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UNLOCKING BARRIERS TO INCLUSIVE **WASH**

LEARNINGS FROM
SLUMS IN
BHUBANESWAR

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Urban sanitation in the Indian policy space received focused attention only after the mid-2000s with the introduction of a slew of programmes such as Jawaharlal Nehru National Urban Renewal Mission (JNNURM), followed by National Urban Sanitation Policy (NUSP), Swachh Bharat Mission (SBM), Atal Mission for Rejuvenation and Urban Transformation (AMRUT) and the National Policy on Faecal Sludge and Septage Management (FSSM). However, there remains limited literature based on empirical research on urban sanitation in India from the perspective of inclusion.

While India made considerable physical progress in sanitation infrastructure creation in the last decade, it continues to grapple with ground realities that are causing widespread social inequalities in accessing water and sanitation. These inequalities differently affect marginalised groups – women, adolescent girls, transgender and persons with disabilities – in accessing water and sanitation, and act as barriers to opportunities for them.

For the country to fulfil the commitment to the global Sustainable Development Goals (SDGs) based on the principle of ‘Leave no one behind’, it is imperative for it to place marginalised groups at the centre of programme and policy research. Often, those who are left behind face multiple marginalisations, as they live in poverty, under precarious conditions, with limited access to safe water and sanitation services.

Against this backdrop, this study was conducted in 2018-19 across ten slums in Bhubaneswar (Odisha) to explore to what extent marginalised groups access benefits of sanitation schemes and programmes. The government of Odisha has introduced a range of water and sanitation policies and strategies. These include the Odisha State Water Policy 2007, Odisha Urban Sanitation Strategies 2011 which was revised in 2017, Odisha Urban Sanitation Policy 2017, and Odisha State Urban Water Supply Policy 2013 that deal with provisioning of water and sanitation facilities for the urban poor. While this provides a conducive policy/ legal environment, it is critical to identify both the enabling mechanisms for inclusive sanitation and the barriers to inclusion that exist for marginalised groups in slums in the state.

In this context, the study examined tangible and intangible effects of SBM-Urban at both household and community levels. At the household level, the study attempted to understand whether the programmes had a transformative impact on the gendered division of labour within the domestic sphere, particularly concerning water and sanitation roles and responsibilities. At the community level – in this case the slum level – the study examined whether the government programmes strengthened the participation of the most marginalised groups in decision-making processes of planning and implementation. The research proposes recommendations to support the government, Civil Society Organisations (CSOs), researchers and academics in developing inclusive sanitation policies and programmes as well as promoting inclusive approaches on urban sanitation. Some of the key recommendations include developing a framework and guideline for inclusive sanitation, initiating inclusive WASH budgeting, and upgrading the design of existing community toilets (CTs) and public toilets (PTs) to cater to specific needs of transgender and persons with disability.

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ACRONYMS

AMRUT	Atal Mission for Rejuvenation and Urban Transformation
ASHA	Accredited Social Health Activist
AWWs	Anganwadi Workers
BDC	Basti Development Committee
BMC	Bhubaneswar Municipal Corporation
CT	Community Toilet
CMC	Community Management Committee
CSO	Civil Society Organisation
CWIS	City-wide Inclusive Sanitation
EWS	Economically Weaker Section
FGD	Focus Group Discussion
FSM	Faecal Sludge Management
FSSM	Faecal Sludge and Septage Management
FYP	Five Year Plan
GAD	Gender and Development
HH	Household
HUDD	Housing and Urban Development Department
IEC	Information, Education and Communication
IHHL	Individual Household Latrine
ILCS	Integrated Low-cost Sanitation
JNNURM	Jawaharlal Nehru National Urban Renewal Mission
KII	Key Informant Interview
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LNOB	Leave No One Behind
MAS	Mahila Arogya Samiti
MDG	Millennium Development Goal
MDWS	Ministry of Drinking Water and Sanitation
MHM	Menstrual Hygiene Management
MHUA	Ministry of Housing and Urban Affairs
MSW	Municipal Solid Waste
NGOs	Non-governmental Organisations
NUHM	National Urban Health Mission
NUSP	National Urban Sanitation Policy
OBCs	Other Backward Classes
OD	Open Defecation
O&M	Operation and Maintenance
OUAT	Odisha University of Agriculture and Technology
PMU	Project Management Unit

PT	Public Toilet
PwD	Persons with Disability
SBM	Swachh Bharat Mission
SBM-U	Swachh Bharat Mission-Urban
SC	Scheduled Caste
SCM	Smart Cities Mission
SDG	Sustainable Development Goal
SECC	Socio Economic and Caste Census
SHG	Self Help Group
ST	Scheduled Tribe
ULB	Urban Local Body
WAD	Women and Development
WASH	Water, Sanitation and Hygiene
WID	Women in Development





1. BACKGROUND

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The global debate on inclusive sanitation has evolved over the last four decades. The focus on gender in water, sanitation and hygiene (WASH) policies and programming aligns with the evolution of a gender perspective in development theories. The shift from 'women' to 'gender' to 'inclusion' / 'equity' in WASH projects and programming has evolved with simultaneous changes in global debates on 'women in development (WID)', 'women and development (WAD)' and, now, 'gender and development (GAD)' (Fisher et al., 2017).

WID and basic needs approaches in the 1970s recognised that women were contributing to the economy through 'unpaid labour' in the domestic realm. These approaches demanded the integration of women in the development plan. Developments in WASH analysed women's roles in households and began to design responsive programmes to ease their domestic workloads. In the 1980s and 1990s, GAD emerged as a critique of WID and questioned the unequal power relations that stem at the level of households. However, the WID approach was adopted by the WASH sector to provide opportunities for women to develop their leadership skills and self-confidence through participation in different activities.

In the 1995 Beijing Conference, the concept of **gender mainstreaming** emerged and paved the

way for a greater emphasis in the 2000s on women's empowerment in organisational structures and culture. It pushed for adequate representation of women at all levels of decision-making. During the same period, critical thematic work in WASH around disability, school children and pregnant women was emerging. In line with this, during the millennium summit of the United Nations in 2000, Millennium Development Goals (MDGs) were adopted for 2000-2015 (Fisher et al., 2017). Target 7c aimed to ensure environmental sustainability by the reduction of the population without sustainable access to WASH to half by 2015. However, in 2012, there were still 998.49 million people defecating in the open across the world, of whom 597.48 million or 60 per cent resided in India. The scale of the sanitation problem in India was enormous.

Consequently, India, and the world as a whole, failed to meet the sanitation targets set in the MDGs. The year 2015 marked a shift from MDGs to Sustainable Development Goals (SDGs). The SDGs announced for 2015-2030 included a separate SDG for water and sanitation for all (SDG 6), with particular emphasis laid on women and girls.

Additionally, in 2010, **rights-based approach** to safe drinking water and sanitation¹ was first recognised by the United Nations General Assembly. It marked a shift from tackling gender-based vulnerabilities

More information on human right to water and sanitation is available from here: <https://news.un.org/en/story/2010/10/354542-right-water-and-sanitation-legally-binding-affirms-key-un-body>

in the WASH sector to equitably addressing needs and interests of various marginalised groups at a more nuanced and segregated level. Since then many countries and states have moved towards the adoption of a **city-wide inclusive sanitation** (CWIS) approach. This approach recognises that ‘business as usual’, based on the adoption of centralised conventional infrastructure planning that benefits only a small section of the population, will not work for delivering safe sanitation for all in urban areas. CWIS calls for a radical shift in mind-sets and practices. It espouses that urban sanitation planning should cater to specific needs of disadvantaged and marginalised groups. Furthermore, emerging themes related to the needs of women, like menstrual hygiene management and issues around access to sanitation, have gained prominence. These perspectives are critical in deepening the understanding of vulnerabilities that different marginalised groups face in accessing WASH.

1.1 TRAJECTORY OF URBAN SANITATION SCHEMES, POLICIES AND PROGRAMMES IN INDIA

While there is literature on the global debate on inclusive WASH, there is limited literature on urban sanitation from the perspective of inclusion in the Indian context. A focus on WASH has been a part of the country’s five-year plans (FYPs); nevertheless, rural sanitation coverage in 1981 was posited at a mere 1 per cent. Considering the sheer scale of the challenge, urban sanitation received limited policy attention. Sanitation programmes specifically designed for urban areas were sparse. For instance, the Integrated Low-cost Sanitation (ILCS) scheme, launched in the 1980s, was the first programme to specifically target urban areas. However, its focus was limited. It targeted only Economically Weaker Section (EWS) households, supporting them in converting existing dry latrines into low-cost pour-flush latrines and by constructing new toilets for them if they did not have any. Post the ILCS scheme, urban sanitation in India did not receive much attention. It continued to be a small component in sanitation programmes which primarily focused on addressing the rural challenge. Further, within this restrictive focus, inclusion received scant attention.

It was only in the mid-2000s that urban sanitation received any direct policy attention with the

introduction of the Jawaharlal Nehru National Urban Renewal Mission (JNNURM) in 2005. The mission aimed at creating infrastructure for water and sanitation and providing basic services to the urban poor. The National Urban Sanitation Policy (NUSP) in 2008 directed **cities to make city sanitation plans**. It was only in the last decade that the central government has refocused on urban sanitation as a national priority. In this period, the government introduced a wide range of policies and schemes: Swachh Bharat Mission-Urban (SBM-U) in 2014, Atal Mission for Rejuvenation and Urban Transformation (AMRUT) in 2015, and the National Policy on Faecal Sludge and Septage Management (FSSM) in 2017. Now 19 states in India have framed strategies or policies on urban sanitation focusing on FSSM. Odisha is one of the pioneer states in this respect. It notified the Odisha Urban Sanitation Policy focusing on Faecal Sludge Management (FSM) to address the state’s pressing sanitation challenge in 2017.

