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SUMEDH M.K.

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## ABOUT THE AUTHOR

**Sumedh M. K.** works with the Government of Maharashtra's health department, through the Tata Trusts. A medical doctor by profession, Sumedh was previously a Fellow in Observer Research Foundation-Mumbai, where he did research on public health issues and worked on documentary filmmaking on diverse topics. He obtained his Master's degree in Public Health from the London School of Hygiene and Tropical Medicine.

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# Community-Based Approaches to Tackle Open Defecation in Rural India: Theory, Evidence and Policies

## ABSTRACT

Open defecation (OD), an age-old practice in India, impacts the health of individuals as well as their communities. To tackle the problem, the Government of India launched the Swachh Bharat Mission (SBM) in 2014, aimed at making the country open-defecation free (ODF) by October 2019 by giving more attention to community-based approaches. However, while such approaches have helped solve the sanitation riddle in many countries, curbing OD in India is much more complicated: the root of the problem is a combination of lack of sanitation infrastructure and deep-seated habits. So far, India's sanitation policies have used the top-down approach, focusing on financial assistance for latrine construction. While this is necessary, considering the social determinants at play, the emphasis must be on changing collective behaviour through participatory methods, a component that has been largely absent from past policies on sanitation. Demand-driven approaches must be adopted, keeping in mind their strengths and weaknesses and ensuring equity-focused actions through community-monitored, locally appropriate and culturally sensitive interventions.

## INTRODUCTION

Globally, around 2.4 million deaths occur each year due to lack of hygiene, sanitation and water.<sup>1</sup> The practice of open defecation (OD) is considered one of the major causes of the persistent worldwide burden of diarrhoea and enteric parasite infection among children under the age of five,<sup>2</sup> which lead to preventable deaths. Sanitation has been recognised as a public-health issue since John Snow's work during the London cholera epidemic of 1853.<sup>3</sup> Reducing OD requires access to and use of improved sanitation facilities which, in turn, prevent human faeces from re-entering the environment.<sup>4</sup> A range of interventions has been undertaken by various agencies all over the world to tackle the problem of OD. The results have been mixed.

OD is widespread in many developing countries such as India, Indonesia, Nigeria, and Ethiopia. India remains in the lead, with 524 million people defecating in the open every day (as compared to 31 million in Indonesia, 47 million in Nigeria, 27 million in Ethiopia).<sup>5</sup> As estimated in 2015, the number of people defecating in the open in India was double the total number from the 18 countries ranked after India, and 59 percent of the total number of people in the world defecating in the open.<sup>6</sup>

According to the 2011 Census, more than 67 percent of rural Indian households did not have access to toilets. However, after Prime Minister Narendra Modi announced the Swachh Bharat Mission (SBM) in October 2014, the country witnessed a massive surge in efforts towards improving cleanliness and sanitation, and ending OD. The SBM has since been promoted, celebrated and popularised across the country. As of this writing, the SBM-Gramin website reports that the household latrine coverage in rural India has increased from 38.7 percent on 2 October 2014 to 96.08 percent as of 17 November 2018. However, the

government's claims are being debunked by some of its own agencies. For example, the National Family Health Survey-4 (NFHS-4) in Ajmer, Rajasthan, had found 39 percent OD in July 2016, while the district was declared ODF during the same month as per the annual National Rural Sanitation Survey (NRSS).<sup>7</sup> In a more recent instance, the Comptroller and Auditor General (CAG) of India tabled a report in Gujarat assembly in September 2018, stating that 29 percent of households did not have latrines in 120 test-checked villages and as many as 17,423 latrines were in a state of neglect, although the state government claims Gujarat to be ODF.<sup>8</sup>

### **Statement of the Problem**

In many parts of India, OD is not the result of the absence of toilets but of the social acceptance of such behaviour. Research shows that other than demographic factors, it is “social dynamics” that influence the decision to build (and use) a latrine.<sup>9</sup>

