is also an important dimension of water utilization. Very small sections (26 percent) of the surveyed households were found to be purifying the water before use and among them only 50 percent would do this on a regular basis (Graph 2.14).

Table 2.20: Prevalence of water related diseases (% of households)

	Delhi	Jaipur	Kolkata	Total
Percentage of households whose members suffered	81	73	74	78
Diarrhoea	68	77	72	70
Typhoid	42	45	68	49
Jaundice	25	29	40	29
Worm infection	27	30	3	21
Skin diseases	3	27	14	9
Boil and pimples	7	17	0	6
Itching	3	18	3	5
Others	0	5	0	1
Stomach ache	4	4	0	3

Source: IHD End-term survey 2015-16

Contaminated water and unhygienic use of water may result in prevalence of several illness and diseases. Seventy eight percent of the total households reported incidence of water related diseases in their families in the end-term survey. Diarrhoea (70 percent), typhoid (50 percent), jaundice (30 percent) and worm Infection (21 percent) were found to be the four most common forms of ailments (Table 2.20).

2.3.1a Delhi

The people living in the capital city of Delhi are expected to have much better access to a safe drinking water facility within or outside the premises of their houses. The end-term survey indicated that among the slum dwellers in the clusters of Indira Camp Trilokpuri, Rajeev Nagar, Rajeev Camp Chitra Vihar and Subhash Camp Dakshinpuri, more than 50 percent of the households had Jal Board connections at home. In J. J Camp Anand Vihar cluster, all the surveyed households depended on the Jal Board stand post. In the Rajasthani Camp, Saboli Khadda, Jain Mandir, Indira Camp, Khichadipur, Janta Majdoor Camp clusters, more than 50 percent of the surveyed households depended on the Jal Board stand post. More than one-third of the households in NTPC Subhash Camp depended on government water tankers and 11 percent purchased water from the market. Bore wells were important sources of water in certain clusters: 26 percent households of Jhilmil Industrial Area, 41 percent in Priyanka Camp, 45 percent in Rajeev Camp Chitra Vihar, 27 percent in old and new Priyanka Camp, 34 percent in Rajasthani Camp and 26 percent in Saboli Khadda depended on bore wells for water. Near to one-third of the total households in two clusters - Jhilmil Industrial Area and Priyanka Camp - depend on various other sources like fetching water from other clusters.

Table 2.18 indicates an overall profile of the water sources in the three cities. It shows that the primary drinking water source in 43 percent households of Delhi are government water tankers and hand pumps, 28 percent have Jal Board water connections at home and 19 percent have private sources, mainly bore well connections at home.

As far as the responsibility for fetching water is concerned, in Delhi, irrespective of the source, adult women have to bear the burden in the case of 70 percent of the households. Also, the male child, rather than the female child in the households shared more of this responsibility. Scarcity of water results in quarrels among the cluster residents. Among 45 percent of the households who said that quarrels were a usual phenomenon, 87 percent stated that such quarrels were mainly between slum residents and neighbors and that the nature of such quarrels would even go beyond verbal clashes. Fighting (80 percent) and beating (20 percent) were more common under such circumstances.

Qualitative findings clearly indicate that the situation of access to water is more or less the same in almost all the studied clusters of Delhi and that the problem becomes grave in summer and during the rainy season. Water-related quarrels and fights are now a normal feature of these clusters. The following are some illustrative examples of problems faced by the households as captured during FGDs.

In Nandnagari Railway Quarter cluster, fights over water are a regular phenomenon. Once a huge fight took place between two groups in a cluster. The fight became so serious and intense that one group attacked a young girl of the other group. The girl was severely injured and had to be hospitalized.

In the Saboli Khadda cluster, people fetch their water from the Jal Board stand post located 2km away from the cluster at Mandolin Chungi. Further, there is just one Jal Board water connection for the entire lane which creates huge problems and fights among the households. Only some households were able to install private tanks/motors within their homes, individually or as groups.

In the Shastri Mohalla cluster, access to drinking water has always been a major problem. Water pipe lines are laid in one part of the cluster and the other part of the cluster has no water pipe line due to uneven terrain. This becomes a reason for frequent fights among the people of the cluster. As a result, some of the households have to fetch water from the Jal Board stand post located near the petrol pump across a park. A few households as a group have contributed money for installing private bore wells for their collective use.

The existing sources of drinking water were found to be adequate for daily needs by 42 percent of the households. Among the households which find the sources inadequate, nearly 50 percent claimed that they had to arrange for water from other places (neighboring cluster, etc) and another 35 percent continued to depend on government sources (mainly, water tankers) for meeting their requirements. However, during severe water shortages, 14 percent said that they had to purchase water from the market as well.

Buckets were the most commonly used (48 percent) vessels for storing water, 38 percent used plastic bottles, and 32 percent used cans for this purpose. Almost all the households were found to be aware of the fact that water storing vessels should be kept clean and covered. More than 99 percent of the households would cover their container, but only 75 percent cleaned the vessel used for storing water for drinking and cooking every day.

Further, while 75 percent stored the collected water for just one day, 20 percent stored it for two to three days and five percent for five days. As far as taking water out of the container was concerned, 30 percent poured water directly from the container and 23.5 percent used a mug for the purpose, 22 percent used a tap attached to the container and 18 percent used a ladle pot. Nearly six percent of the households used their hands.

More than one-third of the households in NTPC Subhash Camp in Delhi depended on government water tankers

Purification of water before use was done by 26 percent of the households. Among them, 77 percent would boil water, 14 percent used cloth for filtering and 11 percent used a water filter for purifying the water. Even among this small proportion, just 30 percent said that purification of water was a regular practice, while 40 percent would do it only when someone fell sick.

Prevalence of water related diseases seemed high in Delhi slums:

Eighty percent of the households said that their family members had suffered from a water borne disease. Among them, 68 percent said that they had suffered from diarrhea, 42 percent from typhoid, 27 percent from worm infection and 25 percent from jaundice. In the month preceding the end-term survey, 11 percent of the surveyed households in the city said that a family member had fallen sick due to impure water: diarrhoea (50 percent) and jaundice (36 percent) had been the main forms illness.

2.3.1b Jaipur

The surveyed slum clusters of Jaipur had primarily two distinct sources of water: in Ambedkar Nagar, Jhalana Kunda and Soothmill Colony, almost all households depended on the Jal Board stand post and in Baba Ramdev Nagar and JP Colony nearly 70 percent households had Jal Board connections at home.

The overall profile from Table 2.18 indicates that almost 80 percent of the households depended on government sources for obtaining drinking water, mainly, the Jal Board stand post. Water connections at home were available only in the case of 19 percent of the households. As far as the work of fetching water was concerned, female adults (80 percent) and female children (30 percent) had to bear this responsibility, whether the water had to be brought from government sources or from neighboring clusters. Also, collecting water generated quarrels/violence (mainly between slum residents/neighbors) among 45 percent of the households. The nature of the quarrel/violence varied between fighting (80 percent), beating (16 percent) and bossing around (four percent).

Almost 70 percent of the households found the existing sources of drinking water adequate for their daily needs. Among the remaining 30 percent, nearly 60 percent had to arrange for water from other places and 25 percent continued to depend on government sources (mainly, government water tankers) for fulfilling their requirements. However, during severe water shortage, 74.5 percent said that they had to get water from other sources while 41 percent depended on government tankers.

Steel pots (78 percent) and mud pots (67 percent) were the most commonly used vessels for storing drinking water. More than 99 percent said that they were aware of the fact that water should be stored in a clean container and that the container should be kept covered. The end-term survey indicated that more than 99 percent of the households kept their vessels covered and 98 percent were now in the habit of cleaning these vessels daily. Eighty seven percent of the households said that they stored water for one day and the rest stored it for 2 to3 days or more. Nearly 72 percent of the households purified the water before use, of which 92 percent used cloth for filtration; 77 percent did this on a regular basis. The end-term survey indicated that 46 percent of households continued to use their hands for taking water out of containers. Among the rest, 38 percent used a ladle pot. Thus, despite purification by a good section of households, the practice of putting the hand in the water container creates doubts about the hygienic usage of water. Seventy three percent of the households said that their family members had suffered from water-borne diseases. Diarrhea was the most commonly occurring disease (77 percent), followed by typhoid (45 percent), worm infection (30 percent), and jaundice (29 percent). Several households reported the prevalence of skin diseases (27 percent) itching (18 percent) as well as boils and pimples (17 percent). During the month preceding the survey, 10 percent of the households said that their family members had suffered from a water-related illness and 52 percent of them named diarrhea as the disease.

Water being stored in plastic containers in Jaipur

2.3.1c Kolkata

As noted above, the overall profile from Table 2.18 indicates that 56 percent of the households depended on government sources (government tankers and hand pumps), while the remaining 37 percent made their own arrangements, mainly, hand pumps and motors in their houses. Here, women (90 percent) and men (30 percent) shared the responsibility of fetching water, if the source was anything other than a connection at home. For 54 percent of the 401 households in the intensive cluster, the main source of water was the Jal Board stand post, followed by hand pumps in the houses and government hand pumps; only one percent of households reported buying water. In almost all the clusters there had been an increase in the number of government taps as compared to before. In extensive clusters, out of 207 households, 45 percent reported that the main source of drinking water came from hand pumps in their homes and 15 percent got water from Jal Board stand post and also from government hand pumps. Almost four percent of the households said they bought water.

Previously, the water supply in Uttar Kumrokhali and Ukhila was very poor. There was no government tap connection in the locality and the few hand pumps that were there were not effective. The group members, with the help of CFAR, petitioned the authorities to provide water, following which the government taps started providing drinking water thrice a day. This has prevented water-borne diseases in the areas. Purbapara has had a similar

experience, where the municipality set up iron taps, but availability of fresh water is still a major concern in the locality. There is a demand for a 1000 feet deep tube well to be installed to receive arsenic-free water.

The women's group members in Alor Disha in Ukhila took the initiative to use field testing kits to check arsenic in the local tap water. The group members wanted individual pipelines in their homes, but were prevented by the lack of a proper drainage system. They petitioned the local governing body for the same before the election, saying that they would not cast their votes in future if a proper drainage system was not put in place, but there was no response till the time of the end-term survey. In Pirottopally there was still a lack of enough government taps and supply of fresh water. The residents had applied for a 1000 feet hand pump and a tap water connection in their locality long back, but to no avail.

The group members of Stadiumpara complained that the tap water connections are not only few in number but are also placed at inconvenient distances.

In Uttar Kumrokhali, households having a pump facility had running water in their toilets while other households stored water in buckets which they use to keep their toilet clean. The problems related to drainage still exist. Since it is an open drain system connected to the local ponds, the water for daily use gets polluted. This problem still persists. There are tube wells (3 of 100 ft) in the area and a corporation tap to supply drinking water but the problem of water for daily use still remains.

Water-related quarrels/violence was a less common phenomenon among 20 percent of the households. Among them, 56 percent stated that such quarrels were mainly between slum residents/neighbors and 40 percent said that it also occurred with non-slum residents/neighbors. The nature of the quarrels/violence varied between fighting (57 percent), beating (17 percent), and bossing around (25 percent). For 90 percent of the households the existing water sources were adequate for fulfilling their daily needs. Among the remaining 10 percent, 44 percent depended on government sources and 34 percent arranged for water from other places. In the intensive cluster 88.5 percent of households and in the extensive cluster 95.7 percent of households received adequate water supply.

During severe water shortage, nearly 73 percent of households tried to get water from other sources, 30 percent resorted to government tankers and 15 percent claimed that they had to purchase water from the market. The quality of water is associated with maintenance of preserved water at home. Buckets (70 percent) and plastic bottles (60 percent) were the only vessels being used for storing drinking water. Almost everyone was aware of the importance of covering and cleaning the vessels that being used. More than 99 percent covered the vessel in which water was stored; it was cleaned daily by 73 percent of the households, while, 24 percent cleaned it 2-3 times a week. The households said that they would not store water for more than three days; 90 percent would store it for one day and the rest for a maximum of three days. During the baseline survey almost 96 percent of the households in the intensive cluster said that they knew that water containers should be kept clean and covered at all times; this increased to 99 percent in the end line survey.

Eighty percent of the households used mugs to take water from the container and 8.7 percent poured out water directly from the container. Only three percent of the households used their hands for this purpose. Twenty four percent of the households said that they would purify water before use, among which, 45 percent would boil water, 29 percent used water filters and 14 percent used cloth for the purpose. Also, among these, 63 percent purified drinking water on a regular basis.

Among the surveyed households, 74 percent reported suffering from water- borne diseases. The most common was diarrhea (72 percent), followed by typhoid (68 percent) and jaundice (40 percent). Prevalence of skin disease was reported by 14 percent of the households. The percentage of households falling sick due to contaminated water during the month preceding the survey was seven percent. Among the diseases, diarrhea (25 percent), typhoid (32 percent) and jaundice (32 percent) were the most common.

2.3.2 Transition from baseline to end term

A comparison of the situation in the beginning of the CFAR intervention with that at the time of the end-term survey clearly indicated a change in perception. There was a perceptible decline to nil in the proportion of women who earlier failed to give importance to the need for clean water. At the time of the end-term survey, nearly 70 percent of the surveyed women in each of the three cities considered clean water as a necessity (Table 2.21).

Table 2.21: Change in perception – "Clean water is necessary" (% of households)

City	Baseline	End term	Baseline	End term
	Very low	Very low	High	High
Delhi	19	0	18	68
Jaipur	21	0	2	65
Kolkata	2	1	24	71
Total	15	0	17	68

Source: IHD End-term survey 2015-16

Women and even adolescents said that while earlier they were concerned only about the supply and availability of water in terms of quantity, now they were equally concerned about the quality of water and consequences of unclean water. They were also aware of the need for purifying water whenever the supply was of inferior quality.

2.3.3 Manner of utilizing water

There was a gradual change from using earthen pots and metal containers or reused canisters to plastic buckets with covers. Many more households reported regular cleaning of containers and covering of stored water. Persistent messaging and the use of IEC material also changed the method of taking water out from containers across the three cities. Variations across the cities persisted, with households from Kolkata using mugs and households in Jaipur using ladle pots although several of the households still put their hand into the pot for taking out water. In Delhi, the majority of the households poured out the water; the rest used a mug or a container with a tap.

About 41 percent of households said that they were inspired by print and electronic media to purify the water, while 20 percent were motivated by parents and the neighborhood (Table 2.22).

Table 2.22: Sources for knowledge of water purification (% of households)

	Delhi	Jaipur	Kolkata	Total
Print and electronic media	36.9	43.0	48.2	40.8
Neighbours/parents	12.1	11	42.5	20.1
NGOs other than CFAR	4.5	12.7	11.2	7.4
CFAR	7.3	33.7	16.4	13.3
Anganwadi & ASHA worker/sevika	12.0	26.3	3.1	11.5
School going children	20.3	11.0	4.1	14.6
Doctor	6.4	1.3	0.0	3.9
Others	2.4	3.0	0.7	2.0

Source: IHD End-term survey 2015-16

2.3.3a Delhi

The percentage of communities that said they would purify water before using it rose from seven percent at the baseline to 26 percent at end term. Similarly, the percentage of women who put their hand in the water-storing container to take out water declined from 23 percent to just six percent. As Table 2.22 shows, the households were mainly motivated by the print and electronic media, as well as school children, parents and neighbors, and Anganwadi and ASHA workers.

The magnitude of transition facilitated by CFAR can be assessed from the following instances cited by residents of the clusters during FGDs:

In the Saboli Khadda cluster, members of the women's group said that they were now aware of the relevance of drinking clean water. They knew about the diseases caused by consumption of impure water. They have started filtering water before use. They cover the stored water. One woman told us that earlier she was not aware that diseases like diarrhea, typhoid, etc., were caused by impure water and that water that was not kept covered could breed mosquitoes that could cause dengue and malaria. Knowledge about these diseases has made her more alert about water purification. She said that this information was given to her in meetings and discussions with CFAR members.

In Khichripur clusters 6, 7 and 8, women's groups said that they had received training by CFAR and DUSIB on water purification in their cluster. They also received training with respect to water-related illness in the DUSIB office at ITO to which they went as a group. This training informed them about the methods of water purification, how to store the water and the need for regular cleaning of water vessels. This training has made women more conscious about the need for clean water.

Taps have been installed in several clusters in Kolkata to halt the practice of using contaminated water in ponds for bathing and washing clothes

In the Rajeev Nagar cluster, WASH clubs in the schools has played an important role in generating awareness about water purification among adolescent girls of the cluster. Girls now know about water-borne diseases and diseases like dengue and malaria that spread due to improper storage of water, unclean or unhygienic surroundings, etc. They said that their teachers and friends in WASH club told them about cleanliness, washing hands, boiling water before drinking, regular bathing and ensuring that no water gets stored in the drainage system for a long time.

2.3.3b Jaipur

There was a 46 percent increase in the proportion of households purifying drinking water (from 26 percent in baseline to 72 percent at end term). However, there was only a decline of 13 percent from 57 percent in baseline to 46 percent at end term in the proportion of women putting their hand in the water container.

In the Jhalana Kunda cluster, CFAR members organized a health camp for the people of the cluster, where they were given information about water-borne diseases and the importance of clean drinking water. Women shared that now most of the households used ladles to take out water from the storage vessels. In an FGD conducted in the Ambedkar Nagar cluster, it was revealed that people faced the problem of water-logging near the Jal Board stand post, which is the main source of water. The area became slushy due to lack of proper drainage. This made it

difficult for the people to collect clean water. The 'Daksh women's group' discussed this issue with the CFAR members. Money was collected and a cemented platform was constructed which was connected to the sewer line in order to ensure proper outflow of water. Now this place is free of water logging. Several meetings were organized with the people of the cluster to make them understand the relevance of clean water and hygienic environment.

Earlier, the people in the same cluster used to wash their clothes and utensils near the public tap, which was commonly used as a source of drinking water. Following discussions with CFAR members, they have stopped this practice in order to keep the area clean.

2.3.3c Kolkata

The proportion of households purifying water before use increased from 15 percent in the baseline to 24 percent in the end term which is an increase of nine percentage points. When asked how the residents of the locality came to know about purifying water before drinking it, a majority of them in both the intensive and extensive clusters said that they came to know this from print and electronic media (48 percent), and from their parents (42.5). They also talked about CFAR and other NGOs contribution in this aspect (22.0 and 14.5 percent of households respectively). Almost 11 percent came to know from their neighbors. But in the extensive cluster the contribution of CFAR, other NGOs and the neighbors was not very significant.

The decline in the proportion of women dipping their hand in the container used for storing water has been quite high at 78 percent. In the baseline 81 percent of the surveyed women said that they would put their hand inside the container while taking out water from it. In the end term, just three percent continued to follow this practice. CFAR members advised the women not to use any plastic bottle for long periods. They were also advised to wash the bottles with lemon at regular intervals.