1.2. HOW INCLUSIVE ARE URBAN SANITATION POLICY AND PROGRAMMES IN INDIA?

Despite policy attention at both international and national levels, the sanitation ecosystem in India in its present form does not adequately address elements of inclusion and equity. Government programmes and schemes continue to adopt a traditional approach to gender. Policies like the NUSP (2008) do not have a clear plan on inclusion; they assume that the ongoing urban sanitation schemes address gender concerns. Resultant gender-neutral policies accept the status quo of considering ‘citizen’ as a homogeneous category without accounting for specificities of the excluded and marginalised groups.

In contrast, in the rural space, some efforts have been made to address gender-based vulnerabilities through the introduction of the National Guidelines on Menstrual Hygiene Management (MHM) under the Swachh Bharat Mission-Gramin (SBM-G) scheme by the Ministry of Drinking Water and Sanitation (MDWS) in December 2015. These guidelines have detailed various steps that can be adopted by the states and local government to ensure safe MHM.

Further, in the WASH sector, gender is predominantly subjected to a binary gaze focusing only on men

and women. There is limited understanding of how WASH affects non-normative gender identities: LGBTI (Lesbian, Gay, Bisexual, Transgender and Intersex). While transgender persons in India are legally recognised under the Transgender Persons (Protection of Rights) Bill 2020, they have yet not been fully integrated into society. The transgender community faces dangers of infection, violence, humiliation and corruption in their daily lives as they manage their sanitation needs. Some of the challenges transgender face in accessing public toilets or community toilets include verbal abuse, physical and sexual assault, denial of access, arrest and expulsion.

Beyond the focus on women, adolescent girls, transgender and persons with disability, the sanitation policy framework also focuses on community forums. The ongoing sanitation programme SBM-U – covering all 4041 statutory towns – departs from the strategies of the past. Envisaged as a ‘jan andolan’ (people’s movement) for ensuring safe sanitation, hygiene and waste management, it strives to trigger behaviour change. The mission seeks to elicit active participation of the Ward Committees, Area Sabhas, Mohalla Sabhas, Resident Welfare Associations and Civil Society Groups. Urban Local Bodies (ULBs) in cities are to ensure adequate representation of voices from the community and increased participation of marginalised groups in the decision-making process to make the programme more inclusive (MHUA, 2017a).

In 2017, the Ministry of Housing and Urban Affairs (MHUA) released the guidelines for ‘Community Engagement’ to shift the focus from toilet construction to toilet usage through the involvement of community groups. The guidelines recognise that there is a need to strengthen the linkages of

communities with administrative bodies. For this, the role of frontline groups such as Accredited Social Health Activists (ASHAs), Anganwadi workers, Self Help Groups (SHGs) and community mobilisers is crucial. This community platform provides an opportunity for frontline groups to cross-learn and reach out to excluded groups.

Despite this focus, approaches of coercion are gaining ground, and the participation of marginalised groups in decision-making processes remains low. On the ground, the thrust of SBM remains to tackle open defecation. State efforts have been mostly concentrated on meeting construction targets – the building of individual household latrines (IHHLs), public toilets (PTs) and community toilets (CTs). For instance, goals set for SBM-U phase 1 primarily focused on infrastructure creation including the construction of 66.42 lakh IHHLs; addition of 2.52 lakh CT seats; installation of 2.56 lakh PTs; and achieving 100 per cent door-to-door collection and scientific management of municipal solid waste (MSW) by 2019 (MHUA, 2020).

For sustainable sanitation outcomes, it is critical to adopt an inclusive approach based on the principle of ‘Leave no one behind’ (LNOB). Against this background, the study was rolled out in Bhubaneswar (Odisha) to assess linkages between inclusion and sanitation. In Odisha, a set of sanitation policies is already in place; these include the Odisha State Water Policy 2007, Odisha Urban Sanitation Strategies 2011 and 2017, Odisha Urban Sanitation Policy 2017 and Odisha State Urban Water Supply Policy 2013. In the existing policy framework, there is a growing focus on engaging communities in water- and sanitation-related undertakings; the study explored whether people from marginalised groups in Odisha equitably access benefits of the ongoing SBM-U.



2. RESEARCH QUESTIONS

How does the Swachh Bharat Mission-Urban promote inclusiveness in slums in Bhubaneswar? How does it strengthen the participation of the most marginalised groups in planning, implementation and monitoring?



3. OBJECTIVES

The study aimed to identify both enabling mechanisms for and barriers to the inclusion of marginalised groups (women, transgender, adolescents, poor and persons with disability) in slums in water and sanitation-related discussions. Towards this, it examined tangible and intangible effects of SBM-U at both household and community levels. At the household level, it attempted to understand whether the programme had an impact in terms of changing the gendered division of labour within the household, particularly regarding water and sanitation roles and responsibilities.





4. METHODOLOGY

4.1 RESEARCH TOOLS

This study has used both quantitative and qualitative techniques for data collection. Quantitative research tools included structured household surveys that captured information on water provision, details of sanitation access, usage patterns of the households vis-à-vis IHHL, CT/PT or open defecation (OD), the mechanism for solid waste disposal, and the health and hygiene of households. Qualitative research tools included key informant interview (KIIs) schedules and focus group discussion (FGD) guides. Key informants included caretakers of CTs/PTs, Swachhagrahis¹ Anganwadi workers (AWWs) and the project management unit (PMU) team at Bhubaneswar Municipal Corporation (BMC). Additionally, FGDs were conducted with women practising OD and/or using CTs, adolescent girls practising OD and/or using IHHLs, transgender practising OD and/or using IHHLs, Basti Committee members (mostly male) and Mahila Arogya Samiti² (an all-women's collective).

4.2 SITE SELECTION

The study was conducted by the Scaling City Institutions for India: Sanitation (SCI-FI: Sanitation) project team nested at the Centre for Policy Research (CPR) in collaboration with the KIIT School of Rural Management based in Odisha.

For selection of sites within Bhubaneswar, a set of parameters were considered. These included:

- Representation from all three Bhubaneswar Municipal Corporation (BMC) zones (North, South-west and South-east zones).
- Coverage of both authorised and unauthorised settlements.
- Adequate representation of marginalised groups identified by the Odisha government.

Based on the socioeconomic caste census (SECC), the Odisha government recognises 13 groups as marginalised groups (as per the notification no: 3626, HUD-SAN- 61/15 issued by HUDD on 15/02/16). These are listed below:

¹Swachhagrahis' are a large army of 'foot soldiers' engaged under the Swachh Bharat Mission to facilitate activities to help communities achieve ODF status in their respective areas. They are also responsible for facilitating activities intended for ODF Plus interventions.

² Mahila Arogya Samiti (MAS): Under National Health Mission, Mahila Arogya Samiti- an all-women's collective has been set-up to promote community participation in health at all levels, including planning, implementing and monitoring of health programmes. To fulfil its mandate to improve health of the community, it is also tasked with monitoring the situation of water, sanitation, food, housing and education services in the settlement.



**RELIGIOUS
MINORITY GROUPS
(MUSLIMS)**



**PERSONS WITH
DISABILITY (PWD)
HOUSEHOLDS**



**TRANSGENDER
HOUSEHOLDS**



**BEGGARS AND
RAGPICKERS**



**HOUSEHOLDS OF
PERSONS WITH
CHRONIC ILLNESS
(LIKE LEPROSY)**



**SCHEDULED CASTE
(SC)/SCHEDULED
TRIBE (ST)
HOUSEHOLDS IN
SLUMS**



**SANITATION
WORKER
HOUSEHOLDS**



**OTHER BACKWARD
CLASSES (OBCS)
HOUSEHOLDS**



ADOLESCENT GIRLS



**WIDOW-HEADED
HOUSEHOLDS**



**FEMALE-HEADED
HOUSEHOLDS**



**FEMALE
HOUSEHOLDS**



**+65 AGED-HEADED
HOUSEHOLDS**

Of these groups, only minor-headed households were not covered under the study. All other marginalised groups were part of the household sample survey.

Based on these parameters, the study was rolled out in ten settlements spread across all three zones in Bhubaneswar (see Figure 1).