Since 1986, there have been several attempts to change outdated mindsets and promote sanitation. However, there has been no noticeable change in sanitation-related behaviours, particularly in rural India. Thus, starting 2004, the government shifted the focus of the rural-sanitation programmes to influencing change in behaviour instead of merely creating sanitation facilities. Some such initiatives have been successful in the past.<sup>10</sup> While scaling up these initiatives, however, it is necessary to understand that “pathways leading to health behaviours are mediated through social relations, micro-environments, structural barriers, community norms in addition to individual intent. Understanding variations in behavioural pathways can assist in planning locally relevant, culturally specific, and socially compatible behaviour change programmes.”<sup>11</sup>

## Rationale and Approach

Community-based approaches based on the principle of participatory rural appraisal have been useful in addressing sanitation issues in several countries. This paper sheds light on some of these approaches and their usefulness in the Indian context.

Many interventions that use community-based approaches, such as Community-Led Total Sanitation (CLTS), have been tried, with varying degrees of success. To assess the suitability of such approaches, existing evidence must be evaluated against theoretical paradigms, their strengths and weaknesses, and then moulded as per local needs, keeping in mind the causal diversity of the practice across the country. Thus, this paper also looks at the theoretical underpinnings and practical implications of such interventions.

The success of community-based interventions depends on several factors, including how governance affects the intervention processes. India's sanitation policies in the past have mostly focused on financial assistance for latrine construction, i.e. a top-down approach. However, decentralisation of policies, flexibility in implementation, and empowering of local governing bodies have been the mainstay of community-based interventions, i.e. a bottom-up approach. Whether or not structural interference is necessary in bottom-up interventions is a separate debate altogether.

Sanitation behaviours, much like other health behaviours, are a result of a complex web of social, economic, environmental, cultural and political determinants. Targeting these requires multipronged efforts, and their need varies from place to place, given India's diversity. Therefore, different communities must be targeted differently. Additionally, because the level of disadvantage is not the same everywhere, the required quantum of work also differs. This paper

briefly mentions these arguments in the context of the use of a ‘one-size-fits-all’ approach to policymaking and implementation.

## THE CASE FOR COMMUNITY-BASED APPROACHES

Placing the onus of behavioural change on individuals and communities has long been recognised as one of the more effective ways of health promotion. While health promotion at the individual level has seen many successes, sanitation practices that result from social norms and affect entire communities seem to be better addressed using community-level approaches.

Morten Skovdal of the Department of Public Health, University of Copenhagen says, “Health promotion at the community level is no longer about ‘experts’ providing target audiences with health-related information. It involves engaging with local actors to challenge health-damaging practices, and norms, as well as to facilitate locally defined solutions to health problems.”<sup>12</sup> Based on this concept, there have been many models that come under the umbrella of “total sanitation programmes,” working with communities that have been successful in changing behaviours.

India’s Total Sanitation Campaign (TSC), launched in 1999, was one of the earliest to use community-based approaches. It used a combination of Information-Education-Communication (IEC) campaigns, promotion of “a sense of disgust”, and latrine construction with and without subsidies.<sup>13</sup> UNICEF officially adopted Community Approaches to Total Sanitation (CATS) in 2008 to guide its interventions in the sector. CATS was a new community-led approach, a major shift from previous supply-driven approaches.<sup>14</sup> A similar approach called Community Health Clubs (CHCs) was used effectively in Zimbabwe. The rationale behind the concept of CHCs was to build community cohesion and to promote a “culture of health.” One of the



aims of CHCs was to change norms and existing beliefs that are recognised as determinants of behaviour.<sup>15</sup>

Total sanitation targets a multitude of hygiene behaviours.<sup>16</sup> While such behaviour changes are difficult to influence on an individual level, community-based programmes aim to promote community-wide behaviour change and collective action towards improving sanitation.<sup>17</sup>

One programme that has gained much popularity in the recent decades is Community-Led Total Sanitation (CLTS). It was invented by Dr. Kamal Kar in Bangladesh, in response to the evaluation of a project where existing top-down approaches were found to be ineffective.<sup>18</sup> It is rooted in participatory rural appraisal, which believes that once people are convinced about the need for sanitation, they can act towards making their environment ODF.<sup>19</sup> It does so by creating a demand for sanitation and hygiene.<sup>20</sup> The “sense of ownership” that the community members experience is crucial for the success of CLTS. Making people aware of the collective benefit of stopping OD is believed to encourage more cooperative efforts,<sup>21</sup> highlighting one of the most important principles of community mobilisation: the bottom-up approach.