In Purbopara cluster, CFAR made the group aware of the necessity of using clean water not just for drinking but also for bathing and cooking. Initially, due to lack of government taps and tube wells, women had to bathe in ponds, which were contaminated with sewage resulting in skin rashes and other problems. CFAR helped the group in the installation of several government taps in the locality at regular intervals by motivating them to submit complaints after obtaining signatures from local residents. Now the members along with non-forum members are using water from these taps for bathing and washing clothes.

Fresh drinking water is still a major concern in the locality. Initially the residents were not aware of the possible arsenic contamination of the water. After discussions with CFAR, they became aware of the negative effects of the presence of arsenic in drinking water. The group members took the initiative of using field testing kits to check the presence of arsenic. They have requested 1000ft deep tube wells from the authorities to access arsenic-free water, but so far there has been no response.

Further, though, people are now aware that water should be boiled before use, to prevent water-borne diseases, the high cost of fuel prevents them from doing so. Boiled water is given to children, but the adults are forced to drink unpurified water.

2.3.4 Addressing water-related problems

The end-term findings indicated that 40 percent of the households were aware of the concerned authorities with whom the complaints had to be filed. While 53.5 percent of the households did file a complaint, 47 percent of whom did this along with group members and 27 percent took the help of CFAR members (Table 2.23).

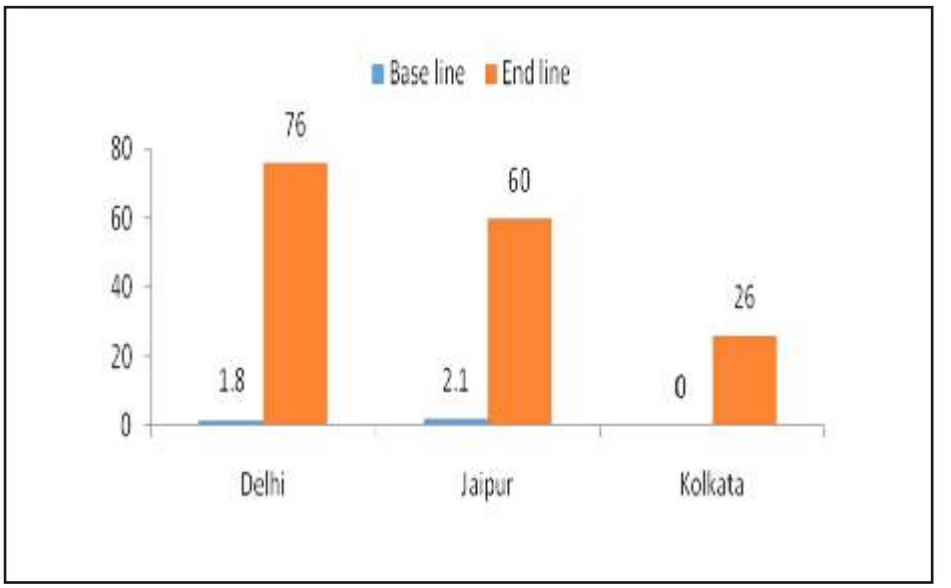
Table 2.23: Percentage of households filing complaints

	Delhi	Jaipur	Kolkata	Total
Percentage know with whom to register complaint	28.1	60.0	57.7	40.0
Percentage actually filed complaints	76.8	60.3	25.9	53.5
Mode of filing complaint				
With the group	77.8	36.6	47.3	63.7
With the group and CFAR member	16.9	60.2	26.4	27.4
Individually	5.3	3.2	26.4	9.0

Source: IHD End-term survey 2015-16

Graph 2.15 indicates the increase from baseline to end term in the number of households that have ever filed a complaint regarding problems with water. During the end-term survey, 76 percent of the households in Delhi, 60 percent in Jaipur and 26 percent in Kolkata, reported filing a complaint against prevalent water problem(s) in their cluster (Graph 2.15).

Graph 2.15: Percentage of households that ever complained about any water- related problems in the cluster



Source: IHD End-term survey 2015-16

2.3.4a Delhi

In Delhi, 76 percent of the households said that they had filed a complaint against water problems. Of them, 78 percent said that it was a group activity, 17 percent were facilitated by CFAR member and five percent made individual efforts. However, just 28 percent of the households knew the right authorities with whom complaints were to be filed. The majority of the households filed complaints with local leaders (60 percent) and 42.6 percent went to the officials of Jal Board. Mostly oral complaints were made (70 percent) and this may be one of the reasons why just 30 percent said that their water-related problem was fully solved.

The streets in the Kalyanpuri block 18 cluster are very narrow due to which pipe lines cannot be laid inside the cluster. There are six public taps in the cluster which are common sources of drinking water. However, they are not adequate for meeting the demands of the people. As a result, there are regular fights in the cluster. Some people go to nearby residential areas to fetch water. CFAR members along with the Mahila Pragati Manch filed several complaints and gave written applications to the Jal Board officials. The situation improved after the installation of a few more Jal Board posts in the centre of the cluster.

NTPC Subhash Camp cluster has an uneven terrain which prevents the laying of water pipelines. Hence collecting water has always been a problem for the people in the cluster. CFAR members helped the women's group to reach the concerned water authorities. Applications were sent to various officials and CFAR also approached the MLA to explain the situation. Since then, a Jal Board post has been installed and a water tanker is being sent as and when required, which has eased the situation somewhat.

2.3.4b Jaipur

In Jaipur, 60 percent of the households said that they were aware of the concerned authorities and an equal percentage of households said that complaints had been filed by them. CFAR facilitated nearly 60 percent of these, 37 percent did this with a group and three percent made individual efforts. Also, 55 percent of the households sent written complaints to the concerned authorities and the remaining 45 percent made oral complaints. Seventy four percent sent their complaints to the Jal Board officials, 30 percent to local leaders and 20 percent to councilors. Following the complaints, 62 percent of the surveyed households claimed that their water-related problems were fully solved, while 23 percent said that it was partially solved.

Table 2.24: Percentage of households that feel they can solve water-related problems without the help of CFAR

	Delhi	Jaipur	Kolkata	Total
Yes	13	26	29	19
No	16	13	32	20
Can't Say	71	60	38	61
Total	100	100	100	100

Source: IHD End-term survey 2015-16

Table 2.25: Most reliable to complain to (% of households)

	Delhi	Jaipur	Kolkata	Total
Local leaders	51	38	4	36
Officials of Jal Board	12	41	6	14
Councillors	3	14	32	13
Municipality office	4	6	57	19
CFAR members	30	1	1	18
Total	100	100	100	100

Source: IHD End-term survey 2015-16

CFAR played an important role in the higher success rate of the city by helping the communities to make written complaints to the right authorities. Several such instances were cited by the people of the cluster during FGDs.

People of Ambedkar Nagar cluster said that whenever there was scarcity of water, Jal Board sent a tanker to the cluster. Earlier there was only one tap in the cluster but now, with CFAR'S help, they have two taps. In the Soothmill cluster, there are presently four Jal Board stand posts which provide water for almost 25 families. CFAR members along with group members helped them to solve problems relating to inadequate and impure water. At first, they tried to approach the Jal Board by filing a complaint. When no action was taken, they collected money through contributions for getting a water tanker to come to the cluster.

Three years back, the Jhalana Kunda cluster suffered from problems of inadequate and impure water. The problems would aggravate during summer, resulting in fights among people within and outside the cluster. People had to fetch water from various places outside the slums. People of the cluster visited various offices several times to file complaints, but with no effect. Once, they even resorted to blocking the road in protest against the inaction by the

authorities. CFAR helped the women's group in solving this problem, by teaching them how to file complaints with the right authorities. The group members went to meet the officials of the Jal Board and the Paarshad of the area. After repetitive complaints, two tube wells were installed and connected to the water tank in the cluster. There are several taps in these water tanks so that the people can easily fill water. This has reduced the fights for water in the cluster.

2.3.4c Kolkata

The end-term survey revealed that 57.7 percent of the households were aware of the authorities with whom a complaint relating to water problems was to be lodged. However this percentage was much higher in the intensive cluster (69.6 percent) than in the extensive cluster (34.8 percent). The majority of these households (53.8 percent) had complained to the municipality office and 38.5 percent had complained to the councilors. Nearly 66 percent had lodged written complaints while 34 percent made the complaints orally.

The survey showed that, in the case of nearly 37 percent of households, the problem was solved fully after they complained; 27 percent reported that the problem was solved partially and for 36 percent of households the problem was not solved at all.

The people of the clusters found it more effective to file their complaints at the municipality office. A large number of households also talked about the local councilors as being reliable for ensuring action against water-related complaints.

The Uttarkumrokhali cluster previously had only one tube well to provide drinking water to the entire cluster. However, with the help of CFAR, the residents wrote applications to the municipal corporations, which have since installed taps around the cluster. As a result the area is now provided with an adequate supply of fresh drinking water which helps in preventing water-borne diseases.

The most important problem of the Dakhin Kumrokhali cluster used to be the lack of any source of drinking water and their dependence on polluted pond water. However, with help from CFAR and the women's group called Alor Disha, the residents were able to set up hand pumps and tube wells for the supply of fresh drinking water. In addition, they store water in buckets for washing utensils and clothes, giving up the earlier practice of washing them in the ponds.

The Ukhila cluster used to have very poor water supply. There was no government tap connection in the locality and the few hand pumps that were there were not adequate. A petition was forwarded to the authorities by the group members with the help of CFAR. At first their petition was not accepted. Then a few more members signed the petition following which the government installed taps which provide water thrice a day. Many households also buy water for drinking but it is only for the use of the men and little children of the family.

Concluding remarks

The realization that clean water is essential and appropriate storing, cleaning of containers and use of correct methods that prevent any contamination of water must be followed came through strongly in the end-term evaluation survey. There has been significant behaviour change over time with the intervention since the women and the communities now recognize and appreciate the health problems that can occur due to use of unclean water. In some instances, the practice of water use tends to slip up given the circumstances under which the households live. However, overall it may be stated that there was a clear improvement of awareness and practice.

The efforts made by women to reach out to the authorities whenever water supplies were discontinued or for any other water-related problems such as contaminated water supplies, or inadequate supply, as well as sending in requests for water tankers under such circumstances were noted across the three cities. Group members along with other women and with help from CFAR undertook the addressing of the problems in their localities. In certain instances they were able to do this even without help from CFAR. Many more written complaints were reported from both Delhi and Kolkata, although Jaipur still recorded more oral complaints.

2.4. Personal Hygiene

Several issues concerning personal hygiene are aggravated due to the absence of basic facilities such as personal toilets within the households, in adequate water supply and economic poverty. Socio-religious norms prevailing around menstruation with several taboos on what women and girls can do while they have their periods and the associated shame restrains them from accessing proper information regarding practices and behaviour concerning personal hygiene. This section deals with menstrual hygiene, use of cloth or napkins, its disposal and behaviour change in the domain of the taboos that have been commonly prevalent. Some of these taboos are being questioned by the adolescents and they are all becoming more open about articulating problems linked to these as a result of the trainings and periodic interactions where discussions on personal hygiene, sexuality, sanitation, etc., take place.

2.4.1 Menstrual hygiene

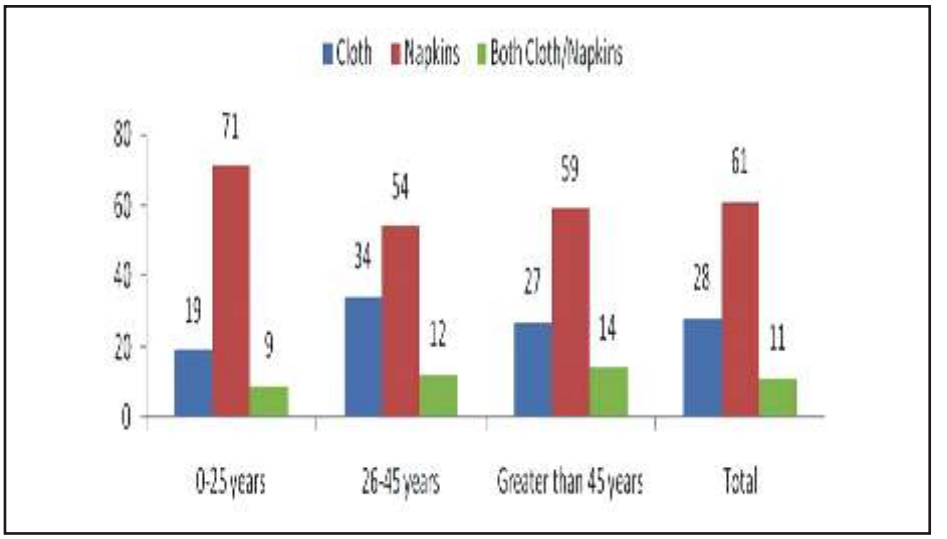
In the end-term survey it was found that 61 percent of the women used napkins, 28 percent used cloth and another 11 percent used both during the menstrual cycle. At the overall level, no group and non-group distinction was visible. The highest level of education of the woman in a household seems to be having an important role in deciding the material used during this phase. In general, it was been found that as the education level increases, dependence on cloth declines and that on napkins increases across all age groups. Among the illiterate, 40 percent used cloth and 52 percent used napkins; however, among those having higher secondary and above level of education, 70 percent used napkins and 20 percent used cloth (Table 2.26). Graph 2.16 below shows that usage of napkins, rather than cloth is highest among the youth (below 25 years), which may be considered an indication of rising awareness among the younger generation on the importance of personal hygiene.

Table 2.26: Material used during menstrual cycle

		Cloth	Napkins	Both Cloth/ Napkins	Total	Total respondent
Delhi	Group member	24	63	13	100	172
	Non-group member	30	59	11	100	1002
	Total	29	59	11	100	1174
Jaipur	Group member	16	80	4	100	115
	Non-group member	41	53	6	100	157
	Total	30	64	6	100	272
Kolkata	Group member	28	58	14	100	144
	Non-group member	25	62	13	100	447
	Total	26	61	13	100	591
Total	Group member	23	66	11	100	431
	Non-group member	30	59	11	100	1606
	Total	28	61	11	100	2037

Source: IHD End-term survey 2015-16

Graph 2.16: Material used during menstrual cycle by age group of the respondent



Source: IHD End-term survey 2015-16

Among 30 percent of the young girls who continued to use cloth during the menstrual cycle, 75 percent said that it was mainly due to financial constraints. Use of cloth lying at home was cheaper, even though unhygienic and 10.8 percent of them were found to be lacking awareness, either about alternatives to cloth (six percent) or about potential health problems due to usage of cloth (five percent) (Table 2.27). Of the total number of surveyed women and girls using cloth, 49 percent said that they faced itching problems, 16 percent felt pain while using it and 16.6 percent said that cloth was not a good absorbent. But very few (four percent) were able to relate its usage to reproductive health problems (Table 2.28).

Table 2.27: Primary reason for dependence on cloth (% of women and girls)

	Are young women or girls still using cloth during menstruation now	If yes why						
		Financial problem	Not aware about alternatives	Hesitate to purchase	Do not face problem	Not available in government hospital free of cost	Others	Total
Delhi	29.1	77.9	5.7	7.6	3.9	4.7	0.3	100
Jaipur	45.7	70.1	8	7.3	7.3	6.6	0.7	100
Kolkata	25.7	73.7	5.1	10.9	4.5	5.8	0	100
Total	30.4	75.3	6.1	8.3	4.7	5.3	0.3	100

Source: IHD End-term survey 2015-16

Table 2.28: Problems faced due to use of cloth (% of women and girls)

	Problems faced due to using cloth					
	Pain	Itching	Other Disease	Disposal not Easy	Cloth not good absorbent	Total
Delhi	19.7	53.2	2.8	16.5	7.8	100
Jaipur	9.1	36.4	9.1	0	42.4	100
Kolkata	2.3	38.6	6.8	11.4	40.9	100
Total	15.9	49.2	4.1	13.9	16.6	100

Source: IHD End-term survey 2015-16

The manner in which the cloth or napkin is used and the way it is disposed of are two equally important dimensions of personal hygiene. The survey indicated that women in general would replace their cloth or napkin after every 6 hours. Among cloth users, 79 percent said that they would throw it away after one use, while 21 percent said that they would wash it and use it again. The survey further revealed that 53 percent of the women would wrap up the used cloth or napkin in a paper and polythene bag before disposing it, while 27 percent would wrap it in a polythene bag, 16 percent would wrap it in paper and another four percent would throw it in the open.

The women were also asked questions relating to reproductive health problems faced by them during the preceding year. Only 16 percent of the total women and girls said that they faced such problems. Among them, 49 percent had lower abdominal pain and 23.5 percent had urinary problems (Table 2.29).

Table 2.29: During last one year have you faced any reproductive health problem (% of women)

	Delhi	Jaipur	Kolkata	Total
Percentage of women facing problems	12.6	22.3	21.1	16.2
Vaginal discharge - clear, cloudy or foul smelling	6.6	43.3	9.4	14.4
Urinary problems- burning and pain	36.1	4.5	17.2	23.5
Itching in the genital area	1.8	6	14.8	7.2
Lower abdominal pain	48.8	49.3	49.2	49
Pain during intercourse	2.4	0	14.8	6.4
Ulcer/Wart/Swelling in genital area	4.8	0	1.6	2.8
Irregular/painful menses	12.7	34.3	7	14.7

Source: IHD End-term survey 2015-16

2.4.1a Delhi

In Delhi, 59 percent of the women were found to be using napkins, 29 used cloth and the remaining 11 percent - used both during the menstrual cycle (Table 2.26). There was no group or non-group distinction in the type of material used. The education level of the women in the household (irrespective of the age group) did seem to be playing an important role in deciding between using cloth and sanitary napkins. Forty seven percent of illiterate women and 75 percent of women with higher secondary and above education were found to be using napkins; 69 percent of the young

women (below 25 years) were also found to be using napkins, while dependence on cloth was higher among women in the age group of 26 to 45 years (see Table 2.30).

Table 2.30: Material used during menstruation by highest education level of the woman in the household and age group - Delhi

	Cloth	Napkins	Both Cloth/ Napkins	Total
Highest education level among females within household				
Illiterate/Informal education	43	47	10	100
Below primary	49	39	12	100
Primary	37	50	13	100
Middle	22	64	14	100
Secondary	25	61	14	100
Higher Secondary and above	19	75	7	100
Total	29	59	11	100
Age group of females				
0-25 years	22	69	8	100
26-45 years	35	52	13	100
Greater than 45	21	66	13	100
Total	29	59	11	100

Source: IHD End-term survey 2015-16

Among 30 percent of the young women and girls using cloth during the menstrual cycle, 78 percent said that financial constraint was the primary reason; 7.6 percent said that they were hesitant to purchase from the market; 9.6 percent lacked awareness relating to availability of alternatives (5.7 percent) and potential health problems (3.9 percent).