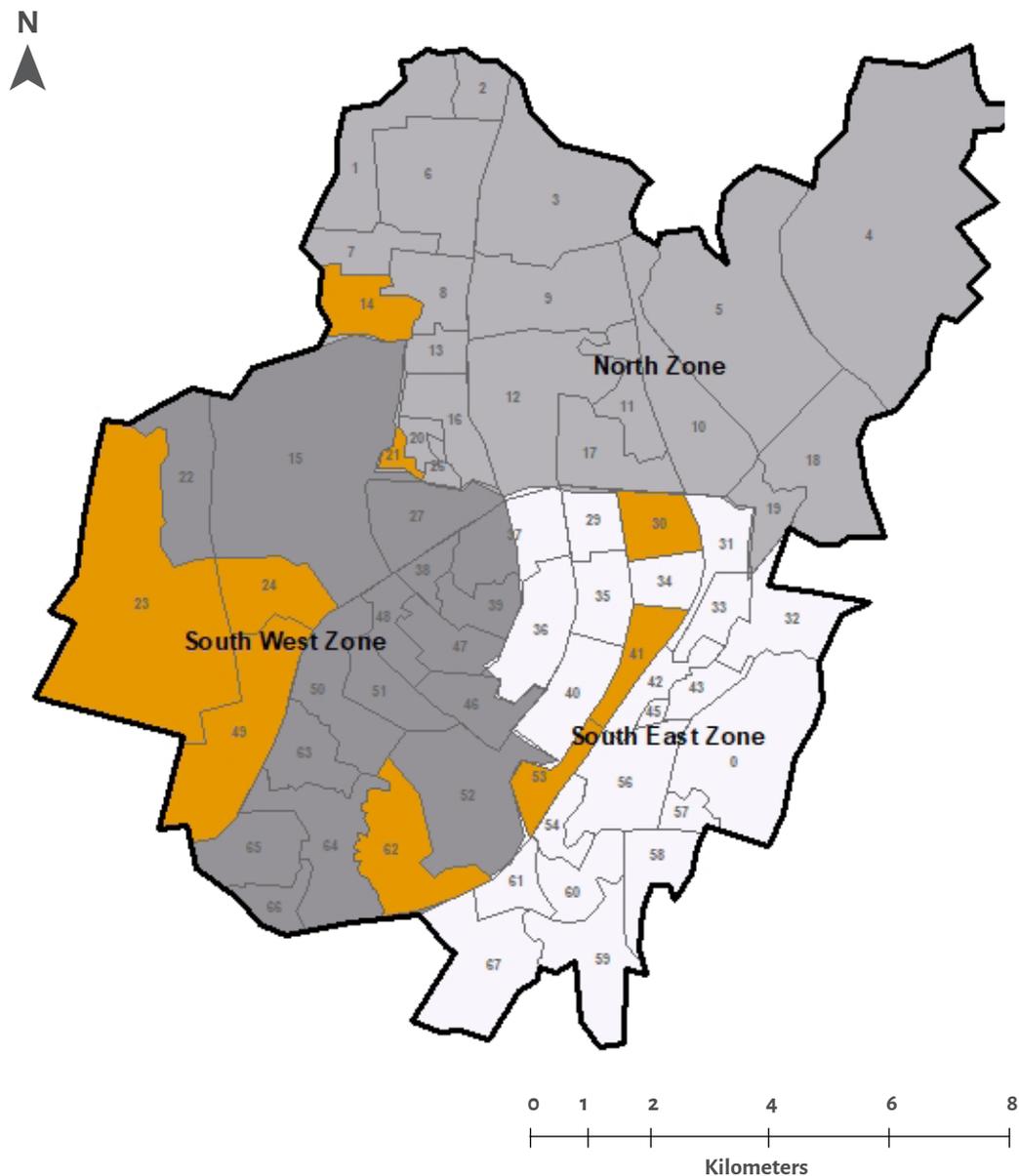


Figure 1: Survey sites distributed across three BMC zones

4.3 PROFILES OF SELECTED SLUMS

Overall ten slums were surveyed under the study. A brief description of the slums is given below:



Masjid Colony: Established in 1962, Masjid Colony has a large Muslim population. Predominantly, residents work as informal solid waste recyclers. Their essential tasks include solid waste collection and segregation, sale of segregated waste, and re-use of remaining waste materials. Several households have workshops for preparing multi-utility bags out of waste material.



Kedarpalli Basti: Known as the 'sweeper's colony', it has a high proportion of SC, most of whom work as sweepers at BMC. In 1984, BMC allotted nearly 120 houses in the basti as official quarters. In 1998, it allocated an additional set of 80 homes. Over the years, the slum has expanded, and people who were not BMC staff also began to live there.

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Lingaraj Leprosy Colony: Set up in 1970, it is one of the six colonies in Bhubaneswar set up to rehabilitate leprosy patients. While begging is the main occupation of most people in the settlement, a few run their own business. Initially, families in the settlement lived in kuchha houses; later, the government built pucca houses which did not have toilets. Residents relied on a CT, which initially did not have a separate wing for women. Much later, a separate wing for women was added. Under SBM, IHHLs were constructed for all dwelling units. Each household has a piped water supply connection.



Kargil Nagar Basti: The second largest slum of Bhubaneswar, this is an unauthorised colony established in 2001. It has a total of 10 Sahis of which Mahavir Sahi, Tarini Sahi, Mangala Sahi and Deula Sahi are the oldest. The basti is home to a small transgender population. It is located within a stone quarry so there are low lying areas. One side of the slum borders a railway track. Papad making at home through SHGs is the main economic activity in the settlement.



Shahid Nagar Telugu Basti: This basti has a Telugu-speaking population and includes some transgender. There are two entry points to the slum. One way is from the main roads where the transgender community lives, and the other entrance is through the residential area, which is the one mostly used by the remaining slum dwellers.



Kalinga Studio: An unauthorised colony, it falls in Ward no. 23 in the South-west Zone. It also has a transgender population. The settlement borders the main road. Transgender share toilets amongst themselves.



Baramunda Bhoi Sahi: This has a large SC population. On one side, the slum borders residential areas while on the other side, it is surrounded by the agricultural fields of the Odisha University of Agriculture and Technology (OUAT). Residents of this settlement include labourers, bus drivers/conductors, auto drivers, cab drivers, trolley drivers, BMC employees and grocery shop owners. Most of the wage labourers work in the OUAT fields. In this settlement, households mostly rely on firewood to cook.



Adivasi Gaon: This unauthorised colony falls in Ward no. 21 of the North Zone. It is dominated by ST. The main occupation here is daily wage labour. Some residents also work as auto drivers, housemaids, tailors, painters, or run a shop.



Mahavir Basti: Also an unauthorised colony, it falls in Ward no. 2 of the South Zone. It has a mixed population. Residents live in semi-pucca houses with asbestos roofs, and work as auto drivers, trolley drivers, daily wage labourers, or own a petty shop.



Rickshaw Colony: Established in 1999 in Ward no. 14. of the North Zone, it is an authorised colony. It has a large SC population. Households have piped water connections. There is a CT close to the settlement.



4.4 DEMOGRAPHIC PROFILE OF THE SAMPLE

There are 436 recognised slum settlements in Bhubaneswar (identified by BMC). Of these, 73 per cent are unauthorised. Consequently, in our sample survey, the proportion of unauthorised sites was

higher. The total sample for the household survey was 550 households across ten settlements. A mixed social composition of the survey sample was ensured by covering all marginalised groups identified by the Odisha government. The sample description is detailed in Table 1.

Table 1: Sample description

BMC ZONE	SLUM NAME	SETTLEMENT TYPE	CHARACTERISTICS OF SLUM	TOTAL HHS	GENDER OF RESPONDENT			TOTAL HHS SURVEYED
					Men	Women	TGs	
North	Rickshaw Colony	Authorised	High SC population	194	11	27	0	38
	Adivasi Gaon	Unauthorised	High ST population	293	19	34	0	53
South West	Mahavir Basti	Unauthorised	Mixed population	340	15	34	0	49
	Baramunda Bhoi Sahi	Authorised	Large SC population	36	3	7	0	10
	Kargil Basti	Unauthorised	Presence of Transgender	1018	47	98	6	151
	Kalinga Studio	Unauthorised	Transgender population	66	0	0	18	18
South East	Sahid Nagar Telugu Basti	Unauthorised	Transgender population	373	15	37	6	58
	Kedar Palli Basti	Unauthorised	Sweepers' colony	641	26	65	0	91
	Lingaraj Leprosy Colony	Unauthorised	Leprosy patients	38	3	7	0	102
	Masjid Colony	Unauthorised	Large Muslim population	507	21	51	0	72
Total respondents					160	360	30	550

Given that a set of parameters was considered to select the site, the sample is representative of marginalised groups. The proportion of 'general' population (37 per cent of the sample) is comparable to the SC population (42 per cent). The ratios of ST and OBC in the sample were 9 per cent and 10 per cent respectively. Transgender from SC, ST, OBC and general population were also part of the study (see Figure 2).

Three slums – Baramunda Bhoi Sahi, Kedarpalli Basti and Rickshaw Colony – have substantial SC populations (Figure 3). While Masjid Colony and Lingaraj Colony have a large general population, it should be noted that the Muslim community predominates in Masjid Colony and Lingaraj Colony is one of Bhubaneswar's six leprosy colonies set up in the 1970s to rehabilitate leprosy patients. These groups are also recognised as marginalised groups in the study.

Figure 2: Distribution of the sample by social groups

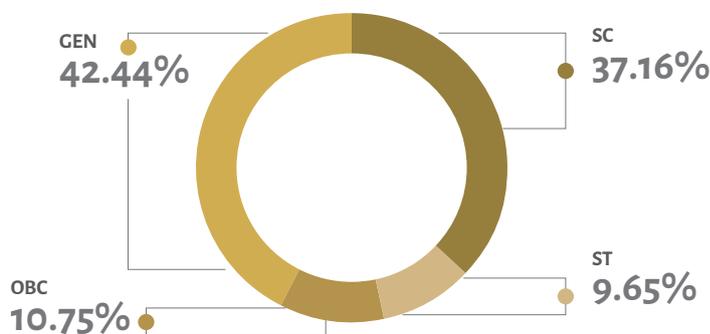
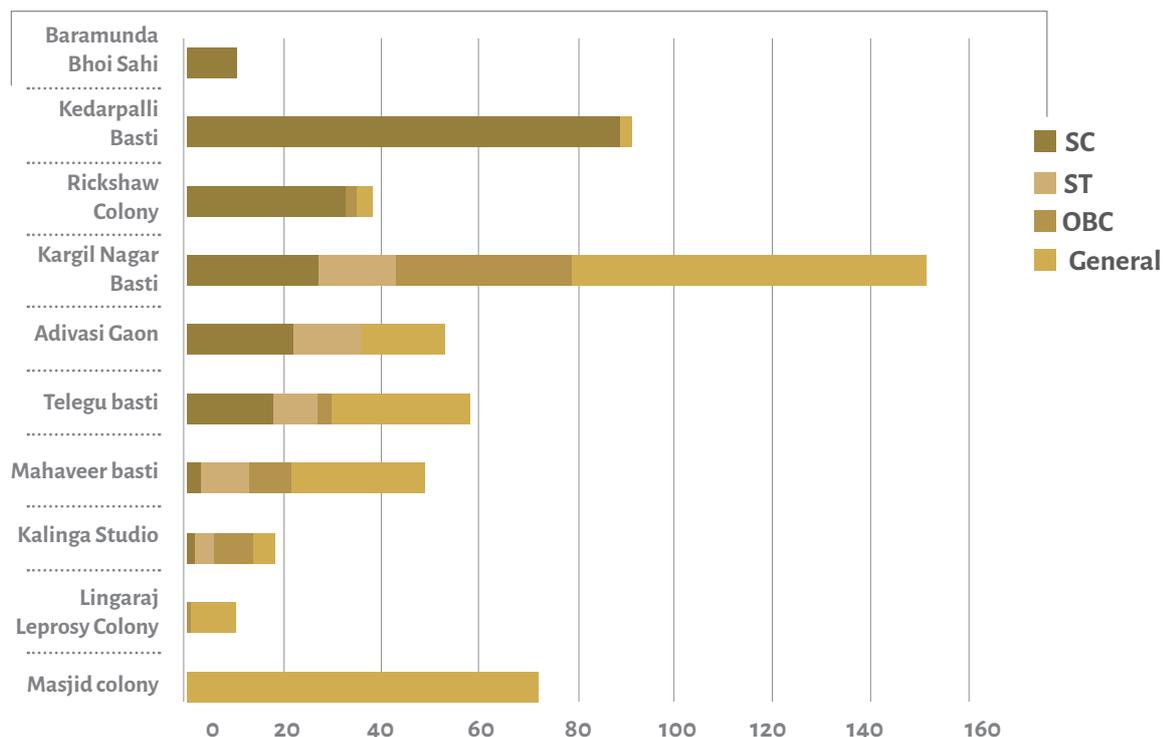