CLTS, by way of its trigger tools—shame, disgust and embarrassment—prompts the community to change. The facilitators are picked from the community and trained to become ‘Natural Leaders’ (NLs). These tools cause an upsurge of emotions that can trigger a strong desire to change the situation, propelling the community into collective action,<sup>22</sup> which is a demand-driven activity.

## Theoretical Underpinnings

Community-based approaches find their basis in theory and have evolved over time. Going by the “social norms” approach, various types

of norms such as descriptive, injunctive, and personal drive human behaviours. The theory is that community standards can be enforced more effectively using social sanctions.<sup>23</sup>

Indeed, it can be difficult for an individual to defy social norms since he/she can change only if the entire community is willing to change.<sup>24</sup> Analysing the sanitation situation from this perspective, people defecating in the open are perceived as contaminating not only themselves but also others, and they assume the undesirable status of ‘culprit’.<sup>25</sup> It is, therefore, logical to infer that these approaches work in an ‘all-or-none’ capacity, ensuring true community empowerment.

Social norms and/or social desirability and aspirations are widely acknowledged to influence sanitation practices.<sup>26</sup> These play a central role in the “Diffusion of Innovations” theory. Many processes in community-based sanitation programmes find their explanation in collective innovation-decision methods described by the theory, in which choices to adopt or reject an innovation are made through consensus among community members.<sup>27</sup> These collective innovation-decision methods have been effective by way of triggering populations in CLTS, CATS and CHCs.

The social-ecological theory also supports these methods. Interrelations among environmental conditions and human behaviour is a core principle of this theory, suggesting that the mutual exchange between environment and people is cyclic: the people influence behaviours and behaviours, in turn, influence the actions of other members. Thus, it is useful to combine person-focused and environment-based components within comprehensive sanitation-promotion programmes.<sup>28</sup>

## Effectiveness and Limitations

Although literature evaluating the effectiveness of these approaches is limited, there are a few rigorous studies that address the effectiveness of CLTS and related approaches. Additionally, there is substantial anecdotal evidence that talks about the effectiveness of participatory approaches in general.<sup>29</sup> Strong evidence also suggests that these approaches have worked well in many rural communities across the world. Since its inception, CLTS has been implemented in 50 countries, with at least 15 incorporating it into their national policy.<sup>30</sup>

Non-CLTS community-based approaches have also been effective in some countries. The Community Health Clubs (CHC) initiative has been instrumental in changing social norms. In this intervention, people were “more prone to accept the way in which CHCs operated using what was termed as a ‘positive’ approach to changing behaviour.”<sup>31</sup> Another study, which evaluates India’s Total Sanitation Campaign in Odisha, concludes that the Information-Education-Communication (IEC) campaign had a “substantial and statistically significant effect on latrine adoption and use,” and that IEC was responsible for two-thirds of the treatment effect.<sup>32</sup> Another intervention in rural Kenya used a theory-informed community-based participatory research (CBPR) method called Photovoice. This was extremely successful in creating social change in hygiene and sanitation behaviours through “participant-employed photography and dialogue.”<sup>33</sup>

Behaviour change must be supported by latrine construction for people to practice it. The cost involved, given the economic crises among the poor, often proves to be a hindrance in making communities ODF. It is thus necessary to consider social determinants of health while implementing community-based approaches. Although many community-based programmes address this issue by providing technical solutions, the implementation depends on various factors.<sup>34</sup>

The innovators of CLTS have cautioned against standardising the programme. While scaling up these models, it is important to be sensitive towards local communities and not let governments and/or funding agencies hijack the programmes.<sup>35</sup>

Although evaluation studies have been conducted, not all of them use robust methodologies.<sup>36</sup> There is also mention of limited follow-up periods.<sup>37</sup> Behaviour change at community level is a slow process, and studies with short follow-up periods cannot evaluate these interventions adequately.<sup>38</sup> While these approaches are being used widely, the upscale has been called into question in view of the absence of published randomised controlled trials of the programme<sup>39</sup> to offer gold-standard evidence.