It was also found that 53.2 percent of the women using cloth faced itching problems because of its usage while 19.7 percent felt pain and 2.8 percent felt that certain unspecified diseases have resulted from using cloth. In general it was found that, on an average, women would replace the cloth or napkin after every 6 hours. Among the cloth users, 94 percent said that they would dispose it after every cycle, while six percent said that they would wash it and use it again and again. As far as the manner of disposal of the used napkins or cloth was concerned, among the section of women who wrapped it in both paper and polythene, 39 percent threw it in the house dustbin and an almost equal percent disposed it in the community dustbin. Another 23 percent threw it in an unsafe manner (Table 2.31).

Table 2.31: Manner of disposal of used cloth or sanitary napkins (% of women)

City		percent Distribution				Total women
		Unsafe place*	In house dustbin	Suppresses into the pit	Dustbin (Community /CTC)	
Delhi	Wrap in a paper	26	54	2	18	171
	In polythene bags	40	26	1	33	161
	Wrap in a paper and polythene bag	23	39	1	37	803
	In the open	64	5	3	28	39
	Total	27	38	1	34	1174
Jaipur	Wrap in a paper	33	17	17	33	18
	In polythene bags	41	25	13	22	32
	Wrap in a paper and polythene bag	38	20	4	37	206
	In the open	62	15	8	15	13
	Total	39	20	6	34	269
Kolkata	Wrap in a paper	30	13	44	13	142
	In polythene bags	32	21	35	12	364
	Wrap in a paper and polythene bag	27	14	33	25	63
	In the open	27	9	45	18	22
	Total	31	18	37	14	591

*Including throws it outside, in toilets, in drains and in open plots

Source: IHD End-term survey 2015-16

The quantitative survey found that in Delhi, 12.6 percent of the women faced reproductive health problems, among which lower abdominal pain constituted a major issue (49 percent), followed by urinary problems (36 percent), and irregular/painful menstrual periods (13 percent). Among the section of women facing such problems, 50 percent claimed that they did not go for any kind of treatment, 22 percent visited local quacks and 17 percent visited government hospitals.

2.4.1b Jaipur

In Jaipur, 64 percent of the surveyed women used napkins, 30 percent used cloth and the remaining six percent used both (Table 2.26). Some group and non-group distinction was visible in the city with 80 percent group members and 53 percent non-group members using cloth. The education level of the women in the household did not seem to play a part in decisions relating to choosing between cloth and napkins; 67 percent of illiterate women were using napkins and this proportion declined to 57 percent in the case of women with secondary education. However, a transition was clearly visible if the age group of the women is taken into consideration: 79 percent of the young women (less than 25 years of age) used napkins and this proportion declined to 40 percent for women in 45 plus age group (Table 2.32).

Table 2.32: Material used during menstruation by highest education level of the female in the household and age group - Jaipur

	Cloth	Napkins	Both Cloth/ Napkins	Total
Highest education level among females in the household				
Illiterate/Informal education	30	67	3	100
Below primary	33	59	8	100
Primary	40	58	2	100
Middle	24	69	7	100
Secondary	36	57	7	100
Higher Secondary and above	20	70	10	100
Total	30	64	6	100
Age group of females				
0-25 years	15	79	7	100
26-45 years	42	53	5	100
Greater than 45	60	40	0	100
Total	30	64	6	100

Source: IHD End-term survey 2015-16

Among 45.7 percent of the young women using cloth during the menstrual cycle, 70 percent said that financial constraint was the primary reason; 7.3 percent said that they were hesitant to purchase from the market; 15.3 percent lacked awareness relating to availability of alternatives (eight percent) and potential health problems (7.3 percent). Women said that the usage of cloth resulted in itching problems (36.4 percent), pain (9.1 percent) and other diseases (nine percent). Lack of awareness about potential health problems may be the prime reason behind the finding that women would change their cloth or napkin every 10 hours on an average. Besides, among cloth users, more than one-half said that they would wash it and use it again and again. Further, among the women who wrapped it in both paper and polythene, 38 percent threw it in an unsafe manner and almost an equal proportion used the community dustbin for this purpose. The house dustbin was used by 20 percent of the women.

In Jaipur, 22 percent of the women had reproductive problems, such as lower abdominal pain (49 percent), vaginal discharge (43 percent), and irregular or painful menses (34 percent). Twenty eight percent of the women facing such problems simply ignored it and did not take any kind of treatment. However, 50 percent claimed that they would visit the government hospital and 36 percent went to allopathic MBBS doctors.

2.4.1c Kolkata

In Kolkata, 61 percent of the surveyed women used napkins, 26 percent used cloth and the rest - 13 percent - used both (Table 2.26). There was no group and non-group distinction visible. The highest education level of the woman in the household seemed to play an important role till secondary level of education. Usage of napkins increased from 48 percent women (illiterate) to 66 percent (secondary level). Again, as in other cities, young girls seemed to be more aware and open to change than older women (Table 2.33).

Table 2.33: Material used during menstruation by highest education level of the woman in the household and age group - Kolkata

	Cloth	Napkins	Both Cloth/ Napkins	Total
Highest education level among female within household				
Illiterate/Informal education	41	48	11	100
Below primary	23	63	15	100
Primary	25	65	11	100
Middle	23	65	12	100
Secondary	21	66	14	100
Higher Secondary and above	24	57	18	100
Total	26	61	13	100
Age group of females				
0-25 years	16	71	13	100
26-45 years	29	59	12	100
Greater than 45	32	52	17	100
Total	26	61	13	100

Source: IHD End-term survey 2015-16

Among 25.7 percent of the young women and girls using cloth during their menstrual cycle, 75.3 percent said that financial constraint was the primary reason; 10.9 percent said that they were hesitant to purchase from the market; 9.6 percent lacked awareness relating to availability of alternatives (5.1 percent) and potential health problems (4.5 percent), 38.6 percent of the surveyed female said that they faced itching problems, 2.3 percent felt pain and four percent encountered some diseases due to the usage of cloth.

Women said that they would change the cloth or napkin every six hours, on an average. However, among cloth users, 38 percent said that they would wash it and use it again and again. The majority of respondents wrapped the used cloth or napkin in polythene bags. Among 35 percent, burying it in a pit was a common practice; another 32 percent threw it away in an unsafe manner; 21 percent used the house dustbin and 12 percent used the community dustbin for disposing it.

With regard to reproductive health problems, 21 percent of the women faced such problems. Of them, 49 percent suffered from abdominal pain, followed by urinary problems (17 percent), pain during intercourse (14.8 percent) and itching in the genital area (14.8 percent). Thirty seven percent of women facing such problems did not take any treatment, 24 percent went to allopathic MBBS doctors, and 15 percent to 16 percent visited the local homeopath and local quacks.

2.4.2 Transition from baseline to end term

A transition is clearly visible in the perception and practices of women during menstruation. A lot of positive change would be seen if an analysis were to be done of the proportion of women following various traditional rules and regulations during menstruation.

2.4.2a Delhi

In Delhi, there is a substantial shift from the use of cloth to sanitary napkins. The percentage of women using cloth has reduced from 58 percent at the start of the programme to 29 percent during the end-term survey. Proportionately the share of women using sanitary napkins has increased from 42 percent at baseline to 59 percent during end term – this is an increase of 17 percentage points in the proportion of women using sanitary napkins.

A substantial amount of change has been noticed regarding the awareness of menstrual health among women and girls.

CFAR, along with GRC, had organized various programmes and health camps, which played very important roles in changing the perceptions of girls and women of the Saboli Khadda cluster. As a result they can openly buy sanitary napkins without any fear or shame. One woman shared her view saying that **" अगर बेचने वाले को शर्म नहीं है तो खरीदने वाले को क्यों शर्म आयें?"** *(If the seller is not embarrassed then why should the buyers feel ashamed?).*

In Delhi, participation in religious activities by women during their menstrual period increased from 29 to 54 percent. Similarly, participation in domestic activities also increased from 12 to 55 percent (Table 2.34). Further, there was a decline in the number of women who kept their daughters at home during their menstrual period (Table 2.35).

Table 2.34: Percentage of women follow traditional rules during menstruation cycle

		Participate in religious activities	Do domestic work	Sleep away from husband	Bath many times in a day	Eat light meal
Delhi	Baseline	29	12	73	3	17
	End line	54	55	60	7	18
Jaipur	Baseline	26	71	33	16	7
	End line	19	87	94	35	42
Kolkata	Baseline	0	55	63	10	7
	End line	47	69	52	15	22

Source: IHD End-term survey 2015-16

Table 2.35: Percentage of women who allow daughters to participate in school during menses

City		Allow your daughter to attend school during menstruation cycle
Delhi	Baseline	78
	End line	92
Jaipur	Baseline	63
	End line	94
Kolkata	Baseline	67
	End line	78

Source: IHD End-term survey 2015-16

In the NTPC Subhash Camp, women said that CFAR and other health camps helped them to understand menstrual hygiene. Now they use sanitary napkins which protect them from many reproductive diseases. They also know how to dispose sanitary napkins properly, after wrapping it in polythene or paper. In the case of those using cloth, CFAR members told them the proper way of using it so as maintain hygiene.

The girls of Rajasthani Camp have started discussing their menstrual and reproductive health problems with their mothers and CFAR staff. The girls were given training by Goonj and CFAR relating to various issues of personal hygiene like how to use sanitary napkins, how to dispose it, number of times it has to be changed, etc. They were also trained in preparing their own sanitary napkins. Under the same programme, girls were given "My Pad Kit" which included two packets of sanitary napkins and three undergarments. As far as traditional taboos are concerned, in the Sanjay Camp cluster, girls shared that they were not allowed to enter the temple, touch the god's idol, tulsi leaves, pickles, and so on. After CFAR's intervention, even though many girls continue to follow the restrictions, there have been instances of change.

2.4.2b Jaipur

In Jaipur, there has been a decline in use of cloth by more than half among the surveyed women and use of napkins has almost doubled. This change has been brought about by CFAR's intervention and a consequent increase in comfort. Women using cloth used to face difficulties such as cleaning them, drying them, and disposing them. Some of them also said that it was quite uncomfortable because the cloth could fall out while in use. However sanitary napkins posed no such problems (Table 2.36). They also felt that there was a reduction in their reproductive health problems, namely, white discharge, irregular menstruation, itching and pain in genital area, etc.

Table 2.36: Change in material used during menstruation (% of women)

	Baseline	End line			
	Cloth	Napkin	Cloth	Napkin	Both
Delhi	58	42	29	59	11
Jaipur	75	28	30	64	6
Kolkata	64	36	26	61	13

Source: IHD End-term survey 2015-16

However, among the section of women using cloth, there has been no decline in the proportion of those who use the same cloth again and again after washing (Table 2.37).

Table 2.37: Method of using cloth during menstruation (% of women)

		Use again & again after wash	Throw after one time use
Delhi	Baseline	6	94
	End line	6	94
Jaipur	Baseline	57	43
	End line	56	44
Kolkata	Baseline	90	10
	End line	38	62

Source: IHD End-term survey 2015-16

Participation in domestic activities during menstruation has increased from 71 to 87 percent and 42 percent of the women have started consuming light meals during this time (from seven percent in baseline). Also, in comparison to 46 percent (in baseline) of the women who refused to allow their daughters to attend school, in end term just 16 percent impose such restrictions (see Table 2.34).

In Jhalana Kunda, women told our team that CFAR members had explained that the menstrual cycle was a regular process and they should continue doing their regular work even during this time. Also, girls should not be stopped from attending school. They were clearly told about what should be done and what should not be done during menstruation.

Similarly, in Soothmill there used to be lots of myths about menstrual hygiene, mainly due to ignorance and illiteracy. As a result, women and girls had to face many restrictions like not being allowed to work in the kitchen or outside the house, and not attend any religious activity. In some cases, the girls were also not allowed to attend school. But after CFAR's intervention, change became visible.

Awareness was generated among women and girls by organizing meetings, discussions and health camps on menstrual hygiene

CFAR members generated awareness among cluster women by organizing meetings, discussions and health camps on menstrual hygiene. They were also told about possible reproductive diseases and how to prevent them through proper hygiene. For instance, they told them how to clean their genital area during menstrual period. They made them aware of the importance of using sanitary napkins. CFAR members taught those who could not use sanitary napkins due to financial constraints, the proper way of using cloth during this time and how the cloth must be cleaned and dried in direct sunlight before using it again.

Similar experiences were shared by women and girls from J P Colony. Now most of the girls of this cluster use sanitary napkins. Some girls buy sanitary napkins from their pocket money. Groups of adolescent girls have generated awareness among neighborhood women of the cluster about menstrual hygiene. More importantly, now girls have stopped disposing their sanitary napkins randomly. They throw it into the municipal garbage vehicle after wrapping it with paper. In Muslim communities earlier girls were prohibited from taking a bath during menstruation. Following CFAR's group meetings and discussions they know what to do and what not to do; they now bathe regularly and maintain personal hygiene.

2.4.2c Kolkata

In Kolkata, the use of cloth by women and girls reduced by almost 40 percent and use of napkins increased by 30 percent. Among the section of women using cloth, there was a steep decline in the proportion of women using the same piece of cloth again and again (from 90 percent in the baseline to 38 percent in the end term). A change in perception was visible in the proportion of women following traditional rules and regulations during menstruation. There was a steep increase of almost 47 percent in women's participation in religious activities. Restricting school attendance during menstruation reduced from 33 percent in the baseline to 22 percent in the end term. CFAR members have generated awareness among women and girls towards personal hygiene. Some of the instances are indicated below.

In the Dakhin Kumrokhali cluster, earlier women would use cloth and were hesitant to buy sanitary napkins from the market. With the formation of the group Alor disha, women of the cluster became conscious of certain practices necessary for living a healthy life. CFAR helped them understand the importance of using sanitary pads to prevent diseases. Alor Disha members would sell pads to the women. Now, women not only buy pads on their own but also send their husbands to buy pads for them. CFAR members organized health camps to encourage women to come out and talk about their reproductive health problems. Despite the availability of female doctors, several women were shy of attending such camps. Slowly, a change was visible with more and more women participating in public meetings, visiting health camps for gynecological problems and discussing their problems with others.

In Stadiumpara cluster, the Alor Disha group generated awareness regarding menstrual health among adolescent girls. Previously they would use cloth during menstruation, but now most of the girls use sanitary pads during periods. The group also organized Dance Movement Therapy on health-related issues and provided them with proper knowledge on biological changes relating to women's bodies. In Ukhila cluster, forum members made door-to-door visits to advise the women to save money for buying sanitary napkins. And even if someone continued to use cloth, she was warned of not using the same cloth the next month.

Concluding remarks

In the end-term evaluation, a lot more women and girls reported use of sanitary napkins during menstruation with awareness regarding its use, disposal and personal hygiene. Fewer women resort to reuse of cloth and then too they are aware of the fact that the cloth must be washed and dried in the sun before reuse. The availability of sanitary napkins from various sources at subsidized rates, schools, ICDS centres, Gender Resource Centres and so on were proving to be a great support for the women of poor households. There was some extent of distress among the women and girls due to its discontinuation towards the latter period of the intervention for various reasons. The introduction of partnership with Goonj was very well received as it illustrated and taught groups of women how to make their own cheaper pads. This experiment was positive and may help women to move from use of cloth to using homemade napkins. The easing of socio-religious taboos associated with menstruation has been witnessed in the course of this intervention. The training sessions and open conversations have enabled women, especially adolescent girls to talk openly about their problems, doubts and issues concerning personal hygiene, menstruation, and related subjects. The health camps can now address women's personal hygiene and reproduction-related problems better, since the women and girls are now being able to articulate and speak up on matters they were earlier shy to broach.

MHM class in progress in a school in Kolkata

2.5 Partnership and Its Sustainability

An intervention like the one that CFAR initiated to strengthen the ability of communities to demand and benefit from service provisioning in the areas of sanitation, water and hygiene can clearly benefit from strategic partnerships. The partnership model followed by CFAR was to use the strengths of other organizations and leverage their efforts in different domains to achieve the desired objective of sustainably enabling women and communities to ensure gender responsive provisioning of facilities and services through participatory actions. By spreading the awareness of other initiatives in similar domains, the intervention sought to develop more confidence among women in the community both to join groups and also to take the initiative and participate in the efforts being made.

The partnerships were during different phases such as: while preparing curriculum, IEC material, identifying the areas, providing trainings, organizing camps, exposure visits and interactions with other organizations and experts to assist and learn from their experiences regarding solving of problems and challenges. The partnerships covered different aspects relating to physical, community or social development, institutional arrangements and mobilization of communities.

The partnership model uses the strengths of other organizations and leverage their efforts to enable women and communities to ensure gender responsive provisioning of facilities

Partnerships were formed with civic bodies to help construct paved or pucca roads, sewerage systems, drains, water sources (taps, hand pumps, bore wells, etc.), renovations, repair and construction of CTCs, helping residents to construct personal toilets and regular maintenance and cleaning of these facilities wherever required. These partnerships fall in the physical development domain.

CFAR helped in the forming of community level groups of women, adolescents, youth and men, and assisted in their registration. These groups were trained and provided critical support in the intervention. This mobilization formed a part of the community or social development component of partnerships within the intervention programme. Apart from this, there were institutional arrangements and associations formed for an entire range of activities that were seen as relevant across the three cities with NGOs, government departments and officials, experts and professionals.

The innovative and very important aspect of partnerships included association with government and non-government departments. Such partnerships were not one of fund sharing but one wherein mutual objectives were sought to be attained by working together. CFAR entered into an MOU with DUSIB towards the end of the end-term evaluation. The partnership will work towards better functioning of the facilities in one cluster – Kalyanpuri. The MOU recognizes that DUSIB is committed to provide toilet complexes, Basti Vikas Kendras, Shishu Vatikas, and road, pavements and drainage. The agency has devoted teams to undertake regular monitoring of cleanliness and making the toilets user friendly. Keeping in view the mandate of moving towards an open-defecation-free state as per the Swachh Bharat Mission, DUSIB recognizes the growing need for community participation in cleanliness, sanitation, hygiene and awareness campaigns, for which this partnership has been initiated with CFAR and Mahila Pragati Manch as a pilot experiment.

Similarly, in Jaipur, a partnership was developed with the Health Department under NUHM wherein community-based women's forums were used to form the Mahila Aarogya Samiti (MAS) and organize

regular meetings as mandated under the programme. CFAR also reached out to the Department of Urban Development after the launch of SBA to illustrate what they had managed to initiate by the introduction of new technology toilets and received acceptance from the government for the initiative.

In Kolkata, partnerships were forged with ICDS and the Department of Women and Child Development to establish links between the ICDS representatives, mothers and the community for moving towards the objectives of the intervention.