Figure 3: Demographic profile of the sample





5.

FINDINGS: SANITATION ACCESS AND USAGE PATTERNS

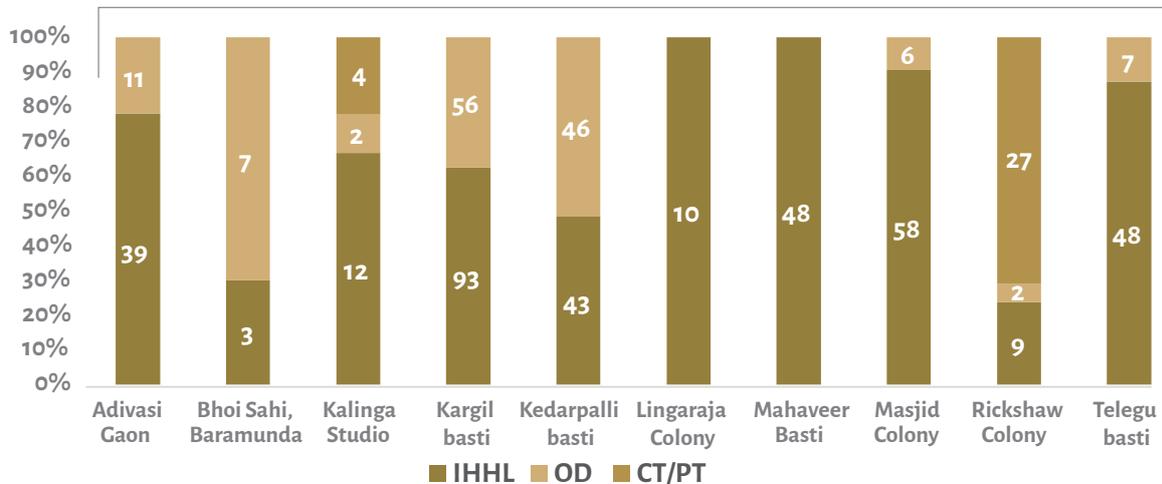
SNAPSHOT

Analysis of sanitation access and usage patterns reveals that 66 per cent of the sample (363 of 550 households/ HHs) always use IHHLs, 25 per cent of respondents (137 HHs) always practise OD, and 6 per cent (34 HHs) always rely on PTs or CTs. Merely 3 per cent of respondents (16 HHs) rely on a mix of IHHL and CT/PT, or practise OD. Additionally, the sanitation usage pattern of all household members is mostly similar. Only 2.1 per cent of the households (12 HHs) reported intra-house variation in sanitation usage.

Table 2: Sanitation access and usage pattern

GENDER	ALWAYS			SOMETIMES			TOTAL SAMPLE
	IHHL	OD	PT/CT	IHHL+OD	IHHL+PT/CT	OD+CT/PT	
Male	102	45	8	0	4	1	160
Female	243	87	19	6	5	0	360
Transgender	18	5	7	0	0	0	30
Total	363	137	34	6	9	1	550

Figure 4: Sanitation usage pattern across slums



5.1 ENABLING FACTORS FOR IMPROVING ACCESS TO IHHL FOR MARGINALISED GROUPS

The survey reveals that SBM triggered IHHL construction across all slums. An enabling policy and programme thrust benefitted the urban poor slum dwellers in improving access to IHHLs. Nearly 67 per cent of respondents who have access to an IHHL constructed it during SBM (2014-2018). Figure 4 details the slum-wise sanitation usage patterns of households whose usage patterns are consistent, that is, they always rely on either an IHHL or PT/CT, or practise OD (see Figure 4).

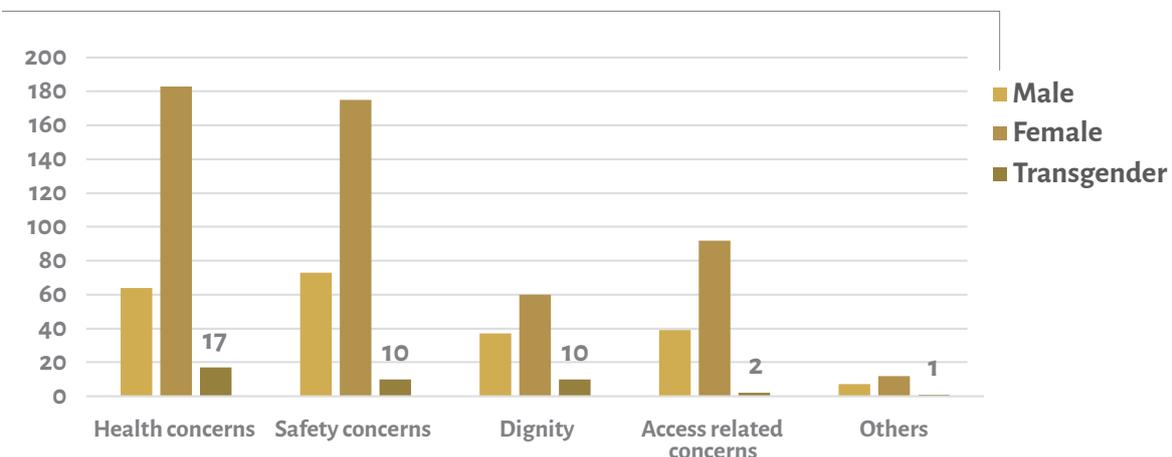
Lingaraj Leprosy Colony, Mahavir Basti and Telugu Basti show a high reliance of households on IHHLs. Each household in Lingaraj Colony has a piped water supply connection. In 2017, all households in this basti were provided support of INR 8,000 under SBM for the construction of an IHHL. In Mahavir Basti, which has reported a large number of IHHLs, more than 50 per

cent of the IHHLs were constructed before SBM. It has a vibrant Mahila Arogya Samiti (MAS); these women's groups, formed by the central government to focus on the improvement of health in the community, often take on water- and sanitation-related functions. In Telugu Basti, 66 per cent of the IHHLs were constructed during the SBM period but without any government funding. In this basti, nearly all residents (99 per cent) own their house. The elected representatives were effective in mobilising communities to trigger IHHL construction.

5.1.1 IHHL construction vis-à-vis women, transgender and PwDs

For both men and women, the top three reasons for the construction of an IHHL are health concerns, safety concerns and access-related concerns. However, the study reveals that for transgender, dignity is one of the top three reasons, along with concerns related to health and safety (see Figure 5).

Figure 5: Reasons for constructing an IHHL



In the WASH sector, there is limited understanding of how WASH affects non-normative gender identities. This study reveals that 60 per cent of transgender households covered under the survey (18 HHs of 30 transgender HHs) have access to IHHLs (see Figure 6). Prior to construction of IHHL, they practised OD. For instance, in Shahid Nagar in Telugu Basti, transgender practised OD earlier, but over time, as the settlement expanded and the surrounding area became denser, the OD spots reduced. Consequently, they pooled resources to construct a toilet in the common area to be used by all. Additionally, in other settlements such as Kargil and Kalinga, households came to know about the government scheme through media, government and ward members. After construction of an IHHL, transgender have experienced a reduction in physical or psychological threat of harassment. Other benefits include feeling safer, better privacy, reduction in instances of illness and, correspondingly, medical expenditure.

In almost 4 per cent of surveyed households (21 HHs), at least one member was a PwD. Nearly 66 per cent (14 HHs) of these households reported access to an IHHL. Almost 78 per cent of PwD households (11 HHs) with access to an IHHL are from Lingaraj Leprosy Colony and Masjid Colony. These settlements have a high percentage of marginalised groups (including leprosy patients and the minority religious group, i.e. Muslims). Nearly 80 per cent of households have constructed an IHHL under a government scheme. While the support provided by the government varies between INR 3,500 to INR

8,000, the study shows that marginalised groups like PwDs have received support on the higher side, amounting to INR 8,000, for the construction of an IHHL. In some households, the IHHL has handrails and a portable toilet to facilitate PwDs for their sanitation needs.



5.1.2 Access to piped water for IHHLs

If households have access to piped water supply, they are more likely to have an IHHL. Survey findings show that almost 73.8 per cent of those with access to piped water have constructed an IHHL (see Figure 7). However, a high proportion of those who rely on a CT also have a piped water connection. As KIIs in bastis with strong reliance on CTs—such as Rickshaw Colony—revealed, the reason for the reliance on a CT in spite of the presence of a piped water connection at home is that water supply is inconsistent. Rickshaw Colony receives water only once a day. The CT there has a well within its compound and therefore does not face water scarcity.

Figure 6: Sanitation usage by transgender across slums

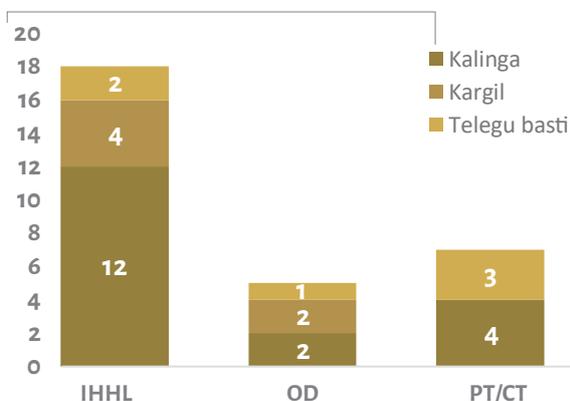


Figure 7: Coverage across piped water supply and sanitation usage

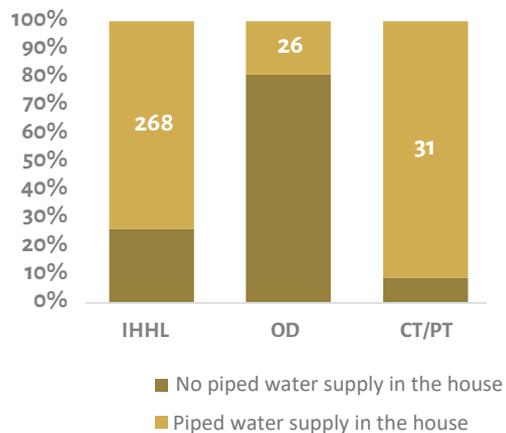
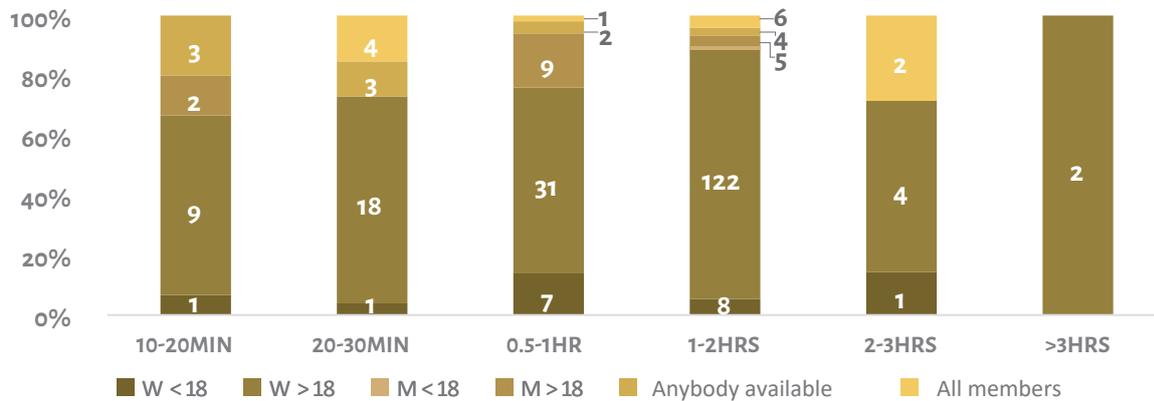


Figure 8: Time taken to fetch water by different HH members



5.1.3. Water time burden

The study discloses that women are disproportionately affected by the unavailability of water for IHHLs due to their assigned gender roles and associated vulnerabilities. Nearly 14.2 per cent of respondents with access to an IHHL reported that they face difficulties in using it. Almost half of these respondents stated that the IHHL has led to an increased burden of fetching water. As Figure 8 shows, there is a clear trend of women bearing the burden of bringing water for the entire household. Nearly three-fourth of the respondents reported that girls below 18 years of age were responsible for fetching water at home. Almost 60 per cent households (145 of 245 HHs) with the burden of

fetching water reported that between one to two hours each day were spent on water collection (see Figure 8).

Additionally, in some settlements like Masjid Colony, although houses have been provided water connections by the government, these taps mostly run dry. The three wells centrally located in the slum are the primary source of water for washing and cleaning purposes for the slum dwellers. Due to shortage of water supply, water conflicts in the slum are frequent.

5.1.4 Community consultation for IHHL construction

SBM has been envisioned as a jan andolan with a



CASE STUDY: WATER WOES IN KEDARPALLI BASTI

In Kedarpalli Basti, residents mostly work as sweepers with BMC and more than 95 per cent of households are SCs. The survey reveals that 48 per cent of households have an IHHL, while more than half practise OD. Access to water and the burden of fetching water by women are critical concerns in this basti. This also affects the continued usage of IHHL.

Water Conflict in Kedarpalli

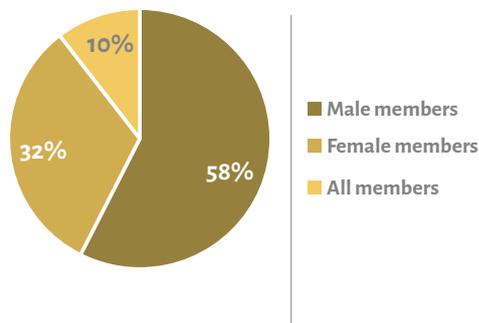
While piped water connections were provided by the government nearly a year ago, these taps are dry. Residents mostly rely on common water collection points for household use. Inadequate access to water creates insecurity amongst the slum residents, with water conflicts being common. Residents revealed that water sharing is a critical factor in interpersonal disturbances in the slum. For instance, Renu (name changed) shared that:

'If I go and fill my buckets with water and the person after me in the queue does not get water, they would blame me. They would say, you will cook and eat today – what about us?'

Further, residents complained that water quality was inferior. Often they had to consume muddy water despite its adverse health effects.



Figure 9: Who attended public consultation on IHHL construction from the HH?



thrust on community participation. According to the study findings, 36 per cent of the households knew of IHHL funding through elected representatives such as ward members and councillors. Elected representatives were most effective in Kargil Basti, Mahavir Basti and Telugu Basti in creating awareness, holding consultations and filling the application forms, leading to high sanitation coverage in these areas. In Masjid Colony, the construction of all IHHLs under the government scheme was triggered by a sustained media campaign and facilitation of neighbours and Swachhagrahis. While an Information, Education and Communication (IEC) campaign helped to trigger awareness, Swachhagrahis played a critical role in identifying households that did not have access to IHHLs and then in hand-holding them in applying for incentives for IHHL construction. Neighbours and community forums also played an active role in the dissemination of scheme-related information, thereby bridging the communication gap.

Despite socioeconomic and cultural constraints, women’s empowerment goals can be achieved through their sustained involvement at all levels. Close analysis of meetings held to trigger IHHL construction at the community level reveals that men attended these consultations for 58 per cent of the households. Only in one-third of the cases did women household members participate in these consultations (see Figure 9).

5.1.5 Women’s participation in collectives and forums does not necessarily translate into their empowerment

Community forums such as SHGs, MASs and Basti Committees played a critical role in promoting IHHL construction in some settlements. For instance, in Mahavir Basti, where nearly 45 per cent of total IHHL construction (49 IHHLs) has been without government support, active community forums played a critical role in triggering the community.

However, these forums are gender-segregated based on social norms that reinforce stereotypical roles and responsibilities.

In most slums in Bhubaneswar, the members of the Basti Development Committees (BDCs) are usually men. These committees are mandated to work towards slum development related to aspects perceived as masculine functions. Most communities have a separate group for women, the Mahila Arogya Samiti (MAS), set up by the government under the National Urban Health Mission (NUHM) for improving health. Study findings reveal that these groups often take up WASH-related activities, seen as feminine functions by the community.

The BDC is responsible for organising temple-related activities, collecting donations and resolving conflicts between community members. There are very few women members in BDCs, and their engagement is limited to playing tokenistic roles. For instance, in Mahavir Basti, there are 12 members in the committee, 10 males and 2 females.

The FGD in Kargil Basti also revealed similar trends. Health was perceived as women’s responsibility in the basti, and thus was dealt with by the women’s group MAS. In contrast, the BDC, which was male-dominated with token women representatives, looked at the broader issues related to the slum.



The Kargil Basti BDC consists of 60 members (50 men and 10 women). During the FGD with the BDC, the male members revealed that there are more men in the committee as they are ‘smart, intelligent, responsible and with good organising skills’. They stated that ‘women find it difficult to take out time for basti meetings’. They also emphasised that there already exists a MAS committee for women in the slum.

While women’s participation in water and sanitation programmes through local committees is often deemed necessary for the effectiveness of such schemes to ensure an increased use of the facilities, survey findings reveal that women’s inclusion in these committees rarely translates into improving their participation at the community level. Survey findings also reveal that transgender do not participate in the discussion of their basti’s BDC or MAS. They have their own collective and are unaware of the meetings in the larger basti.

5.1.6 Women’s voices in decision-making related to IHHL construction

The study reveals that women are under-represented in the decision-making process on toilet construction at the household level. While the head in a male-headed household is likely to decide the design of IHHL, in female-headed houses, masons and other family members play a more active role in determining the design, as evident from Figure 10 and 11.