Another critical element of the intervention programme relates to the experienced and well trained staff of CFAR which served as a boost to the partnerships as well as the effective implementation of strategies. Efforts were constantly made to organize trainings of trainers (TOTs) and learn from the experts as well as other NGOs working in related fields.

Using materials that have already been developed by partners is often an efficient approach. This also helps in avoiding the mistakes that were made by other NGOs or organizations. Collective meetings and brainstorming on problems and challenges faced by the community helps in reflecting together, leveraging each other's strengths and coming up with participatory solutions that ensures a continuity of support by building rapport, ownership and a sense of accountability among different stakeholders. One example here relates to the joint training workshop organized with CURE in 2012 at the beginning of the intervention programme.

Box 1.2: Leadership as defined by different catalysts

During our discussion in Jaipur we asked both officials as well as community leaders to define a "leader".

The sanitation inspector, Jhalana Kunda, Mr. Satish Ch. Gupta, defined a good leader as one who is a social person and his/her behaviour towards staff members is good and humble.

The community leader Maya Devi, Jhalana Kunda, Jaipur defined a good leader as one who knows all the problems in the cluster and he/she can solve whatever problems occur.

The aim of the CFAR's programme is to generate a capable leadership within the community so that the community itself can tackle the issues faced by residents in slum settlements. Good leadership within the cluster itself has an advantage as the leader belongs to the community and has access to the residents.

Organizing interactive public meetings at regular intervals in which service providers and government officials are also participating provides a good platform for discussion between community members, NGOs and service providers. Several instances have come up during the FGDs and qualitative surveys wherein problems have been heard, listed, and even addressed.

CFAR, through its partnership with various organizations, provides a platform for interactive discussions and camps between service providers, NGOs and community members. In these interactions community members put questions to the service providers who give the answers. In such interactions, both the community people and the service providers benefit. These meeting also provide space for the community leaders to share their views and concerns relating to sanitation and garbage problems in their localities.

The end-term evaluation team participated in two of the Jan sabhas held in Delhi, i.e., in the NTPC Subhash Camp and the Trilokpuri Camp. In the NTPC Subhash Camp Jan Sabha, service providers and representatives like the local MLA, the MCD worker and local police were present. Generally, the participation in such meetings is not very high. Therefore, interesting methods are used to make the entire process interactive and entertaining. This meeting began with a short play on safe sanitation and garbage disposal. In the play the actors tried to involve the audience by asking questions relating to

many sanitation-related problems and sought their probable solutions, making it very participatory and engaging. Complaints were made relating to the regular cleaning of drains by MCD workers. Often, they did not go to some of the inner lanes of the clusters (gali) for cleaning of drains. Since the MCD worker was also present at the meeting, he promised the community that he would regularly visit the slums.

A third complaint was raised by the community, i.e. replacement of a fused street light that was leading to the harassment of women and adolescent girls. The representative of the local MLA present at the meeting assured the gathering that the street light would be replaced within 24 hours. Similarly, some other members complained that the police who are in charge of the slum are often absent and when the community people need their help, it is not available. The representative of the MLA suggested that they write a letter to the concerned police officers through the MLA and assured them that action would be taken against the police. This interaction helped the community people to become aware of concerned department and officials to whom their complaints must be directed for problems relating to sanitation, security and health. On the other hand, this interface also helped the service providers to work responsibly.

In another public meeting on issues concerning CTCs held on 12th March 2015, the women from Mahila Pragati Manch, CFAR staff and DUSIB officials were present. The women from the community raised various issues relating to CTCs like broken seats, blocked seats, broken tiles, water overflow coming inside the cabin, lack of divider wall between male and female sides of toilets and the installation of a pipeline inside the toilet. The DUSIB officials present in the meeting took serious note of all the complaints and assured the community that they would solve the problems as soon as possible. They agreed to construct a 3ft divider wall between male and female sides of the toilet, and came up with several suggestions to facilitate the process of filing complaints which could be addressed by them. Recognizing their problems in preparing the complaints, DUSIB officials proposed that a seat number be marked on the wall of each cabin so that while complaining one can refer to the seat number. The department also suggested that a register be placed in the CTC so that the community could write down their complaints, and that a mobile number would be provided to the community for registering complaints.

It was also decided that the NGOs (including CFAR) and CBOs working in a particular slum would create awareness among women regarding menstrual hygiene, especially with regard to disposal of used cloth or napkins, open defecation and hygiene. The meeting also discussed issues like the amount to be paid as user fee for the toilets and the distribution of responsibilities among community members for toilet management and safety related issues. After the meeting, CFAR and Mahila Pragati Manch together prepared and submitted the list of the CTC vigilance committee to DUSIB. This activity resulted in an improvement in services and the condition of CTCs over the three years intervention period.

Partner NGOs played a critical role during the intervention by building awareness with regard to open defecation and hygiene

During discussions on the SBA programme in Jaipur it was suggested by the officials that the Inter Personal Contact (IPC), Information Education and Communication (IEC) aspects and the subsidy of the programme (if any) should go hand in hand to successfully run the programme. They gave the example of toilet construction in the SBM programme, under which a subsidy of Rs. 8000 from the department and Rs. 4000 from local body was granted to the household. But, according to the officials, if the people did not have awareness about the importance of toilets they continued to defecate in the open even though the toilets were there. Hence the department needed the IPC and IEC activities to be concurrently conducted during the initiative, for which the involvement of NGOs was necessary as they had rapport in the slum and were capable of organizing meetings in the clusters. He added that IPC and IEC were also necessary on the issue of hand washing.

Table 3.38 provides a summary of basic questions and the selected indicators in answering the question on partnerships.

Table 2.38: Partnership question and indicators

Partnership question	Partnership indicators
• How effective was the partnership model of CFAR with different agencies to empower women? • How well has the partnership of CFAR with different government and non-government agencies helped in achieving the goal? Will the partnership be carried forward beyond the project period? • Has the existing partnership of CFAR been leveraged to help build further partnerships during the project period? Has it moved from strength to strength? What are the learnings from this?	• Progress reports of CFAR relating to this programme over last three years. • Joint agreements between CFAR and government and/or organizations including joint work plans • Input from discussions with NGO partner with CFAR • Input from discussion from CFAR members (intervention and implementation) • Changes in approach due to partnership also captured during discussion with all the catalysts • Input from investigators/supervisors in three towns.

2.5a Delhi

Prevalence of open defecation had been one of the major problems in Delhi's slums. Ignorance, financial constraints, lack of space and non-availability and non-maintenance of community toilet facilities were some of the reasons for the continuous practice of open defecation among slum households. In order to bring about a change, CFAR had to begin by generating awareness about the harmful effects of open defecation and then convince them to construct personal toilets and use them. Secondly, CFAR had to make provisions for accessible and usable community toilet facilities for those who could not avail a personal toilet. In addition, availability of safe drinking water in adequate amounts, together with its utilization in a hygienic manner were some of the issues which required ground level work on accessibility and awareness. CFAR also had to deal with problems associated with lack of personal hygiene, particularly menstrual hygiene, poor drainage, garbage disposal and street cleaning. All these tasks involved establishing partnerships with several institutions from grass root level to higher authorities.

CFAR tried to build partnership with Urban Shelter Improvement Board (DUSIB) for some of its goals.

CFAR members with the help of the group in Delhi (18th block Kalyanpuri) held meetings with the officials from DUSIB. The meetings focused on the problem of open defecation and issues of behavioral change. The group members raised three important demands: increase the height of CTC's boundary wall for safety and security purpose, construct a divider wall between men's and women's toilets to avoid harassment and teasing etc. and make provision for a dustbin in the women's toilet to dispose sanitary waste and maintain proper sanitation. During one of the meetings, the point was also raised that the major part of the expenses would have to be borne by the group if the community groups were to run the CTC. In order to see if this was viable, the women's groups undertook a cost analysis to see how much each household would need to pay and how much revenue they could generate so that the group running the CTC would be able to pay for the services of a caretaker.

The DUSIB officials reiterated that in any partnership both parties should be interested and ideally be working towards a common goal. Initially the partnership of government officials and NGOs tended to be one-sided. They quoted the MoU with CFAR and MPM to make 60 selected slums into model slums as an example of an effective partnership.

CFAR also reached out to other NGOs who were working on similar issues in Delhi clusters. These included: Right to Sanitation Campaign, Water aid, Action India, Save the Children, Aga Khan Foundation, CURE, Myrada, and so on. Meetings were held with them and their suggestions were incorporated in the implementation process.

Box 1.3: DUSIB's concern and initiative for partnership

"While adding toilet seats is a key concern, another major issue before DUSIB is the process of bringing about behavioral change. DUSIB plans to trigger the process of creating self-help groups with the help of voluntary organizations to sensitize slum dwellers about water conservation, sanitation and the proper use of toilets. A list of NGOs working on sanitation, hygiene and health is being prepared to facilitate the community sensitization and awareness building." - The Times of India, 24.04.2016

Exposure visits were undertaken to expose outreach workers, staff members of CFAR as well as community members to the innovative work being done by the Aga Khan Foundation in Nizamuddin Basti of Delhi where they have a model community sanitary complex.

Meeting of officials and the community to discuss facilities

The Gender Resource Centres (GRCs) have been actively working in different clusters. Their activities include creating awareness on health and sanitation, providing medicines, organizing health camps, and providing information on legal issues. The GRC members have regular interactions with the community. CFARs association with GRCs was of great help to the cluster households.

In many cases both CFAR and GRC jointly organized health and other camps. As CFAR had a stronghold within the community the GRC members took their help in organizing camps. With Santi Sahayog, CFAR arranged health camps and doctors and motivated the households to participate in the camp and have check-ups. Another

important partnership with GRC was to celebrate different events like World Sanitation Day, World Toilet Day, Global Hand Washing Day and De-worming Day and Swachh Bharat Abhiyan under the sanitation campaign, etc. Both the organizations have a good partnership in generating awareness among people regarding different diseases like dengue, malaria, etc., through door-to-door visits.

CFAR also maintains a partnership with Delhi Jal Board (DJB), and, together with women's groups, holds meetings with Jal Board officials in order to solve water-related problems of the slums. For instance, concerned about the limited water supply in one part of the settlement of Kalyanpuri, forum members including Kiran, Geeta, Sashi and others from the same block wrote an application and submitted it to DJB. After meeting with the authorities, the engineer from DJB asked the forum to draw a cluster map. With the help of the people of the cluster, the members drew the cluster map, highlighting the water pipelines and tap positions and submitted it to DJB. Though there has been some improvement in the water flow, people are still facing shortage of water in the cluster (Source: CFAR report).

Similarly, group members like Noorjahan, Nitu and Rachna from Blocks 17-21 wrote an application and met with area MLA and DJB to sort out the water shortage problem. They also complained about people who have taken individual water connections from the main water pipe line resulting in the water not reaching everyone in the cluster.

CFAR members regularly interacted with the local MLAs to discuss water, sanitation, and garbage disposal problems of the cluster households. The periodic Jan Sabhas organized by CFAR along with other institutions provided a platform for interactions and sharing of concerns on issues/problems faced by residents.

CFAR also partnered with the Municipal Corporation of Delhi (MCD) for solving sanitation and water-related problems of the cluster. CFAR members and the outreach workers frequently meet the MCD officials to discuss different pending works. For instance, in Kalyanpuri in Delhi, outreach workers Sashi and Noorjahan went to the project offices of MCD in Patpadganj and Krishan Nagar on 20th August 2014 to find out the status of the new toilet block which was being constructed on the main road of Kalyanpuri. Concurrently, group members from blocks 19and 20 submitted a written complaint to MCD about the community toilet which was not functioning due to an electrical problem in the water motor board.

ASHA and Anganwadi workers in the slum clusters are closely related to the households and are very approachable. Hence, when CFAR started its programme, its members first discussed the issues and problems relating to sanitation, hygiene and health with them. In some of the clusters the ASHA and Anganwadi workers also became members of the group. The group members are now well informed about the benefits that they can get from ASHA workers and Anganwadi centres. The cluster households said that over the last three years these service providers have been more active and more and more people are demanding their share of benefits from them.

Showcasing its achievements :

CFAR has also been facilitating visits of International NGOs and organizations to the clusters. Eleven visits have been made in the WSH catchments areas since July 2014 by organizations like Gates Foundation, JICA (Japan International Cooperation Agency), corporate groups like- KHOLER, Deutsche Bank, UNESCAP and media like NDTV.

2.5b Jaipur

In Jaipur, CFAR had to primarily generate awareness among people of the cluster about harmful effects of open defecation, disposal of children's excreta in open spaces, the importance of personal toilets, the need for purifying water and health problems which may arise due to lack of menstrual hygiene. In the

baseline survey, it was found that nearly 46 percent of the surveyed slum women refused to allow their daughters to attend school during their periods. A change in perception and subsequent practice were found to be very important issues for the effective implementation of the project.

To address these issues, CFAR established a partnership with the health department and the NUHM. CFAR identified a space for formal community involvement by creating a support group at the field level. The health department adopted the slum-based women's forums under Mahila Aarogya Samiti (MAS). The ASHA worker is the secretary of MAS. They have regular meetings in the village where different issues relating to health and sanitation are discussed. The members of MAS are actively involved in the polio campaign of the department and have been successful in reaching out to 300 children in the slums. One of CFAR's volunteer has also been selected as the supervisor. CFAR also cooperates with the department by providing training on hygiene, health, sanitation and related issues to MAS members and others.

CFAR staff took outreach workers to Bikaner to learn about different kinds of toilets. As noted earlier, the two-pit toilet was found satisfactory, and this has been adopted by households in the slums. CFAR is now working with SBM to ensure all help to the households to construct such toilets.

Some outreach workers also visited Sawai Madhopur to attend a deliberation and training relating to the issue of child marriage. This initiative was made with an NGO named MAMTA.

In order to address the issues relating to hygiene, particularly, menstrual hygiene, CFAR formed a partnership with the Education department, in Jaipur. Following repeated complaints by community members on the status of sanitation in schools, CFAR in association with 10 civil society organizations undertook a survey of 105 government schools, after getting permission from the Department of Education. The findings were then discussed and recommendations of the report shared with the Departments of Education and Health.

In cooperation with the health department, CFAR also organized health camps (RTI/UTI screening and general illness camp). Some private hospitals and NGOs also extended help for such camps. Some of the women were referred to government hospitals.

In collaboration with the department CFAR published booklets and posters on food hygiene, personal hygiene and mother and child health.

2.5c Kolkata

In Kolkata, CFAR entered into a partnership with ICDS and the Department of Women and Child Development. As part of this intervention, CFAR submitted a formal proposal to the office of the District Project Officer, to work across 73 ICDS centres. The focus would be on establishing the critical linkage between WSH and nutrition and hygiene for ICDS representatives, mothers and the community at large. Once the proposal was accepted, work began in a phased manner. A survey of 26 ICDS centres revealed that 96 percent of them did not have toilets, close to 70 percent did not have dedicated space for cooking and would cook in unhygienic surroundings, 73 percent did not have any water facility and workers had to carry water from a distance, and practices like washing hands before cooking, washing of vegetables and utensils were minimal. What was most shocking was that the surroundings of close to 90 percent of

the centres were unclean, exposing the children, pregnant and lactating women to diseases. A consultative meeting was organized in the presence of workers, teachers, supervisors of all the 26 centres surveyed, along with the Child Development Project Officer (CDPO) and Assistant CDPO (ACDPO). The consultation aimed at establishing how the insanitary and unhygienic practices affected the nutrition and health of the ICDS beneficiaries.

Following the consultation, CFAR has been constantly engaged with various segments of the population that ICDS services caters to along with local gatekeepers and stakeholders to improve the hygienic practices of ICDS workers, helpers and mothers alike. As a result, in one area, a local club has agreed to let the ICDS centre use the toilet, and in another area, a primary school located nearby has agreed to allow the centre's workers to use their toilet.

In collaboration with the department CFAR published booklets and posters on food hygiene, personal hygiene and mother and child health. The Department of Women and Child Development will be printing and making them available at all 73 ICDS centres.

The following are some of the cluster-wise activities that CFAR is undertaking with the ICDS and other organizations in Kolkata.

- **Channels of awareness generation:** In order to generate awareness, CFAR has been celebrating important days in association with ICDS. For instances, "World Breastfeeding Week", "Nutrition Week", and "Children's Day", etc., enabeled it to reaching out to approximately 97 mothers and 100 children with messages relating to good practices on hand-washing, personal hygiene, intake of nutritious food etc.
- **School health programme convergence with the National Health Mission:** Given that National Health Mission (NHM) will divide its resources equitably between ICDS centres and schools in urban areas, CFAR will facilitate a scheduling of their visits to all the Centres and schools through SMCs (School Management Committees) and Anganwadi Development Committees (ADCs), initially in Wards 7 and 27 of Rajpur Sonarpur Municipality and then the entire municipality as part of the plans for scaling up.
- **Development of curriculum on personal hygiene and Menstrual Hygiene Management (MHM):** The first School Sensitization programme was held at Green Park Shishu Sadan High School in Kamalgazi, Rajpur Sonarpur Municipality for 60 high school adolescent girls. The feedback from the students as well as the attending teachers was positive; the session is being replicated in another school in the municipality, reaching out to about 50 adolescent girls. CFAR is in the process of submitting a proposal to the district chairperson, Secondary Education, seeking to organize such workshops for other secondary schools in the municipality and possibly others of South 24 Parganas. CFAR is also making an attempt to develop an instructionally sound curriculum which would cover gender and body related issues, understanding adolescence, specific social norms relating to menstruation, awareness-raising on taboos and breaking of silence, involving men and boys in the entire process and the health and mental well-being of the community at large, along with the physiological, behavioral and psychosocial aspects of adolescence and menstruation. This curriculum would also include an important component of WSH, to promote the usage of toilets.
- **Facilitating health-seeking behavior:** The convergence with NHM will serve as a forum to encourage health-seeking behaviour among the community, particularly among women and girls. This will be achieved with the tools of: counseling, health camps, awareness programmes and intense advocacy, led by the community and specifically by the School Management Committee.

- **Facilitating School Management Committees (SMCs):** Encouraging community members to take active participation in the SMCs and facilitating the regularization of the activities of the same is another aspect that CFAR is focusing on. These committees apart from their primary responsibilities of preparing school development plans, beautifying the school environment and so on, also have a role to play in ensuring the enrolment of all non-enrolled children through enrolment drives (RTE) and preventing adolescent girls from discontinuing their education due to lack of proper toilet facilities in schools).

- **Collectivization and creation of health champions:** Over the past two years, six women's forums, four adolescent girls' group, and three boys' groups have been created across the six intervention clusters. A total of 211 women, girls and boys reach out to 2700 households. The adolescent girls' groups are simultaneously reaching out to their peers across six schools. Of all the groups' members, 30 are now functioning as Health Champions and are actively participating in various initiatives taken by the community. The ICDS survey, the survey of toilets in local railway stations and negotiating with local clubs were facilitated by the health champions themselves. Three performing groups comprising 22 adolescent boys and girls has been formed for spreading the messages of WSH across all clusters of the operational area as well as in neighboring clusters. Thanks to the efforts of the health champions intervention has also begun in a new cluster, in Ward No. 7.