In 53 per cent of the male-headed households, the

household head decides the location of the toilet (see Figure 12). In comparison, only in 45 per cent female-headed households does the household head determine the location (see figure 13). In male-headed homes, merely 21 per cent of the respondents reported that other family members were consulted for deciding the location of the IHHL. In contrast, in a woman-headed household, 31 per cent of the respondents reported consultation with other family members for this aspect.

Women’s non-involvement in sanitation decision making at the household level is attributed to their low socioeconomic status and inability to influence the household’s financial decisions.

5.2 OD: LIVED REALITY OF MARGINALISED GROUPS

Marginalised groups like SCs are less likely to have access to IHHLs. More than half the surveyed SC population practiced open defecation (see figure 14). High open defecation was reported from 3 settlements that is, Baramunda Bhoi Sahi (70 per cent), Kedarpalli Basti (more than 50 per cent) and Kargil Nagar Basti (almost 40 per cent). The first two bastis have large SC populations. Study findings reveal that access to consistent water supply is a critical issue in Kedarpalli leading to low willingness for IHHL construction. Of 47 households who practise OD, 80 per cent (38 HHs) revealed that water scarcity was a constraint in the settlement.

Mostly, OD is practised in three sites- railway tracks, open fields and near open drains. It should be

Figure 10: Decision-making for IHHL design in male headed households

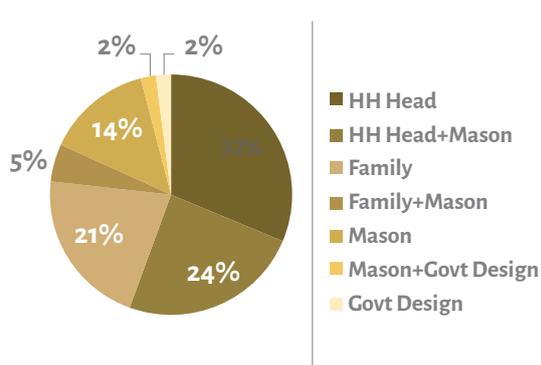


Figure 11: Decision-making for IHHL design in female headed households

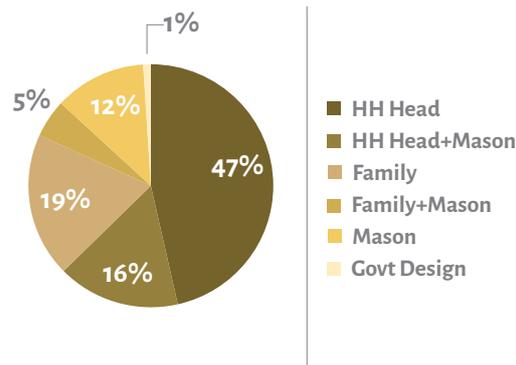


Figure 12: Decision-making for IHHL location in male headed households

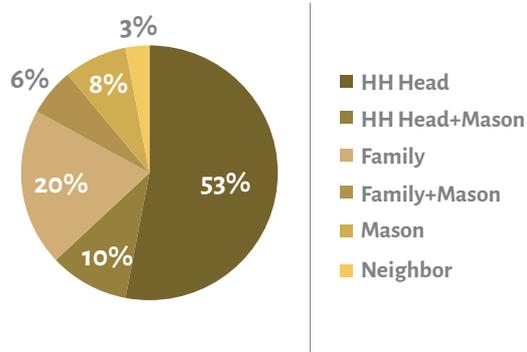
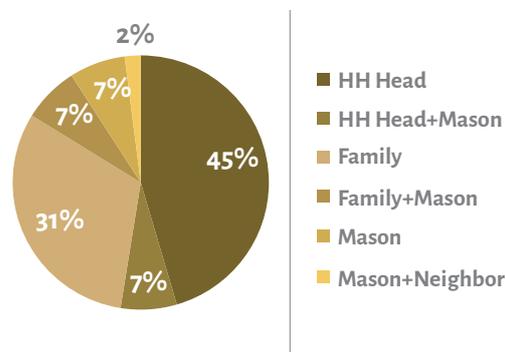


Figure 13: Decision-making for IHHL location in female headed households



noted that Kargil Nagar Basti, where high OD has been reported, has easy access to open areas and railway tracks. In Rickshaw Colony, fear of animal attacks (snakes and elephants) makes practising OD difficult.

5.2.1 Issues in practising OD

Survey findings reveal that OD behaviour patterns among men and women in the morning are similar. Nearly 93 per cent men and 90 per cent women practise OD before sunrise. But 63 per cent of men reported practising OD after sunset in contrast to only 44 per cent of women who do so at that time.

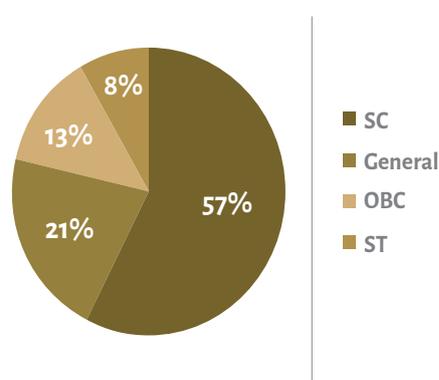
Women discipline their bodies around the unavailability of sanitation facilities because they face embarrassment or shame going outside at odd hours during the day, or feel unsafe about OD post sunset. Findings from the survey reveal that almost one in three people practising OD regulates the intake of food and water. Consequently, they develop a series of ailments, including gastric issues, feeling nauseous, frequent headaches and loose motions.

5.2.2 Reasons for non-construction of IHHL

Despite the above-mentioned difficulties, many households had not constructed an IHHL because of three main reasons: financial constraints, space constraints and IHHL maintenance burden (see Figure 15). There were some households which had applied for the government subsidy and, were waiting for the application to be processed.

Financial constraints related to the O&M of IHHLs is a critical factor that discourages poor households from constructing an IHHL. Nearly 18 per cent of households which do not have an IHHL reported

Figure 14: Practice of open defecation by caste



constraints related to maintenance costs in building one. Households revealed that one of the key maintenance expenses is for regular desludging of the on-site sanitation system. Almost 75 per cent of IHHLs are connected to an on-site sanitation system, of which 68 per cent connects to a single pit, 4 per cent to septic tanks, and merely 3 per cent to twin pits. The remaining IHHLs are connected to open drains and sewers. Government operators charge between INR 700 to INR 1,800 for desludging, while private operators charge between INR 700 to INR 2,000. Although desludging services provided by private and government operators are similarly priced, nearly 70 per cent of the households that reported desludging rely on private operators.

5.3 COMMUNITY TOILETS AND PUBLIC TOILETS

Out of 550 respondents, 6 per cent of respondents always rely on a CT and/or PT. Another 2 per cent

ANECDOTES ON OD BY VARIOUS MARGINALISED GROUPS



Transgender

‘People take our pictures and make videos while we are defecating.’

‘People throw stones, stare, abuse, make lewd comments, and sneer at us.’

‘People are curious about our bodies. They stare.’

‘Passers-by make dirty moves on us. Sometimes they ask us to show our body parts.’

Women

‘When we defecate people throw stones at us. They shoot videos.’

‘During the day, we feel shy to go for defecation. Also, we avoid going for OD when there is housework.’

‘We are embarrassed to defecate in the open when a man is crossing the street.’

Adolescent girls

‘We often go out to relieve ourselves in the early hours of the morning to avoid being ‘leered at.’

‘We go together in groups.’

use CTs and/or PTs sometimes. Key concerns in using a PT include that it is far from the place of residence, crowded, unclean, locks are broken and men enter the women’s section. Nearly 80 per cent of respondents confirmed that there are no dustbins in CTs.

While there are several issues in the O&M of community toilets, study findings reveal that CTs that have high community ownership are better maintained (see the case study below).

5.3.2 Issues faced by marginalised groups in accessing CTs and/or PTs

Difficulties faced by women in CT or PT usage

Survey findings identify four severe difficulties

faced by **women** in using CT and/or PTs. These include broken locks and doors in CTs; men entering the women’s wing to use the toilet in case of heavy footfall on the men’s side; male sanitation workers appointed to service the women’s side; and lack of adequate facilities to manage MHM safely.

Moreover, a large capital investment is often made for men’s urinals in CTs and/or PTs. As a result, men are charged less for urination compared to defecation. However, women are end up paying a flat rate for both urination and defecation.

Survey findings reveal that while care economy functions played by women require that they

Figure 15: Reasons for not constructing an IHHL



use bathrooms for washing clothes, assisting children, they are often berated by caretakers for taking excessive time, using too much water, or dirtying the CT more than men (see the case study below). Consequently, at some CTs they end up paying more for consuming more water while performing household chores such as washing

clothes of all family members or catering to the sanitation needs of their children.

5.3.4 Difficulties faced in ensuring safe Menstrual hygiene management (MHM)

The focus on menstrual hygiene management in the Indian water and sanitation sector is relatively new.

CASE STUDY – COMMUNITY TOILET IN RICKSHAW COLONY

Although established as long ago as 1999, Rickshaw Colony continues to face the problem of inconsistent piped water supply. More than 70 per cent of respondents from this basti said they rely on a CT for sanitation. In 2012, an NGO built the CT on land provided by BMC. Before this, people practised OD at the periphery of the settlement. Three key factors led to the shift of high reliance on the CT. Once the CT opened for use, families from adjacent neighbourhoods – Harekrushna Colony, Rickshaw Colony and Panda Park – gradually began to use it. Open fields that acted as OD spots were fenced and guards stationed. .

Operation and management

After building the CT, the NGO in coordination with BMC provided training to community members to operate and maintain the toilet. Around 50 people attended the training. A Jan Kalyan Sauchalaya Committee was set up to manage the CT, with a President, Secretary and Cashier as core committee members. Today, the Secretary, Rama Chandra Swain, plays a critical role in making decisions for CT management.