- **Reaching out to the railways:** A consultation titled 'Train, Travel and Toilets' was organized in partnership with Parichiti – A Society for Empowerment of Women, at the Academy of Fine Arts on 3rd December 2014. The consultation sought to facilitate a focused exchange and dialogue between the railway authorities, regular commuters of railway and other NGOs, and address the critical issue of lack of toilets on local trains and deficient infrastructure and maintenance of toilets in local railway stations. The consultation was followed by an in-depth survey of four stations in the suburbs of South 24 Parganas - Dakshin Barasat, Joynagar, Baruipur and Lakshmikantapur. The Health Inspector for this route, who was present at the consultation, expressed his interest and support for CFAR's initiative to bring focus to the condition of toilets in these four stations and partner with the railway authorities to ensure clean toilets and the repair and maintenance associated structures such as septic tanks. This entire initiative is currently under process.

- **Health screening camp for women in Ward No. 7:** Through this health camp CFAR reached out to a total of 89 women and adolescent girls**.** Of them 58 women were detected with Respiratory Tract Infections (RTI)/ Sexually Transmitted Infection (STI)/ Urinary Tract Infections (UTIs) RTI/STI/UTI and 25 of them were diagnosed as critical and referred to the nodal health facility at the M.R. Bangur Hospital. The health champions along with outreach workers are constantly following up on them and eleven have been reportedly cured of the problem.

- The community leader of Uttar Kumrokhali announced that a water project named 'Aamrup Water Project' with 17 reservoirs had recently been sanctioned and would very soon be launched in 35 wards with the help of the corporation and local leaders.

- The female ICDS workers from Ward No. 11 (Ghoshpara and Langalpara) and Ward No. 27 (Ukhila, Laskarpara) of Sonarpur Rajpur area spoke of the positive impact of CFAR's intervention on ICDS. The respondent from ward no 27 said that they were acquainted with the CFAR group for the last five years. CFAR's first initiative was a training programme where 12-15 mothers from ICDS were present. There were further meetings on the issues of health and hygiene related to hand-washing with soap, cleanliness, nutrition etc. According to the ICDS

worker, when ICDS came into being it was also concerned with health and hygiene issues and tried to spread the same message to the mothers, but the work got strengthened only after the intervention of CFAR.

- In Pragati Milon Sangha Club of Ward No. 5, the ICDS centre had no hygienic toilet. In Kusumba Muktitirtha Club of Ward No. 7, there was no electricity. CFAR tried to spread awareness in these areas about health, hygiene, cleanliness and vaccination of children and mothers. The members of CFAR made frequent visits and held discussions with club members for proper maintenance of toilets. Meetings with the mothers were held to make them aware of proper cleaning of feeding bottles, nutritious food and cooking methods to prevent the loss of vitamins. CFAR also organized health camps for mothers.

- In Jagannathpur of Ward No. 8, the ICDS centre is located in Madrasah School. Many visits have been made by the CFAR group for improvement of the centre. They do six day trainings with the mothers on making healthy and nutritious food, regular cleaning of clothes, cleaning of infant bottles and related issues.

- In the discussion with the principals of St. George Day High School (Ward No, 59: Tiljala road, Park Circus); George Day English School (Ward No. 21: Habib Chowk, Mallickpur) and Ramkrishna Vidyapith (Ward No. 15: Baguipara, Rajpur Sonarpur Municipality) it was revealed that while they were not aware of CFAR or the WASH project, they are aware of the importance of maintaining hygiene and cleanliness through a different hygiene-related project 'Gali Gali Sim Sim' by another NGO.

o A workshop had been held at St. George's Day High School where the students were made aware through a variety of demonstrations on the importance of washing hands with soap after using toilets, before and after having food and also on wearing shoes while going to the toilet. The students were very enthusiastic about the demonstrations, calling it 'magic'. The students started practicing these habits, and even made posters and drawings related to them and displayed it in a workshop. Parents meetings have also been conducted on these issues. The school also wants to be a part of such hygiene and sanitation based projects in future to maintain a sustained habit of hygiene and cleanliness among students. CFAR intervened in Mallickpur area by setting up health camps at schools where the mothers of the children attended the free health check-ups in large numbers. They became aware of different women's health related problems including the incidence and severity of reproductive tract infections (RTI). CFAR also organized a WASH-related workshop in the ICDS School for children between 3-8 years.

Awareness training camp for ICDS staffers

o According to the principal of Ramkrishna Vidyapith the children were aware of certain hygiene practices through the Sarva Shiksha Abhiyan, Nirmal Vidyalaya Abhiyan and Swachh Bharat Mission, but they did not follow them. It was only after CFAR's intervention including picture demonstrations, playing with balls, etc., that they have started following these

practices. The principal is hopeful of having more such interventions from CFAR and other NGOs in the future in the form of workshops and training programmes on hygiene, sanitation and cleanliness.

- In the Sonarpur ICDS project, CFAR works closely with the CDPO to make mothers aware of maintaining hygiene while washing vegetables and cooking food. They have also been made aware of how to cook without destroying the vitamins and the importance of nutritious food. According to the CDPO, the number of children taking enrolment in the ICDS centre is decreasing. CFAR's collaboration with the CDPO aims at increasing enrollment as well as evaluating the results. CFAR has organized training programmes for mothers including celebrating Mother's Day by holding health camps. CFAR has also been organizing quiz programmes with the mothers on health and hygiene issues. According to the ICDS representative, earlier the ICDS had no health schemes or facilities. But after the intervention by CFAR, the problem of health related issues were solved to some extent.

o Since the ICDS representative wants closer association with CFAR, especially for workshops and training programmes, interactions will be needed between the officer, the ICDS supervisors, the ICDS workers and CFAR to develop action plans. On some occasions there has been a sort of communication gap between the supervisors, the ICDS workers and CFAR members. The officer said that the role of CFAR in ICDS is that of supporting the system or acting as a catalyst to improve the functioning of ICDS. So the organizing of meetings of ICDS workers, supervisors and CFAR at least once in a month with proper monitoring of different problems will bring out effective and desired results. However identifying the focus area and accordingly planning for effective intervention and regular evaluation of the functioning and the outcome remains a challenge for CFAR.

Global Hand Washing Day being observed with ICDS beneficiaries

o An interview with the supervisors of ICDS revealed that there are 21 supervisors working in 36 wards of Rajpur Sonarpur area. The main responsibility of these supervisors is to conduct the training programmes involving the ICDS workers, the helpers and the mothers of the children coming to the school. They are aware of the service facilities that should be provided by these ICDS centres. It is also the duty of the supervisor to check the functioning of the centres by providing assistance and guidance if an employee is absent on any particular day.

o CFAR also tried to create awareness about menstrual health and hygiene among the adolescent girls of these wards by imparting knowledge about sanitary napkins and free supply of folic tablets in their educational institutions. The ICDS supervisors acted as a connecting link between CFAR and the adolescent girls. Women's "Swonirbhor goshthi" (self-dependent forum) has started participating in social issues like Hand Wash Day and political events like elections. They have made posters with the help from CFAR and ICDS supervisors to spread

awareness about health and hygiene issues. The women themselves pose as models for the posters, because they think it is the best way to serve the purpose.

2.5.1 Sustainability of partnership

The evaluation revealed the sustainability of CFAR's partnerships with other organizations and institutions. The reasons for this include the following:

- CFAR has been working in the area even before the programme period and they have a strong network with different NGOs and government organizations who are working in the field area.
- Many a time the government agencies need CFAR's help in finding solutions to problems that arise in implementing government programmes, such as identifying the beneficiaries of individual toilets under the CBA programme in Jaipur and convincing the community people to register themselves.
- CFAR has been able to generate some efficient community leaders who are now able to interact with officials and political representatives whenever any problem arises.
- Although the intervention strategy is to enable women to stand up for their rights and ensure service delivery from different authorities, in many areas continuation of CFAR's involvement may be required for a few more years.
- New initiatives and changes made in the strategy of intervention such as formation of male member groups and youth groups, and intermingling of community members from different parts of the same cluster to develop collective identities will be required.
- Moreover because of its long time experience of working in urban slums, CFAR has a rapport among different funding agencies which could assist it in generating funds for following up the programme in the future.

2.6. End-term Evaluation from the Three Cities

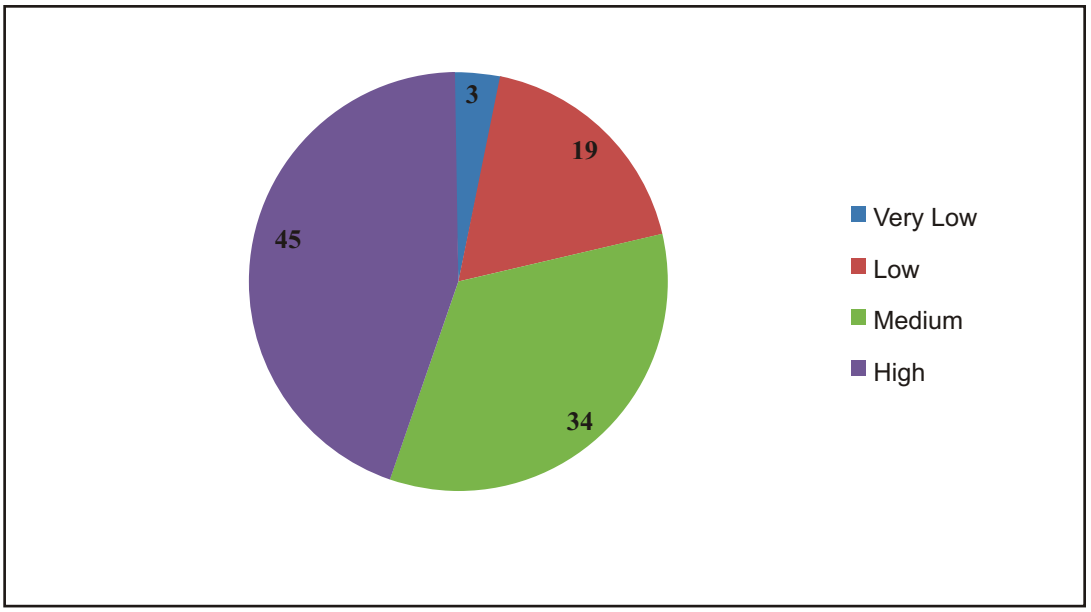
This section deals with two sets of issues – one, behavior change over time as captured through the pictorial survey tool administered during the end-term evaluation survey; and second, the changes that can be directly attributed to CFAR and its intervention. The information on behaviour change is largely based on the pictorial survey with a little interpolation from the qualitative survey. The directly attributable changes have been measured through a combination of different elements posed as queries for which respondents have identified CFAR's role; which includes all its members and the various programmes initiated during the intervention period of this project.

2.6.1 On behaviour change over time

The relevance of the critical issues on which the programme intervened was assessed on the basis of a few statements against which the respondents were asked to express their perception of the situation three years ago before the programme and the present scenario.

On water and its necessity, especially that it must be clean and the consequences of unclean water, less than one-fifth of the households reported that the relevance and its recognition was high even at baseline, while the majority of them reported it to be low or medium. This picture has changed drastically with a lot of the respondents, close to 70 percent, clearly stating that they gave high priority and significance to clean water and its requirements. Substantial efforts under the programme through IEC material, camps, trainings and communications during periodic meetings have aided the process of bringing about this change. Although many women said that they knew the importance of water in their lives, the significance of it being clean and how to ensure that through various methods of storing, ways of using water, etc., was emphasized through the intervention. Women across localities in all the three cities said that the reiterating such information can make a big impact on the health of the women and their families. There are marginal variations across cities with slightly fewer women reporting high significance in Jaipur about clean water being necessary. We measured the change over time by examining how many respondents who reported very low at the beginning of the programme have changed or shifted their perception on the matter by providing relatively more importance to the issue of clean water and its necessity.

Graph 2.17: Of those who responded 'very low' to the statement "clean water is necessary" at BL



Graph 2.17 shows that almost one-half of the women who gave very low priority to clean water in their perceptions prior to the intervention have reported as giving the matter high importance during the end line.

On the relevance of toilets and change in the perception of its importance over the period of the programme, nearly 45 percent of the women surveyed attributed very low or low priority to toilets being necessary at the beginning of the programme. Post intervention, a very negligible share of women, less than five percent, gave it a low ranking, with most women attributing it medium or high priority (see Graph 2.2). The change over time even in the perception of those women who reported very low priority to toilets at baseline is significant with more than 80 percent now reporting it to be medium or high.

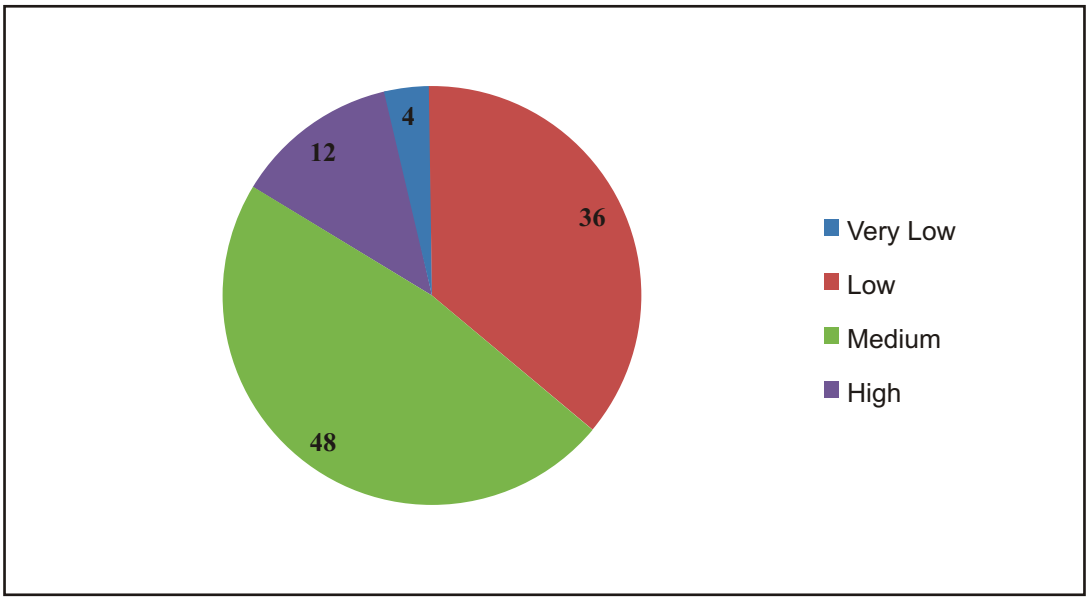
The subject of washing hands with soap and detergent has been the focus of the intervention through different methods and the survey reveals substantial changes in the practice. Many women gave low priority to washing hands with soap before the intervention, but now even those who reported very low priority have begun to perceive it as important with more than half of them now considering it of high priority.

Ability to complain about non-provision of or lack of access to water and sanitation facilities

This has also changed over time but more slowly. Although the number of women who did not have the agency to do so prior to the intervention has reduced, more than one-fifth of all women continued to report very low ability in Delhi. The situation in Jaipur and Kolkata was relatively better. Overall even now, after the intervention, only one-fifth of all women across the three cities reported high levels of ability to complain on WSH issues.

It probably takes time for women to build the capacities and confidence to complain. One-half of those who reported very low ability at baseline prior to the intervention now shifted to the next level of low, while only 12 percent of them reported medium and only four percent high (Graph 2.18).

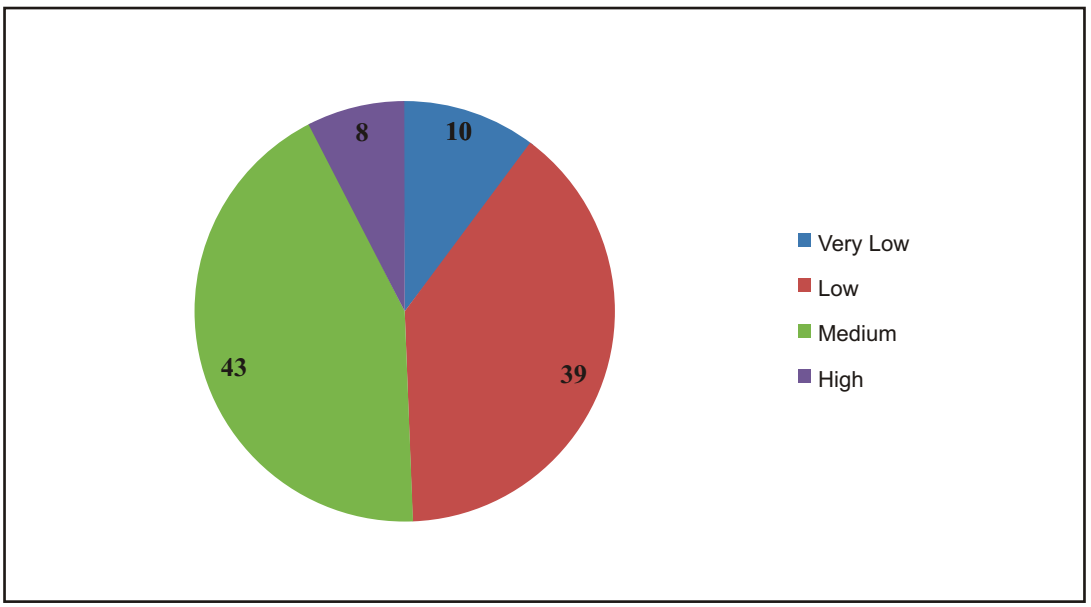
Graph 2.18: Changes in women who reported very low ability to complain pre-intervention by the end term



On confidence to talk to others and discuss issues, while three-fourth of the women did not feel they could do it before the intervention, now only 38 percent feel that way (very low and low).

In terms of helping others or joining them in complaining or addressing the issues, Kolkata appears to have recorded higher levels of change for the positive. However, across all cities, among those who reported very low agency pre-intervention, almost 20 percent seemed to have gained confidence in themselves by end term.

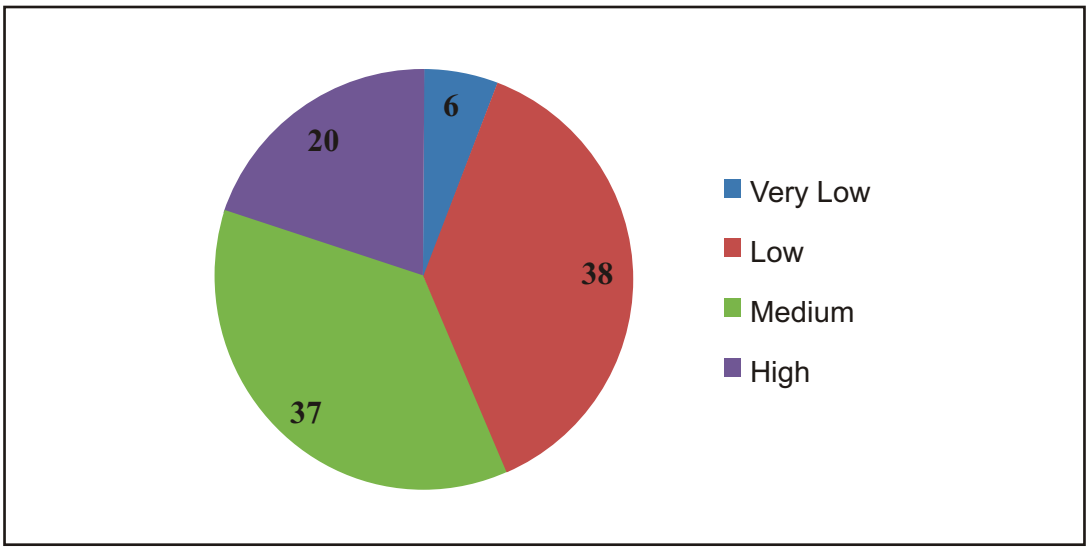
Graph 2.19: Changing scenario of percentage of women who were very low in addressing common issues pre intervention



This reflects that, post intervention, the confidence levels of the women are gradually improving and so is their shared concern for issues.

Prioritizing their own health was never high for most women with less than 10 percent stating that they prioritized their own health before the intervention; however, this has also been changing with the intervention. The inhibitions and constraints women felt to discuss personal, sexual, menstrual matters with doctors or even among themselves within the household are also gradually beginning to change. This was especially the case among the adolescents who articulated this in the FGDs (Graph 2.20).

Graph 2.20: Changing scenario of percentage of women who were very low at pre intervention stage and are now giving importance to their own health



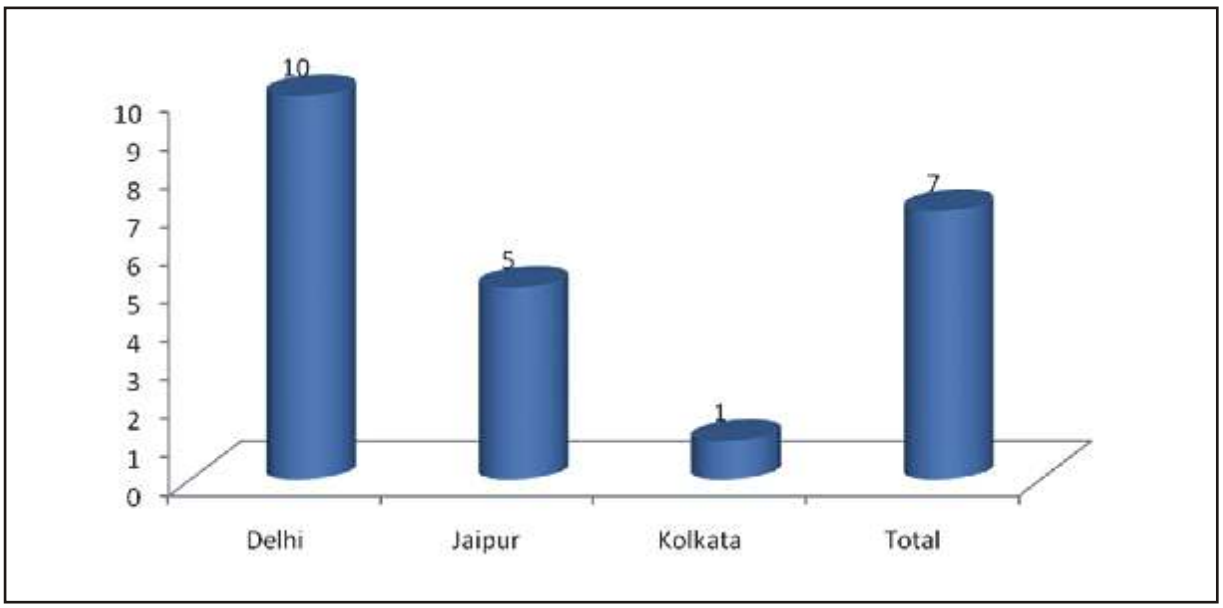
As witnessed from the analysis based on the pictorial questions in the tool used for end-term evaluation survey, there have been substantial positive changes noted over time during the intervention period from baseline to end term. Not all the domains have shown similar gains, with a few aspects highlighting the need for continuing the intervention for a longer period perhaps before any changes are visible (for detailed changes over time from this exercise see Annexure Tables 1.11 to 1.25).

2.6.2 On changes attributable directly to CFAR and its interventions

This section deals with the achievements that can be attributed directly to CFAR's intervention. The measure through which this has been ascertained is based on the responses to the survey questions posed to respondents in all the three cities on each major theme such as sanitation, water, drainage and street cleaning and personal hygiene. The impact of CFAR as reported by respondents in terms of who informed them about these issues, with whose help did they complain on these issues when service delivery improvements were required and so on. These achievements which may appear small at times are significant as these have been directly attributed to CFAR and its role (which includes all its interventions activities, the members who have been involved in the programme and so on). The change however, as reported in this end term report, tends to be much larger. There might be other influences over and above that of CFAR in such cases which is not always easy to disaggregate.

Sanitation

Graph 2.21: Role and achievement of CFAR in toilet related issues (% of women)



Source: Calculated from IHD Field Survey, 2016

Note: Achievement captured from CFAR's role in generating awareness to construct and use of toilet and filing of complaints related to sanitation

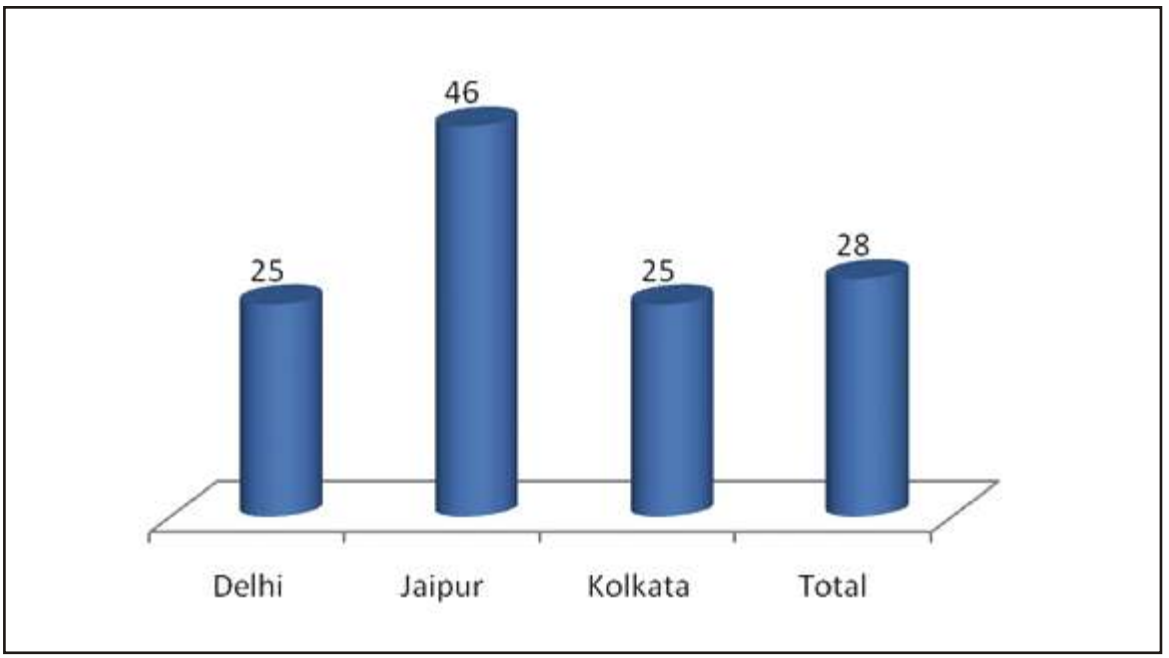
By taking into consideration the role of CFAR's intervention in sanitation-related issues, especially with regard to recognizing the significance of construction and use of toilets, as well as with their ability to file complaints relating to these issues with help or assistance from CFAR, the end-term evaluation finds nearly seven percent of the respondents stating clearly that they benefitted from the intervention and credited this to the organization and its members (Graph 2.21 and Annexure Table 1.28). The extent of benefit reported was maximum for Delhi since most of the locations and households therein did not have any toilet provisioning or poor public toilet facilities. In Jaipur, the

respondents who had the space and resources to benefit from the new technology were able to build two-pit latrines. Overall, by the time the end-term evaluation survey was undertaken the presence of many more factors in the midst of the SBA may have been at play. Also, the measure used here aggregated a set of two different aspects to calculate the degree to which the changes and gains may be attributable to CFAR.

Water

Quantitatively capturing CFAR's role and achievement in the arena of water-related issues, 28 percent of the surveyed households felt that CFAR members helped them in generating awareness about necessity of purifying water and filing complaints to get their water-related problems solved (Graph 2.22 and Annexure Table 1.26). Now, a higher proportion of people are able to approach the concerned authorities if their basic right of clean drinking water is not fulfilled. In Jaipur, 46 percent of the surveyed households supported this view. In the city of Delhi and Kolkata, 25 percent of the households felt this to be the achievement of CFAR.

Graph 2.22: Role and achievement of CFAR in water related issues (% of women)



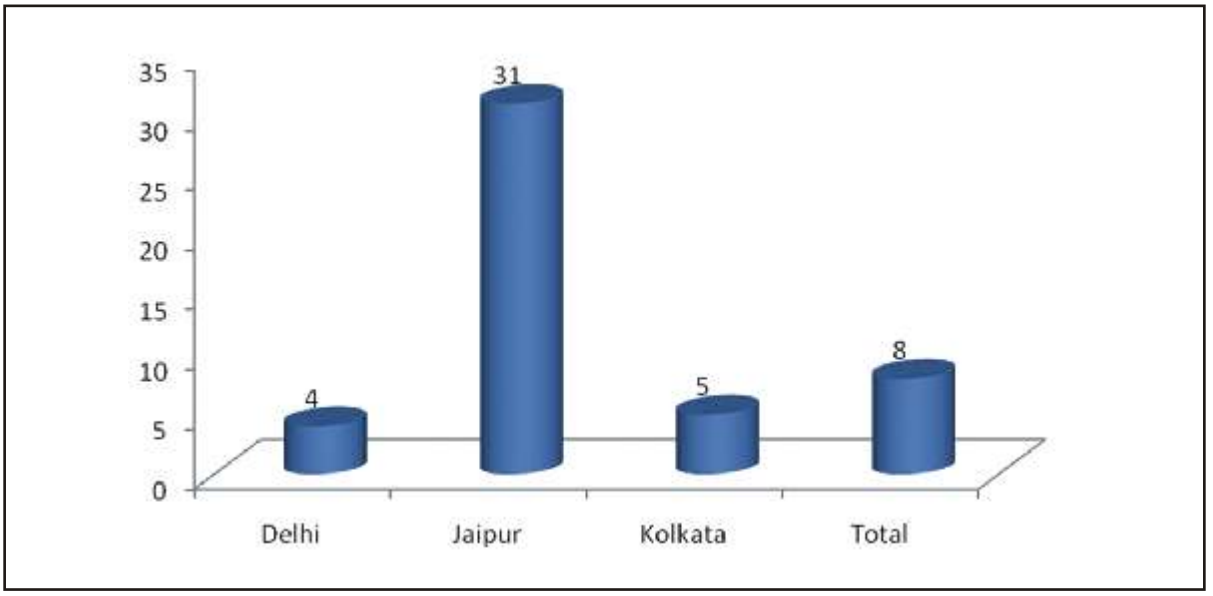
Source: Calculated from IHD Field Survey, 2016

Note: CFAR's achievement captured from generating knowledge regarding purification of water and filing of water supply-related complaints.

Garbage disposal, drainage and street cleaning

Quantitatively capturing CFAR's role and achievement in the area of garbage disposal, drainage and street cleaning through field survey findings shows that a total of eight percent of the surveyed households felt that CFAR members helped them in solving all such problems (Graph 2.23 and Annexure Table 1.27). They motivated and helped the people of the clusters in approaching the concerned authorities when they faced problems relating to garbage disposal and water logging due to lack of proper drains. In Jaipur, 31 percent of the surveyed households supported this view. In the city of Delhi and Kolkata, four to five percent of the households felt this to be the achievement of CFAR.

Graph 2.23: Role and achievement of CFAR in garbage related issues (% of women)

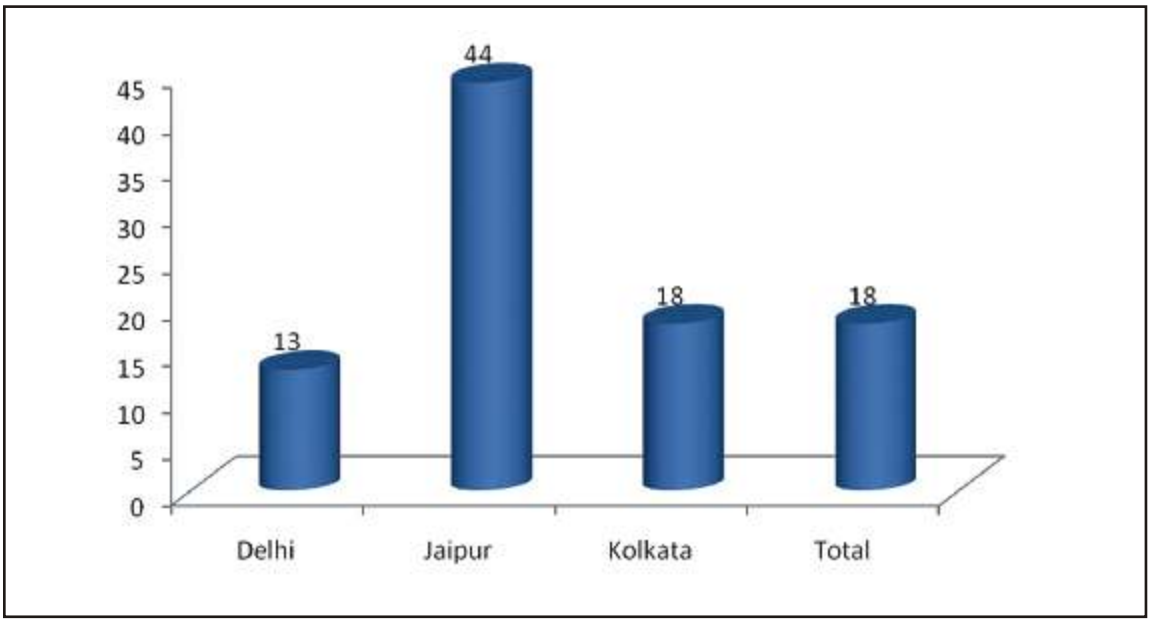


Source: Calculated from IHD Field Survey, 2016

Note: CFAR's achievement captured from respondents finding CFAR most approachable in solving problems relating to garbage and filing complaints.

In the area of personal and menstrual hygiene, the data captured through field survey findings show that a total of 18 percent of the surveyed households felt that CFAR had brought about a change in terms of shifting to usage of napkins (from cloth) and inculcating the practice of washing hands (Graph 2.24 and Annexure Table 1.29). They also felt that the organization of health camps by CFAR had been beneficial for them in getting awareness about reproductive health problems, necessity of menstrual hygiene and the importance of discussing such problems with others. Forty four percent of the surveyed women in the city of Jaipur, 13 percent in Delhi and 18 percent in Kolkata upheld the above views.

Graph 2.24: Role and achievement of CFAR in hygiene related issues (% of women)



Source: Calculated from IHD Field Survey, 2016

Note: CFAR's role in shifting from cloth to sanitary napkin, following hand washing and finding health camps beneficial.

At the end of the discussion on the changes over time, it can be stated that substantial changes have been achieved in all the three cities, although with variations across issues. The domains where there has been maximum change tend to be those pertaining to behaviour change (water-related and personal hygiene), while sanitation and garbage collection as reported tend to remain more difficult to address due to structural difficulties.

The findings of changes attributable to CFAR's intervention show a significant difference between the group and non-group members (see Annexure Tables 2.26 -2.29). While this is in a sense a reflection of the positive outcomes resulting from the intervention through formation of forums consisting of women members mostly, and few instances of adolescent girls and also men/youth, the difference among the forum members and non-forum members shows that in this phase of the programme it was only possible to bring about changes amongst a set of community people. The expectation that this intervention would also translate through transmission to other non-group households has been slower and would perhaps require much more efforts on the part of CFAR and its members through concerted intervention for a more prolonged period. CFAR is already making efforts to reach out to other members of the community within the localities where the programme is operational, and some signs of benefits are visible. However, a lot more needs to be done before the benefits are shared by all sections of the community.

Community Toilet Complex in Trilokpuri Cluster, Delhi

3. CONCLUDING REMARKS AND WAY FORWARD

The end-term evaluation of CFAR's intervention on generating awareness and changing behaviour related to water use, sanitation and hygiene have been quite effective in several ways though a few challenges remain which need to be addressed in the way forward. By making personalized rapport and connection with women and adolescent girls in the locality through various mechanisms, the programme created awareness among women. The programme employed different strategies keeping in mind the issues in any given area. What was remarkable was their effective use of interpersonal communication over and above IEC material to bring about behaviour change, which is one of the most difficult aspects to modify or alter.

After the first phase of the intervention, newer strategies were evolved and the end-term evaluation shows that the impact on the area as a whole has been quite positive. The groups have been able to percolate some of the learnings to the non-group members of their communities and also across communities at times. Through demonstrations, the group members and leaders as well as CFAR worked towards creating awareness among the communities in localities where they are active. They are also trying to address some of the conflicts with community members who felt left behind by initiating interactions between group and non-group members. Efforts to initiate activities in areas other than the ones where group members' households are located are being made to bridge the gaps perceived during the various phases of the intervention.

In terms of seeking to make WSH concerns central, the CFAR programme has been very successful in creating the relevance for these concerns and also ensuring participatory involvement of the women who have also exercised their agency in articulating their needs. These issues have become central in the lives of the community women. They are recognizing these needs, raising their voice, where needed, seeking help of CFAR members or local leaders and actively working towards having their voices heard.