In the first three years, the community trialled a salary system to manage the CT. Children below eight years of age and infants with their mothers were exempted from paying the user fee set at INR 1 for every use. However, the O&M costs were very high. The user fee was not enough to meet maintenance costs. Consequently, it was raised to INR 2. To ensure a sustainable O&M model, in 2015, the concept of the lottery was introduced. Community members could now gain financially from managing the CT.

A total of 50 households from the three settlements (Harekrushna Colony, Rickshaw Colony and Panda Park) participate in the lottery conducted on the 17th of each month. Community members write their names on paper chits and drop it in a box. A child from the community chooses one of the chits and announces the winner who gets to manage the community toilet for a month.

The winner is responsible for the supervision of the CT, payment of electricity, water supply, ensuring availability of cleaning materials, and taking care of minor repairs. The household who manages the CT has to pay INR 5,000 to the committee as a seed fund, INR 7,000 goes towards electricity, and INR 4,500 to the sweeper to clean the CT. Desludging is done once a year with the cost ranging between INR 800 to INR 1,000 per trip. Ten to 12 visits are needed to empty the pit. The desludging costs are met from the corpus fund. There are some other expenditures related to O&M for the lottery winners. Every month plastic pipes, mugs and buckets need to be purchased as they get stolen or broken. Based on findings from this study, a household could make a profit of close to INR 6,000 for managing the CT for one month. However, the winning family cannot participate in the lottery for the next 50 months. This process ensures that all 50 households get a chance to manage the CT, which benefits them financially.

Difficulties in using the CT

There is no separate cubicle for PwDs nor is there a gender-neutral cubicle. If the bathing area in a PT or CT is a common one, it is inaccessible to transgender persons and PwDs. There is also no provision of dustbins in the CT.

It was only in the early 2000s that MHM received any attention. The study underlines that safe MHM continues to be a critical issue. Almost 80 per cent of the respondents confirmed the lack of dustbins in PTs and CTs. Households that now have an IHHL report that this has led to a tremendous reduction in stress levels for adolescent girls and women family members in safely managing menstruation hygiene. Sanitation facilities designed, planned and financed explicitly for the unique needs of women and girls will go a long way in ensuring gender equality in access to sanitation.

Difficulties faced by PwDs in CT or PT usage

Although the Rights of Persons with Disabilities Act was passed in 2016, the design of various public and community infrastructure continues to exclude this marginalised group. The 2016 Act aims to ensure

universal access to infrastructure by PwDs and has specifically emphasised their access to water and sanitation facilities. In line with the Act, the SBM-U revised guidelines released by the Ministry of Housing and Urban Affairs (MHUA) in 2017, provides for differently abled friendly PTs and CTs. Further, the Odisha Urban Sanitation Strategy also mentions that CTs and PTs should be provided with specific arrangements, such as ramps and braille signage, for the convenience of disabled persons. However, the study discloses that the design of CTs and PTs do not cater to the specific needs of PwDs.

Difficulties faced by transgender in CT or PT usage

Study findings also reveal that while all CTs in the survey area have a separate wing for men and women, there were no PTs and CTs with separate wings or cubicles for transgender. KIIIs with

CASE STUDY – PUBLIC TOILET IN MASJID COLONY

A public toilet was built in 1988 for the residents of Masjid colony. There is a well within the compound of the PT which is the primary source of water. Initially, no user fee was charged, but this changed in 2002-03 when a pay and use model was introduced. However, some residents remain reluctant to pay the user fee.

Operation and maintenance

This toilet is run by Sulabh. They have appointed three caretakers to operate the toilet on a rotational basis since taking over its management 17 years ago. None of the caretakers lives on-site. However, the sweeper responsible for cleaning the men's and women's wing does live on-site as he is responsible for opening the toilet in the morning. Operational timings of PT are 4 am to 9 pm. Every day, one of the caretakers has to deposit a sum of INR 1,900 at the Sulabh office. If they fail to do so, they have to pay from their own pockets!

“ Anecdotes from the caretakers

- ◆ ‘Women take children with them. They dirty the toilet so their wing takes more time to clean.’
- ◆ ‘They wash clothes. They use a lot of water. However, they want to pay only 5 rupees! If they take too much time or take one bucket of clothes, they have to pay 10 rupees.’

transgender reveal that for them, public space is not a neutral space. It is, in fact, a place where power is enacted. The built environment of a bathroom that denies their existence forces them to choose between men's and women's rooms. This creates insecurity amongst them in using public restrooms. Unable to cope with the threat of harassment or violence in a public restroom, some transgender chose to avoid them altogether.

To address some of these issues, in a few places in Bhubaneswar hybrid toilets have been built. These toilets have gender-neutral, single-occupancy cubicles alongside male and female toilet blocks. This public infrastructure design discourages gender policing by setting a tone of inclusion while also offering multiple options for accessing bathrooms. However, these are few and sparsely spread through the city.

Moreover, no provisions have been made for upgradation of existing CTs and PTs, so that specific needs of transgender are met. Additionally, the total number of transgender persons is under represented in Census 2011 with transgender being listed in the 'male' category (Biswas, 2019). Transgender are assumed to be men; consequently, transgender persons who identify as women have been entirely left out. As a result, the distribution of transgender-friendly toilets estimated by the government is inadequate.

Overall, there is very limited research into the



ANECDOTES OF ADOLESCENT GIRLS ON MENSTRUAL HYGIENE MANAGEMENT (MHM)

“

'We never go out to buy sanitary pads. Our mother gets it. We use it.'

'For a menstruating girl, it is difficult to manage her periods, especially during the rainy season.'

'When we go for defecation, we also change our pads. We wrap the used pad in a newspaper/polythene and throw it in the open fields or in the pond where people usually throw waste.'



issues transgender face in accessing WASH and how public toilets can be designed to cater to their needs. It is an area of concern from a human rights lens, and also from the perspective of the SDGs, which aim for universal access to sanitation and gender equality while calling for the reduction of inequalities.

5.4 THE CARE ECONOMY BURDEN OF WOMEN VIS-À-VIS WASH

Inadequate sanitation access leads to psychosocial stress, harassment and sexual violence, and increased care burdens. Worldwide it is mostly women who bear the responsibility of taking care of the children, elderly or ill. These socially allocated roles are effort-heavy but invisible, unrecognised and unpaid. Mostly, men do not participate in these responsibilities.

The survey also reveals that women aged more than 18 years old (74 per cent of the total respondents) are responsible for fetching water in the household (see Figure 16). In more than three-fourth of the households that were surveyed, women are responsible for cleaning the IHHL (see Figure 17). More than two-third of the surveyed households reported that women were responsible for disposing of solid waste (see Figure 18), while more than three-fourth confirmed that women were responsible for taking care of household members when they fall sick (see Figure 19).



Figure: 16 Who fetches water?

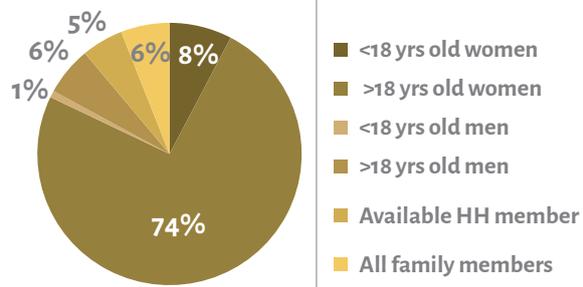


Figure: 17 Who is responsible for cleaning the IHHL?

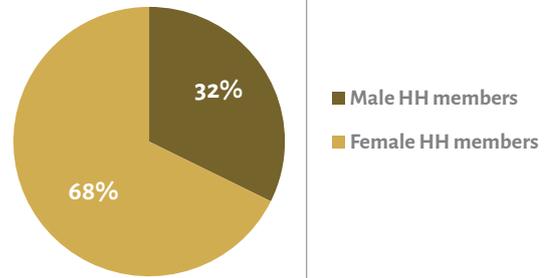


Figure: 18 Who disposes solid waste?

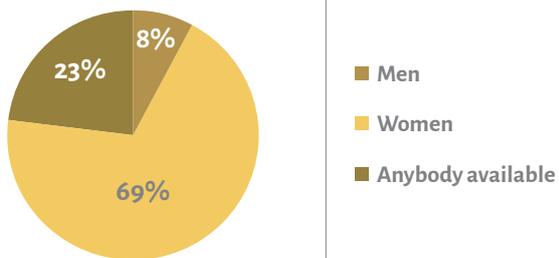
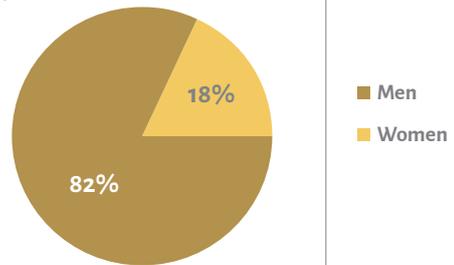


Figure: 19 Who takes care when household members fall ill?





6.

CONCLUSION AND RECOMMENDATIONS

It is crucial to acknowledge that widespread inequalities in accessing water and sanitation exist in India. This study has highlighted how these inequalities differently affect persons with disability, transgender, women, adolescent girls and men in accessing sanitation facilities, and also acts as a barrier to opportunities for them.

Social norms that produce gendered divisions of labour typically dictate that women and girls shoulder a series of roles in the 'private' sphere that, for the most part, men do not share. Consequently, poor women are hit the hardest by inadequate access to services (Bartram, Lewis, Lenton & Wright, 2005, Chaplin & Kalita, 2017). The care burden for women and adolescent girls is higher in settlements without consistent water supply and access to an IHHL. In such scenarios, women have to compensate for absent or inadequate public infrastructure and services by shouldering the burden of fetching water for their families and assisting their children in their sanitation requirements.