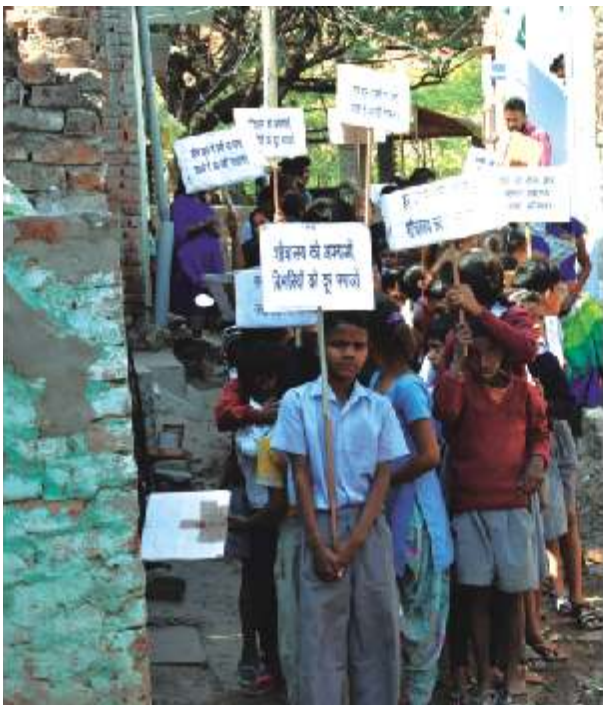
Communities are insisting on overall cleanliness and removal of garbage

The CFAR intervention has not only succeeded in generating awareness regarding the various government programmes, but also with regard to the rights of cluster residents. Among the programmes, women were aware of the *Ladli* scheme and *Swachh Bharat Abhiyan* and were participating in the parent-teacher meetings in the schools of their children. More children have been attending schools and some are even going for private tuitions which their parents have invested in.

Improvements have been noted among the households in locations where CFAR has intervened. There are signs of increasing women's participation and reduction in instances of violence, with women's groups addressing the domestic violence faced in the community. In terms of overall cleanliness and removal of garbage, the communities have been motivated to take up the task themselves, or sharing the tasks by dividing responsibilities. Instances of such behaviour change noted among the women and their communities are indeed noteworthy and highly appreciable. This has been noted by the Delhi Urban Shelter Improvement Board (DUSIB) and other local authorities which are strategizing to involve CFAR in their new ventures of *Adarsh Bastis* (Model Slums). Officials are beginning to realize that technical

approach to problems faced by slum dwellers alone is not sufficient and that it is important to motivate the community to feel a sense of ownership of the facilities in order to sustainably maintain them. This has helped CFAR and other NGOs to work with synergy in partnership with the officials.

The opportunity to help the government authorities wherever feasible is proving mutually beneficial and is strengthening ties to build an integrated architecture. Several of these are illustrations of the transitional structures, which consisted of informal norms and rules which can curtail change or create obstacles and prevent effective intervention. To overcome these obstacles the building of new bridges is being attempted.



New synergies have emerged by involving including boys and youth groups in the intervention

New synergies have emerged by bringing men's and youth groups into the fold. Boys' groups are energetic and quite successful, but the men's groups have been less successful, since the pressure of livelihoods leads to paucity of time for regular meetings and follow ups. However, what has been achieved through this, as the women put it, is the higher level of understanding among their men which is enhancing their support to the women in such work.

The partnerships in Delhi with Mission Convergence, GRCs, other NGOs and DUSIB; in Jaipur, with NUHM through formation of *Mahila Aarogya Samiti* and SBA through the Department of Urban Development and in Kolkata through the ICDS and to some extent with Club members are all instances of the partnerships which were successfully executed between institutions as part of the intervention programme.

The building of awareness and confidence that some minor issues and problems can be addressed by communities themselves, either individually or collectively, is another major shift. Small problems like failure of taps or sweeping of lanes in their clusters are now being independently addressed by people. Children within these clusters have begun rebuking persons who throw garbage on the streets rather than at designated places.

Women and adolescent girls are breaking taboos and beginning to speak on issues such as sexual harassment, violence, discrimination and exploitation, and menstruation. Some of the active members among adolescents are addressing issues of sexual harassment being faced by the girls in the community, and to express their needs to officials.

The SBA used CFAR as a means to spread awareness regarding forms and check for duplication. There has been an up gradation of CFAR's own staff, and members from the community are now working closely with them, or have been inducted as staff members.

The achievements and mid-course corrections based on learnings reflect the successful execution of the intervention to a large extent. The discussions in each domain illustrate how effective some of the transitions have been. Of course any endeavor of such nature will have its own challenges some of which are listed based on the end-term evaluation findings before reflecting on the recommendations for the way forward.

3.1 Challenges

The reception and acceptance of CFAR members elicited a differential response from people. The experiment to bring in male members and form men's groups was not very successful since they could not spend enough time on meetings and discussions. In Jaipur, in the few locations where the CFAR intervention could not succeed or even get established, one of the major reasons was the migratory nature of the population.

The biggest challenge to the intervention and its success stems from the insecurity of tenure and perpetual fear of relocation or removal of their clusters. This automatically and understandably translates into non-involvement, disinterest and demotivation.

The mid-term evaluation report noted the problems stemming from a particular part of the cluster and its inhabitants being covered while the rest of the community felt alienated and left out. CFAR paid special attention in addressing the issues of these uninvolved groups of households in localities. Gradually, in some locations efforts were made to increase their involvement. The displeasure, suspicions and doubts harbored among these uninvolved households are now being cleared. Similarly, activities such as mobilization and organization of *Jan Sabhas*, and so on generally tended to occur where the members were active, neglecting others. Now the members of CFAR forums try to make conscious efforts to go to other segments within their clusters, mobilize and involve the hitherto uninvolved groups, and even have these parts of the cluster as venue for some of their activities.

Interpersonal communications like this hand washing demonstration is bringing about behaviour change

Though there are challenges of going deeper within the same clusters rather than expanding to other clusters. This is an option exercised by CFAR hoping to consolidate their successes rather than spreading thin and losing out on the advantages.

The shifts and changes among CFAR members proved to be a detriment and hurdle for smooth intervention and effective programme implementation. As per the strategy the constant visits and activities could not be carried out in all locations during certain periods due to staff shortfalls.

In terms of effective partnerships, the competition amongst NGOs for the limited resources available for similar programmes can sometimes come in the way of successful collaborations. The effort to do better and get noticed by donors was also noted as a factor at times that affects partnerships.

3.2 The way forward

The recommendations flow from the analysis of the efforts, successes, achievements and challenges remaining as noted from the end-term evaluation. The strategy to use a mix of different methods and inputs for the implementation of this intervention has proven to be effective. However, more rigorous and continuous efforts are perhaps needed in all the areas of focus for it to be successful and transform to the level where it can be viewed as sustainable.

There is also the context of having appropriate support from the government and its programmes for leveraging the intervention efforts effectively. The early phase of this intervention dovetailed with the

Mission Convergence in Delhi for instance and used the Gender Resource Centre platforms, which will now change. However, the vantage point of having the Swachh Bharat Mission is a major support which can boost any intervention of this kind.

The efforts by NGOs to partner with government were often thwarted since the need was not felt by the latter. As governments began to feel the need for NGOs involvement to assist them in achieving their goals, pathways for partnership opened up. Constant efforts towards building such collaborations have been resulting in useful partnerships.

Efforts to form a national collective consisting of different bodies that can come together with their strengths and weaknesses, and build their strong points while helping out in such interventions is being envisaged.

Given the situation of urban poor localities, there is need to move towards no open defecation and ensuring toilets for all under the SBA. The associated concerns require renewed focus on sanitation, water and hygiene in order to improve the lives of urban poor women and girls.

Several partnerships have been successfully executed between institutions as part of the intervention

Annexure Tables

Annexure Table 1.1: Cluster-wise households surveyed in the three cities (Number)

City	Cluster type	Slum/cluster name	Total households
Delhi	Intensive	Indira Camp Kalyanpuri	132
		Indira Camp Khichripur	78
		J.J. Camp Anand Vihar	78
		Jain Mandir	132
		Jhilmil Industrial Area	75
		NTPC Subhash Camp	74
		Old & New Priyanka Camp	111
		Rajasthani Camp	77
		Saboli Khadda	102
	Extensive	Indira camp Trilok Puri	55
		Janta Majdoor Camp	27
		Navjeevan Camp	84
		Priyanka Camp	35
		Rajeev Camp Jhilmil Colony	54
		Rajeev Nagar	57
		Rajiv Camp Chitra Vihar	39
		Shashtri Mohalla	54
		Subhash Camp Dakshin Puri	57
		Total	**1321**
Jaipur	Intensive	Ambedkar Nagar	40
		J.P. Colony	40
		Jhalana Kunda	110
		Soothmill Colony	70
	Extensive	Baba Ramdev Nagar	40
		Total	**300**
Kolkata	Intensive	Dakshin Kumrokhali	60
		Pirottopally	61
		Purbopara	60
		Stadiumpara	80
		Ukhila	60
		Uttar Kumrokhali	80
	Extensive	Habib Chowk	20
		Jagannathpur	30
		Jan Masjid	20
		Jugnu Club	20
		Kandarpapur	53
		Kusumba	31
		Narendrapur	33
		Total	**608**
		Grand Total	**2229**

Source: IHD End-term survey 2015-16

Annexure Table 1.2: List of qualitative interviews Delhi (Forum and non-forum) (Number)

Sl. No	Slum/Cluster	Status	Intervention type	Women - group	Women - non-group	Men - Non-Group	Youth/Child - group	Adolescents	Total
1	19-20 Kalyanpuri	Comprehensive	Outreach Intervention	1					1
2	18 block Kalyanpuri	Comprehensive	Deep Intervention	1	1				2
3	Sunlight Colony Old Seemapuri, near cremation ground	Comprehensive	Outreach intervention	1					1
4	Sanjay camp - Gokulpuri	Comprehensive	Deep Intervention			1		1	2
5	IG camp II	Comprehensive	Outreach Intervention		1				1
6	Nandnagri Railway Quarter Mandoli Road	Comprehensive	Outreach Intervention		1				1
7	Sashtri Mohalla	Extensive	Deep Intervention	1	1				2
8	Rajeev nagar	Extensive	Outreach Intervention		1			1	2
9	Indira camp block 28-29 Trilokpuri	Extensive	Outreach Intervention		1				1
10	17-21 Kalyanpuri	Intensive	Deep Intervention	1					1
11	6-7-8 block Khichdipuri	Intensive	Deep Intervention		1			1	2
12	Rajasthani Camp	Intensive	Deep Intervention		1		1	1	3
13	NTPC Subhas Camp	Intensive	Deep Intervention	1		1	1	1	4
14	Saboli khadda	Intensive	Deep Intervention	2	1				3
15	Anand Vihar Rly. colony	Intensive	Outreach Intervention				1		1
16	Jain Mandir	Intensive	Outreach Intervention		1				1
17	Priyanka camp Aligaon	Intensive	Outreach Intervention		1				1
		Grand total		**8**	**13**	**1**	**2**	**5**	**29**

Source: IHD End-term survey 2015-16

Annexure Table 1.3: Qualitative interviews - leaders, decision-makers, officials Delhi (Number)

Sl.No	Person(s) interviewed	No. interviewed
1	DUSIB officials (a) Mr. Singla (b) Mr. Mahajan (c) Mr. KP Singh	3
2	Network NGOs Goonj CURE	2
3	Anganwadi Centre of North-East and South District	2
4 .	MCD officials of sanitation department Dr. Mamta (South MCD) Dr. Parul (East MCD)	2
5	GRCs ASHA Deep Foundation Shanti Sahayog	2
6	Corporate house as CSR - NTPC Mr. Sabarwal	1
7	CFAR members	1
	Total	**13**

Source: IHD End-term survey 2015-16

Annexure Table 1.4: Qualitative interviews - Jaipur (Forum and non-forum) (Number)

Name of the Slum	Women - Forum	Women - Non-forum	Adolescents	Youth	Total
Soothmill Colony	1	1	1	1	4
Ambedkar Nagar	1	1	1		3
Jhalana Kunda	1	1	1	1	4
J.P. Colony	1		1		2
	4	3	4	2	13

Source: IHD End-term survey 2015-16

Annexure Table 1.5: Qualitative interviews - leaders, decision-makers, officials - Jaipur

Sl. No.	Meeting	Number
1	Meeting with Town Project Officer of Municipality	1
2	Meeting with community organizer	1
3	Community leaders (Sooth Mill and Jhalana Kunda)	2
4	Planning consultant (Jaipur I)	1
5	State Mission Director cum Director - Swachh Bharat Mission/Director of local bodies	1
6	Sanitation Inspector, JMC - Jhalana Kunda (Ward 51)	1
7	Anganwadi worker- Sooth Mill Colony	1
8	ASHA - (Sooth Mill Colony)	1
9	NGO personnel Pariwar Seva Sansthan AVI Pharma, Jaipur	2
10	State consultant - NUHM	1
11	Ward councilor Ward 51	1
12	CFAR members	1
Total		**14**

Source: IHD End-term survey 2015-16

Annexure Table 1.6: Qualitative interviews - Kolkata (Forum and non-forum) (Number)

Sl. No.	Name of cluster	Women - forum	Women - non-forum	Adolescent boys - group	Adolescent girls - group	Men - group	Community dweller	Cluster level Advisory committee	Club member/Men - group	Total
1	Uttar Kumrokhali Cluster	1	1		1				1	4
2	Dakhin Kumrokhali Cluster	1	1	1				1	1	5
3	Stadium Para Cluster	1		1	1				1	4
4	Purbopara Cluster	1	1							2
5	Ukhila Cluster	1			1					2
6	Pirottopalli Cluster	1								1
	Uday Sangha*						1			1
	Total	**6**	**3**	**2**	**3**		**1**	**1**	**3**	**19**

Note: Beside the qualitative interviews mentioned in above table conduct of four interviews in extensive clusters among students getting ICDS benefit and two among mothers of children getting ICDS benefits were requested.

Source: IHD End-term survey 2015-16

Annexure Table 1.7: Qualitative interviews of leaders, decision-makers, officials – Kolkata (Number)

Sl. No.	Meetings	Number
1	Community leaders	1
2	Cluster level advisory committee/organizer ICDS workers: From intensive clusters	1 2
3	From extensive clusters Government officials/political leaders/other NGO members/other key informants: School Principal CDPO	2 3 1
4.	ICDS supervisor	1
5	Residents	1
6	club member	3
	Total	**15**

Source: IHD End-term survey 2015-16

Annexure Table 1.8: Localities/clusters covered during baseline – Jaipur (Number)

Cluster	Households
Soothmill colony	45
J.P Colony Gurjar Basti	16
Ambedkar Nagar	21
Jhalana Kunda	105
Rajeev Nagar	17
Braj Lal Pura	10
Baba RamDev Nagar, Gurjar Ki Thadi-1	22

Source: Baseline database, CFAR

Annexure Table 1.9: Localities/clusters covered during baseline – Delhi (Number)

Clusters	Households
Indra Camp Kalyanpuri	130
Old & New Priyanka Camp	85
Rajeev Camp Jhilmil Colony	50
Saboli khadda	60
Jain Mandir	160
Indra Camp Khichripur	40
J.J Camp Anand Vihar	50
Rajasthani Camp	59
Subhash Camp NTPC	50
Total	**684**

Source: Baseline database, CFAR

Annexure Table 1.10: Localities/clusters covered during baseline – Kolkata (Number)

Clusters	Households
Uttar Kumrakhali	60
Dakshin Kumrakhali	50
Purbapara	50
Stadiumpara	60
Ukhila	50
TOTAL	270

Source: Baseline report, CFAR

Perception and Change: End-term evaluation Findings (Annexure Tables 1.11 – 1.25)

Annexure Table 1.11: Clean water is necessary (row %)

			At End Term				
			Very low	Low	Medium	High	Total women
At Start of Programme	Delhi	Very low	0.4	17.5	30.6	51.6	252
		Low	0.0	2.9	46.9	50.2	414
		Medium	0.0	0.0	22.4	77.6	415
		High	0.0	0.0	0.0	100.0	231
		Total	0.1	4.3	27.7	67.9	1312
	Jaipur	Very low	1.6	20.6	52.4	25.4	63
		Low	0.0	3.0	35.6	61.5	135
		Medium	0.0	0.0	4.3	95.7	93
		High	0.0	0.0	0.0	100.0	7
		Total	0.3	5.7	28.5	65.4	298
	Kolkata	Very low	63.6	36.4	0.0	0.0	11
		Low	0.0	8.8	53.8	37.4	91
		Medium	0.0	0.0	30.0	70.0	357
		High	0.0	0.0	0.0	100.0	142
		Total	1.2	2.0	26.0	70.9	601
	Total	Very low	2.8	18.7	33.7	44.8	326
		Low	0.0	3.8	45.5	50.8	640
		Medium	0.0	0.0	23.6	76.4	865
		High	0.0	0.0	0.0	100.0	380
		Total	0.4	3.8	27.4	68.4	2211

Annexure Table 1.12: Toilet is necessary (row %)

			At End Term				
			Very low	**Low**	**Medium**	**High**	**Total women**
At Start of Programme	Delhi	Very low	2.6	12.5	43.8	41.1	265
		Low	0.0	4.2	52.8	43.0	381
		Medium	0.0	0.0	23.1	76.9	402
		High	0.0	0.0	0.0	100.0	264
		Total	0.5	3.7	31.3	64.5	1312
	Jaipur	Very low	2.3	11.4	65.9	20.5	44
		Low	0.0	2.8	42.1	55.1	178
		Medium	0.0	0.0	9.0	91.0	67
		High	0.0	0.0	0.0	100.0	6
		Total	0.3	3.4	37.3	59.0	295
	Kolkata	Very low	58.3	16.7	25.0	0.0	12
		Low	0.0	11.9	66.3	21.8	101
		Medium	0.0	0.0	29.6	70.4	324
		High	0.0	0.0	0.0	100.0	162
		Total	1.2	2.3	27.7	68.8	599
	Total	Very low	4.7	12.5	46.1	36.8	321
		Low	0.0	5.0	52.0	43.0	660
		Medium	0.0	0.0	24.6	75.4	793
		High	0.0	0.0	0.0	100.0	432
		Total	0.7	3.3	31.1	64.9	2206

Annexure Table 1.13: Wash hands with soap and detergent (row %)

			At End Term				
			Very low	Low	Medium	High	Total women
At Start of Programme	Delhi	Very low	0.0	4.7	58.1	37.2	43
		Low	0.0	1.8	70.2	28.1	57
		Medium	0.0	0.0	15.2	84.8	46
		High	0.0	0.0	0.0	100.0	46
		Total	0.0	1.6	37.5	60.9	192
	Jaipur	Very low	0.0	7.1	64.3	28.6	14
		Low	0.0	0.0	44.8	55.2	96
		Medium	0.0	0.0	6.3	93.8	16
		High	0.0	0.0	0.0	100.0	5
		Total	0.0	0.8	40.5	58.8	131
	Kolkata	Very low	14.3	14.3	0.0	71.4	7
		Low	0.0	17.5	47.5	35.0	40
		Medium	0.0	0.0	28.2	71.8	71
		High	0.0	0.0	0.0	100.0	28
		Total	0.7	5.5	26.7	67.1	146
	Total	Very low	1.6	6.3	53.1	39.1	64
		Low	0.0	4.1	52.8	43.0	193
		Medium	0.0	0.0	21.1	78.9	133
		High	0.0	0.0	0.0	100.0	79
		Total	0.2	2.6	35.0	62.3	469