Although women are most adversely affected by poor sanitation, when it comes to decision-making

about sanitation issues, they have little power. Additionally, their control over financial resources remains weak due to the low status accorded to them in society. For more holistic and gender transformative outcomes, WASH schemes and their applications must be gender-sensitive and inclusive.

Against this background, we put forward the following set of recommendations based on primary research to support the government, CSOs, researchers and academics in developing inclusive urban sanitation policies:

a. Develop a framework and guidelines for inclusive sanitation at the national, state and city levels.

- ◆ Enabling policy frameworks that mainstream inclusion across the sanitation value chain is essential. It helps decision-makers develop inclusive strategies and approaches that benefit marginalised sections of the society.
- ◆ National guidelines for urban areas need to be developed that address vulnerabilities of marginalised groups in WASH across the value chain.

- ◆ It is also vital that state governments develop adequate frameworks and policies that are inclusive. Odisha was among the first states in India to develop both a strategy and a policy for urban sanitation – the Odisha Urban Sanitation Strategy and Odisha Urban Sanitation Policy – to address the challenge of poor sanitation. Building on these initiatives, it is suggested that the state government develop a **‘Framework and Guidelines for Inclusive Sanitation’** to demonstrate the government’s commitment to and move towards equitable access to sanitation.
- ◆ There is a **need to adopt a city-wide inclusive sanitation approach**, so that safe sanitation services are equitably delivered and sustained. An enabling mechanism should be created for promoting inclusive sanitation. In line with this, in India, some legal provisions – such as the Transgender Persons (Protection of Rights) Act, 2019, and Rights of Persons with Disabilities Act (PWD Act), 2016 – exist to safeguard the rights of these marginalised groups. But these have proved inept to ensure adequate access to water and sanitation for transgender and PwDs.
- ◆ The state and central governments can initiate a rewards and incentives scheme for cities which demonstrate and establish practices favouring inclusive sanitation.

b. Initiate an ‘as-is assessment’ of sanitation coverage for marginalised groups

Data on marginalised groups is a prerequisite for designing inclusive policies and schemes that cater to the specific needs of these groups. Further, to evaluate the impact of policies on marginalised groups, the size of these groups need to be accurately estimated first. Currently, Census 2011 in India estimates the total population of transgender to be nearly 4.88 lakh. In the primary database released by the government, the transgender data was clubbed under the head of ‘males’. Moreover, these are conservative estimates as this data was collected before transgender were legally recognised in the country (Boyce et al., 2018).

While the state government of Odisha has identified marginalised groups, there is a critical need to initiate an ‘as-is assessment’ of service

delivery to these groups. Study findings have clearly shown that PwDs and transgender continue to have limited access to CTs and PTs. Unfriendly user design of public utilities does not cater to the specific needs of PwDs and transgender. To ensure that public infrastructure is designed to meet the specific needs of marginalised groups, it is critical to first estimate the size of marginalised groups, map their location in the city, and assess their access to services in a city. Findings from this assessment would be useful in developing a city-wide inclusive sanitation plan. Accordingly, short-term, medium-term and long-term goals need to be prepared to address inequalities in sanitation in a phased manner.

c. Ensure inclusive WASH budgeting

Given that gender-responsive budgeting is critical for ensuring gender-transformative outcomes, it is suggested that cities integrate gender budgeting with planning. Encouraging inclusive budgeting for sanitation service delivery in cities based on ‘as-is assessment’ is critical.

- ◆ For PwDs, ramps, anti-skid floor, and adequate space, signage and door latches need to be ensured. For women and adolescent girls, some key enabling mechanisms include locating sanitation infrastructure in safe places to avoid violence and sexual harassment. PTs and CTs need to ensure separate entry for women, proper washing area, bathing spaces and safe MHM facilities, and cater to the requirements of caregivers (WaterAid, 2019). It is also suggested that women caretakers are appointed for the women’s wing of CTs and PTs. For children, the availability of child-friendly seats is essential. Transgender require separate gender-neutral entry to the toilet complex. Their toilet unit must have a bathing space.
- ◆ To ensure that operation of CTs and PTs is sustainable, an adequate and equitable tariff structure is to be built in. The user charge can be differential and yet inclusive. It can be decided through a consultative process with transgender, women, children, PwDs, elderly, and other urban poor and marginalised groups. It is also important that the user charge is displayed prominently within the toilet complex.
- ◆ Greater focus on IHHLs vis-à-vis CTs needs to be

placed in policy frameworks. The evidence from the study strengthens the rationale for investing in IHHL construction rather than in CTs wherever there is space. Where not, CTs need to be carefully managed. Furthermore, CTs are non-operational at night, it remains inaccessible to the community for at least 10 hours in a day, thereby undermining the SDG goal of providing sanitation for all at all times. In contrast, IHHLs ensure security and dignity to users (especially to women, adolescent girls and transgender). Study findings reveal that there is no physical or psychological threat of harassment in using IHHL. A clear policy thrust on IHHLs is critical for achieving SDG goals.

d. Subsidise costs for marginalised groups in the sanitation value chain

The government of Odisha has identified the most marginalised categories who are eligible for higher subsidies for toilet construction. The same principle can be applied to the complete sanitation value chain to make safe sanitation services affordable. Sanitation maintenance costs such as desludging of on-site sanitation systems can be subsidised for marginalised groups identified by the state. In this way, **municipal finance planning can play a critical role in prioritising the needs of the most marginalised groups while simultaneously subsidising sanitation services** for them.

e. Ensure adequate representation of marginalised groups in the City Sanitation Task Force (CSTF)

At the city level, a City Sanitation Task Force (CSTF) needs to be constituted with adequate representation of women (more than 35 per cent), elderly, persons with disability, transgender, migrants, marginalised and urban poor. There should be participation of all such group members in the planning and decision-making processes. At the ward and slum levels, inclusive sanitation committees can supervise construction and management of all ward-level and slum-level public sanitation infrastructure.

f. Reimagine the structure of the community forum

Although SBM-U has led to large-scale construction of IHHLs, it is yet to have a gender-transformative impact on the community. Study findings reveal that there is **low participation of marginalised groups** (especially women, transgender and PwD members), **at both household and community**

levels, on decision-making processes related to WASH.

There is a need to **reimagine the structure of the community forum**. Often interactions with community organisers are restricted to a mere exchange of scheme-related information. The challenge of meaningful engagement with the most marginalised groups remains. Engaging more with men and boys in community forums on water- and sanitation-related at the community level could go a long way in building synergies between men's and women's groups. It would also aid in debunking the gender stereotype of WASH as the responsibility of women. Unless men's collectives are also promoted to work on issues of water and sanitation, the burden on women will likely remain high.

g. Women in leadership roles

Going forward, the government of Odisha plans to engage SHGs in the service delivery of utilities. In this context, the Odisha government has made some efforts towards mobilising women SHGs in Berhampur, Baripada and Sambalpur, and a transgender SHG in Cuttack for managing FSM services. Building on this, further promotion of women's collectives at the slum level, where women are in a managerial role, can go a long way in improving both sanitation services and leading to gender-transformation outcomes. Additionally, there is a need to conduct periodic analysis of the engagement of SHGs from inclusive and social benefit perspectives to assess the success of this initiative. This analysis would help understand how the role of women and transgender entrepreneurs is leading to gender transformation at the family and community levels.

h. Capacity building of ULBs, CBO and SHGs

Capacity gaps in cities, both at the institutional and individual levels, in the delivery of inclusive sanitation act as a critical bottleneck in providing equitable sanitation services (Nair & Dwivedi, 2018).

- ◆ Provision of safely managed sanitation services to citizens is one of the significant functions of ULBs. In this context, strengthening the capacities of ULB officials, elected representatives and other sanitation staff on inclusive sanitation is a prerequisite for ensuring sustainable sanitation service delivery. For this, ULBs and elected representatives need to be periodically trained

on inclusive frameworks, inclusive budgeting and gender-sensitisation processes. Further, their capacity on all existing laws – such as the Sexual Harassment of Women at Workplace Prevention, Prohibition and Redressal Act, 2013, and Prohibition of Employment as Manual Scavengers and their Rehabilitation Act, 2013 – needs to be built.

- ◆ ULBs need to conduct gender-sensitisation training and build capacities of male and female caretakers of CTs and PTs to ensure that these common infrastructures are safe for female, adolescent girls and transgender users.
- ◆ Building capacities of CBOs, so that community voices are represented strongly in slums, wards and cities across planning, implementation and monitoring phases. A ward-level and a slum-level

sanitation committee can be made the primary agency for monitoring the performance of the public sanitation infrastructures at the ward level and slum level, respectively.

To achieve the SDGs based on the principles of LNOB, government schemes and programmes need to go beyond tracking the physical progress of infrastructures. LNOB underpins the need to interlink SDG 5 (Gender Equality), SDG 6 (Water and Sanitation), SDG 10 (Reduced Inequalities) as critical goals. To ensure equitable and sustainable sanitation outcomes, the focus needs to shift to inclusive sanitation approaches which encourage the participation of marginalised groups in leadership roles and decision-making processes to ensure no one is left behind in the efforts to achieve the SDGs by 2030.



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Scaling City Institutions for India: Sanitation

Sanitation programme at the Centre for Policy Research (CPR) is a multi-disciplinary research, outreach and policy support initiative. The programme seeks to improve the understanding of the reasons for poor sanitation, and to examine how these might be related to technology and service delivery models, institutions, governance and financial issues, and socio-economic dimensions. Based on research findings, it seeks to support national, state and city authorities develop policies and programmes for intervention with the goal of increasing access to inclusive, safe and sustainable sanitation. Initiated in 2013, the programme is primarily funded by the Bill and Melinda Gates Foundation (BMGF).



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