Annexure Table 1.14: Ability to complain about non-provision or non-access of facilities relating to water and sanitation (row %)

			At End Term				
			Very low	**Low**	**Medium**	**High**	**Total women**
At Start of Programme	Delhi	Very low	43.4	43.8	9.2	3.6	671
		Low	0.0	21.8	70.0	8.2	390
		Medium	0.0	0.0	62.3	37.7	146
		High	0.0	0.0	0.0	100.0	98
		Total	22.3	29.0	32.6	16.0	1305
	Jaipur	Very low	5.4	68.8	25.0	0.9	112
		Low	0.0	4.1	85.3	10.6	170
		Medium	0.0	0.0	50.0	50.0	14
		High					0
		Total	2.0	28.4	60.8	8.8	296
	Kolkata	Very low	18.9	53.3	16.7	11.1	90
		Low	0.0	22.9	60.6	16.5	188
		Medium	0.0	0.0	62.9	37.1	291
		High	0.0	0.0	0.0	100.0	31
		Total	2.8	15.2	52.0	30.0	600
	Total	Very low	36.0	48.0	12.0	4.0	873
		Low	0.0	18.0	71.1	10.8	748
		Medium	0.0	0.0	62.3	37.7	451
		High	0.0	0.0	0.0	100.0	129
		Total	14.3	25.2	41.7	18.9	2201

Annexure Table 1.15: Ability to talk to anybody to discuss any issue (row %)

			At End Term				
			Very low	**Low**	**Medium**	**High**	**Total women**
At Start of Programme	Delhi	Very low	26.0	59.1	10.9	4.0	680
		Low	0.0	18.6	69.1	12.3	398
		Medium	0.0	0.8	62.3	36.9	130
		High	0.0	0.0	0.0	100.0	100
		Total	13.5	36.5	32.9	17.1	1308
	Jaipur	Very low	3.5	59.3	32.7	4.4	113
		Low	0.0	6.1	84.1	9.8	164
		Medium	0.0	0.0	52.9	47.1	17
		High					0
		Total	1.4	26.2	62.6	9.9	294
	Kolkata	Very low	22.4	53.1	15.3	9.2	98
		Low	0.0	22.3	58.1	19.6	179
		Medium	0.0	0.0	64.3	35.7	280
		High	0.0	0.0	0.0	100.0	42
		Total	3.7	15.4	49.9	31.1	599
	Total	Very low	22.8	58.5	14.1	4.6	891
		Low	0.0	16.7	69.8	13.5	741
		Medium	0.0	0.2	63.2	36.5	427
		High	0.0	0.0	0.0	100.0	142
		Total	9.2	29.4	41.5	19.9	2201

Annexure Table 1.16: Boy and girls are equal in all spheres (education, health and other facilities) (row %)

			At End Term				
			Very low	Low	Medium	High	Total women
At Start of Programme	Delhi	Very low	8.4	44.8	40.7	6.1	462
		Low	0.7	13.5	71.9	13.9	274
		Medium	0.3	0.5	29.9	69.3	365
		High	0.5	1.0	1.0	97.6	206
		Total	3.3	19.0	37.9	39.8	1307
	Jaipur	Very low	5.1	12.8	56.4	25.6	39
		Low	0.0	6.2	50.6	43.2	162
		Medium	0.0	2.2	15.4	82.4	91
		High	0.0	0.0	0.0	100.0	6
		Total	0.7	5.7	39.6	54.0	298
	Kolkata	Very low	31.9	6.4	53.2	8.5	47
		Low	0.0	29.0	66.1	4.9	183
		Medium	0.0	0.4	63.4	36.2	224
		High	0.0	0.0	0.7	99.3	148
		Total	2.5	9.5	48.0	40.0	602
	Total	Very low	10.2	39.2	42.9	7.7	548
		Low	0.3	16.2	64.6	18.9	619
		Medium	0.1	0.7	39.0	60.1	680
		High	0.3	0.6	0.8	98.3	360
		Total	2.7	14.6	40.9	41.8	2207

Annexure Table 1.17: Participation in addressing common issues (complaining or raising voice) (row %)

			At End Term				
			Very low	**Low**	**Medium**	**High**	**Total women**
At Start of Programme	Delhi	Very low	33.8	52.5	9.2	4.5	686
		Low	0.0	16.8	76.6	6.6	440
		Medium	0.0	0.0	70.5	29.5	88
		High	0.0	0.0	0.0	100.0	96
		Total	17.7	33.1	35.3	13.9	1310
	Jaipur	Very low	12.4	54.0	31.0	2.7	113
		Low	0.0	5.3	83.4	11.2	169
		Medium	0.0	0.0	46.2	53.8	13
		High					0
		Total	4.7	23.7	61.7	9.8	295
	Kolkata	Very low	14.6	53.9	19.1	12.4	89
		Low	0.0	27.9	57.9	14.2	190
		Medium	0.0	0.0	66.5	33.5	284
		High	0.0	0.0	0.0	100.0	34
		Total	2.2	16.9	52.9	28.0	597
	Total	Very low	29.2	52.8	13.0	5.1	888
		Low	0.0	17.0	73.6	9.4	799
		Medium	0.0	0.0	66.8	33.2	385
		High	0.0	0.0	0.0	100.0	130
		Total	11.8	27.5	43.6	17.2	2202

Annexure Table 1.18: Importance of own health (row %)

			At End Term				
			Very low	**Low**	**Medium**	**High**	**Total women**
At Start of Programme	Delhi	Very low	4.3	40.0	34.9	20.7	415
		Low	0.0	6.5	74.0	19.5	527
		Medium	0.0	0.4	45.0	54.6	229
		High	0.0	1.4	0.0	98.6	139
		Total	1.4	15.5	48.7	34.4	1310
	Jaipur	Very low	0.0	34.2	49.3	16.4	73
		Low	0.0	7.4	52.9	39.7	121
		Medium	0.0	0.0	9.4	90.6	96
		High	0.0	0.0	0.0	100.0	6
		Total	0.0	11.5	36.8	51.7	296
	Kolkata	Very low	37.5	12.5	28.1	21.9	32
		Low	0.0	22.0	59.6	18.4	141
		Medium	0.3	0.5	50.3	48.9	370
		High	0.0	0.0	0.0	100.0	58
		Total	2.2	6.2	46.4	45.3	601
	Total	Very low	5.8	37.5	36.5	20.2	520
		Low	0.0	9.4	68.2	22.4	789
		Medium	0.1	0.4	42.9	56.5	695
		High	0.0	1.0	0.0	99.0	203
		Total	1.4	12.4	46.5	39.7	2207

Annexure Table 1.19: Ability to discuss own health with doctor and other members of household (row %)

			At End Term				
			Very low	Low	Medium	High	Total women
At Start of Programme	Delhi	Very low	5.4	56.1	31.8	6.8	576
		Low	0.0	14.0	75.7	10.4	444
		Medium	0.0	0.0	60.8	39.2	171
		High	0.0	0.0	0.0	100.0	120
		Total	2.4	29.4	47.5	20.7	1311
	Jaipur	Very low	1.6	47.2	44.8	6.4	125
		Low	0.0	7.1	78.2	14.7	156
		Medium	0.0	0.0	43.8	56.3	16
		High					0
		Total	0.7	23.6	62.3	13.5	297
	Kolkata	Very low	26.5	35.3	35.3	2.9	34
		Low	0.0	13.2	70.6	16.2	197
		Medium	0.0	0.0	58.7	41.3	293
		High	0.0	0.0	0.0	100.0	75
		Total	1.5	6.3	53.9	38.2	599
	Total	Very low	5.7	53.6	34.1	6.5	735
		Low	0.0	12.4	74.9	12.7	797
		Medium	0.0	0.0	59.0	41.0	480
		High	0.0	0.0	0.0	100.0	195
		Total	1.9	22.3	51.2	24.5	2207

Annexure Table 1.20: Ability to complain to police when violence or any misbehaviour takes place (row %)

			At End Term				
			Very low	**Low**	**Medium**	**High**	**Total women**
At Start of Programme	Delhi	Very low	25.8	55.9	13.9	4.4	859
		Low	0.0	16.4	75.1	8.5	281
		Medium	0.0	0.0	48.0	52.0	75
		High	0.0	0.0	0.0	100.0	94
		Total	17.0	40.2	28.0	14.9	1309
	Jaipur	Very low	3.2	58.7	34.9	3.2	126
		Low	0.0	5.3	82.9	11.8	152
		Medium	0.0	0.0	41.2	58.8	17
		High					0
		Total	1.4	27.8	60.0	10.8	295
	Kolkata	Very low	46.7	27.1	20.6	5.6	107
		Low	0.0	23.5	69.0	7.5	226
		Medium	0.0	0.0	59.1	40.9	232
		High	0.0	0.0	0.0	100.0	36
		Total	8.3	13.6	52.4	25.6	601
	Total	Very low	25.3	53.4	16.9	4.4	1092
		Low	0.0	16.2	74.8	9.0	659
		Medium	0.0	0.0	55.6	44.4	324
		High	0.0	0.0	0.0	100.0	130
		Total	12.5	31.3	38.9	17.3	2205

Annexure Table 1.21: Freedom to move outside the house (row %)

			At End Term				
			Very low	**Low**	**Medium**	**High**	**Total women**
At Start of Programme	Delhi	Very low	12.0	55.1	25.9	6.9	590
		Low	0.0	17.2	75.9	7.0	460
		Medium	0.0	0.0	48.6	51.4	140
		High	0.0	0.0	0.0	100.0	118
		Total	5.4	30.9	43.6	20.1	1308
	Jaipur	Very low	6.0	48.0	41.0	5.0	100
		Low	0.0	7.5	79.4	13.1	160
		Medium	0.0	0.0	52.9	47.1	34
		High					0
		Total	2.0	20.4	63.3	14.3	294
	Kolkata	Very low	25.7	47.3	18.9	8.1	74
		Low	0.0	15.4	57.0	27.5	149
		Medium	0.0	0.0	67.5	32.5	311
		High	0.0	0.0	0.0	100.0	62
		Total	3.2	9.7	51.8	35.2	596
	Total	Very low	12.6	53.4	27.2	6.8	764
		Low	0.0	14.8	73.0	12.2	769
		Medium	0.0	0.0	61.0	39.0	485
		High	0.0	0.0	0.0	100.0	180
		Total	4.4	23.7	48.5	23.4	2198

Annexure Table 1.22: Ability to participate in public meetings (row %)

			At End Term				
			Very low	**Low**	**Medium**	**High**	**Total women**
At Start of Programme	Delhi	Very low	32.1	54.1	11.6	2.2	801
		Low	0.0	23.6	70.6	5.8	326
		Medium	0.0	0.0	40.3	59.7	77
		High	0.0	0.0	0.0	100.0	103
		Total	19.7	39.0	27.1	14.2	1307
	Jaipur	Very low	17.6	61.0	19.1	2.2	136
		Low	0.0	13.6	76.4	10.0	140
		Medium	0.0	0.0	71.4	28.6	14
		High	0.0	0.0	100.0	0.0	1
		Total	8.2	35.1	49.5	7.2	291
	Kolkata	Very low	30.0	47.3	13.6	9.1	110
		Low	0.0	33.5	52.6	13.9	194
		Medium	0.0	0.0	66.5	33.5	257
		High	0.0	0.0	0.0	100.0	34
		Total	5.5	19.7	48.4	26.4	595
	Total	Very low	30.0	54.3	12.8	3.0	1047
		Low	0.0	24.4	66.5	9.1	660
		Medium	0.0	0.0	60.9	39.1	348
		High	0.0	0.0	0.7	99.3	138
		Total	14.3	33.2	35.8	16.6	2193

Annexure Table 1.23: Men share responsibility of household work (row %)

			At End Term				
			Very low	**Low**	**Medium**	**High**	**Total women**
At Start of Programme	Delhi	Very low	36.7	49.8	12.1	1.4	863
		Low	1.9	19.7	75.5	3.0	269
		Medium	1.4	11.4	40.0	47.1	70
		High	0.0	0.0	0.0	100.0	100
		Total	24.8	37.7	25.7	11.8	1302
	Jaipur	Very low	18.8	63.0	18.2	0.0	165
		Low	0.0	16.8	65.5	17.6	119
		Medium	0.0	10.0	60.0	30.0	10
		High					0
		Total	10.5	42.5	38.8	8.2	294
	Kolkata	Very low	40.8	35.8	20.8	2.5	120
		Low	0.0	40.4	55.7	3.8	235
		Medium	0.0	0.0	67.1	32.9	210
		High	0.0	0.0	0.0	100.0	35
		Total	8.2	23.0	49.5	19.3	600
	Total	Very low	34.6	50.3	13.9	1.3	1148
		Low	0.8	27.0	66.1	6.1	623
		Medium	0.3	3.1	60.3	36.2	290
		High	0.0	0.0	0.0	100.0	135
		Total	18.4	34.3	34.0	13.3	2196

Annexure Table 1.24: Stakeholders are more responsive (anganwadi worker, ASHA workers, pradhan etc.) (row %)

			At End Term				
			Very low	**Low**	**Medium**	**High**	**Total women**
At Start of Programme	Delhi	Very low	26.9	61.5	8.8	2.8	703
		Low	0.0	28.7	66.2	5.2	328
		Medium	0.0	0.0	70.1	29.9	174
		High	0.0	0.0	0.0	100.0	92
		Total	14.6	40.6	30.9	14.0	1297
	Jaipur	Very low	4.7	20.9	72.1	2.3	43
		Low	0.0	1.8	76.0	22.1	217
		Medium	0.0	0.0	34.2	65.8	38
		High					0
		Total	0.7	4.4	70.1	24.8	298
	Kolkata	Very low	30.5	58.5	9.3	1.7	118
		Low	0.0	45.8	45.8	8.5	201
		Medium	0.0	0.0	66.9	33.1	242
		High	0.0	0.0	0.0	100.0	30
		Total	6.1	27.2	44.8	21.8	591
	Total	Very low	26.3	59.0	12.0	2.7	864
		Low	0.0	25.5	63.5	11.0	746
		Medium	0.0	0.0	65.4	34.6	454
		High	0.0	0.0	0.0	100.0	122
		Total	10.4	32.0	40.0	17.6	2186

Annexure Table 1.25: Stakeholders are more responsive (Jal board, municipality/ corporation, caretaker of community toilet, sweeper etc.) (row %)

			At End Term				
			Very low	**Low**	**Medium**	**High**	**Total women**
At Start of Programme	Delhi	Very low	44.5	44.6	9.2	1.7	661
		Low	0.0	16.5	78.1	5.3	375
		Medium	0.0	0.0	60.7	39.3	168
		High	0.0	0.0	0.0	100.0	98
		Total	22.6	27.4	35.0	15.0	1302
	Jaipur	Very low	4.3	25.7	57.1	12.9	70
		Low	0.0	5.3	83.6	11.1	189
		Medium	0.0	0.0	23.5	76.5	34
		High	0.0	0.0	0.0	100.0	1
		Total	1.0	9.5	70.1	19.4	294
	Kolkata	Very low	18.0	38.2	42.7	1.1	89
		Low	0.0	44.8	51.4	3.8	183
		Medium	0.0	0.0	69.2	30.8	237
		High	0.0	0.0	0.0	100.0	77
		Total	2.7	19.8	50.5	27.0	586
	Total	Very low	38.2	42.3	17.0	2.6	820
		Low	0.0	20.6	73.0	6.4	747
		Medium	0.0	0.0	62.4	37.6	439
		High	0.0	0.0	0.0	100.0	176
		Total	14.3	23.0	43.9	18.8	2182

Annexure Table 1.26: Role and achievement of CFAR in water-related issues (% of women)

		Attributable to intervention	
City	**Group/ non-group**	**By CFAR***	**By others including CFAR****
Delhi	Group member	60.3	39.7
	Non-group member	18.9	81.0
	Total	25.1	74.9
Jaipur	Group member	65.2	34.8
	Non-group member	31.6	68.5
	Total	46.3	53.7
Kolkata	Group member	40.1	59.9
	Non-group member	20.4	79.6
	Total	25.2	74.8
Total	Group member	55.4	44.6
	Non-group member	20.6	79.4
	Total	28.0	72.1

*Reponses that specifically identified CFAR
**Responses did not explicitly specify CFAR but may include CFAR as well

Annexure Table 1.27: Role and achievement of CFAR in garbage-related issues (% of women)

		Attributable to intervention	
City	**Group/ non-group**	**By CFAR***	**By others including CFAR****
Delhi	Group member	14.4	85.6
	Non-group member	2.2	97.8
	Total	4.1	96.0
Jaipur	Group member	43.6	56.4
	Non-group member	20.9	79.2
	Total	30.9	69.1
Kolkata	Group member	6.8	93.2
	Non-group member	4.6	95.4
	Total	5.1	94.9
Total	Group member	20.3	79.7
	Non-group member	4.6	95.4
	Total	8.0	92.1

*Reponses that specifically identified CFAR
**Responses did not explicitly specify CFAR but may include CFAR as well

Annexure Table 1.28: Role and achievement of CFAR in toilet-related issues (% of women)

		Attributable to intervention	
City	**Group/ non-group**	**By CFAR***	**By others including CFAR****
Delhi	Group member	21.2	78.8
	Non-group member	7.6	92.4
	Total	9.6	90.4
Jaipur	Group member	7.6	92.4
	Non-group member	3.6	96.4
	Total	5.4	94.6
Kolkata	Group member	2.7	97.3
	Non-group member	0.9	99.1
	Total	1.3	98.7
Total	Group member	11.7	88.3
	Non-group member	5.5	94.5
	Total	6.8	93.2

*Reponses that specifically identified CFAR
**Responses did not explicitly specify CFAR but may include CFAR as well

Annexure Table 1.29: Role and achievement of CFAR in hygiene-related issues (% of women)

		Attributable to intervention	
City	**Group/ non-group**	**By CFAR***	**By others including CFAR****
Delhi	Group member	52.9	47.1
	Non-group member	5.7	94.4
	Total	12.4	87.5
Jaipur	Group member	67.4	32.6
	Non-group member	26.2	73.8
	Total	44.4	55.7
Kolkata	Group member	32.7	67.3
	Non-group member	13.7	86.3
	Total	18.3	81.7
Total	Group member	50.6	49.4
	Non-group member	9.7	90.3
	Total	18.5	81.6

*Reponses that specifically identified CFAR
**Responses did not explicitly specify CFAR but may include CFAR as well