## **CLTS IN THE INDIAN CONTEXT: CURRENT EVIDENCE**

CLTS was first introduced in India in 2002–03.<sup>40</sup> Since then it has been used intermittently but has never been incorporated in the national policy sphere. Maharashtra was proactive in using CLTS to overcome the problem of OD and its sustenance. Following the success of the first pilot in Maharashtra, CLTS was scaled up. Before introducing CLTS, there were 1.6 million latrines constructed with government subsidies, and yet, no village was ODF. Within three years of the intervention, Maharashtra had reached more than 3,800 ODF villages.<sup>41</sup> In addition to Maharashtra, CLTS was introduced and adopted most successfully in two states, Haryana and Himachal Pradesh, where it became a state-level policy. In Panipat, Haryana, an intensive campaign with dedicated staff and support driven by the district administration achieved widespread triggering in rural communities and reported high levels of success.<sup>42</sup> With the introduction of the SBM in 2014, community efforts strengthened and CLTS saw mixed success in various parts of India.

A 2016 study conducted by this author found that concentrated CLTS campaigning in Indore district (rural) is one of the best examples of its success in recent times. An organisation that conducts training in CLTS, “Feedback Foundation” (Delhi) partnered with the Zilla Panchayat of Indore, under an SBM initiative started by the then CEO of the Zilla Panchayat. The efforts motivated rural communities to challenge social norms and make the villages ODF. The gram panchayat’s success in attaining ODF status was lauded by awards and accolades, which motivated other gram panchayats in neighbouring districts to proactively work towards it. The NLS, being locals, understood the culture and context of the communities, which allowed them to work innovatively within the CLTS framework. These efforts resulted in community-level behaviour change, massive demand for construction of latrines, their regular use, and community monitoring to ensure sustainability. Consequently, all 610 villages of the Indore district were declared ODF. While there is no empirical data to corroborate this after over two years of the local government’s claim, the study noted that people’s perception about the intervention was overwhelmingly positive, and they now monitored daily activities to ensure sustenance. Follow-up and monitoring activities are crucial to sustaining ODF statuses according to the guiding principles of CLTS,<sup>43</sup> and the anecdotal evidence from Indore proves this.

While CLTS worked for Indore, it has failed in many villages and towns. Whether the model is scalable across the country is, thus, debatable. The use of shaming tactics in CLTS has been a target of much criticism, and justifiably so, after its failure in other geographies (and cultures), such as Gujarat. For instance, during one of the studies undertaken by this author in coastal Gujarat, anecdotal evidence pointed to violence by community members following the negative motivation tactics to curb OD. When NLS tried to convince villagers to build and use latrines by shaming them for their behaviours, the

villagers lashed at NLs and the concerned organisation had to retract their efforts. Similar unceremonious terminations of the campaign due to strong and, at times, violent opposition from the target population were also reported in several other villages. Such examples of the failure of CLTS cite multiple reasons involving a complex web of social determinants.

### **CLTS: Strengths and Weaknesses**

One of the strengths of community-based approaches is their strong focus on motivating and mobilising communities. This is mainly achieved through the involvement and facilitation provided by the NLs. Locally appropriate tools and methods are more easily accepted and, thus, effective.<sup>44</sup> NLs are encouraged not to prescribe but to facilitate communities to come up with their own solutions to their sanitation problems.<sup>45</sup> Involvement of women and children in CLTS has also been instrumental in the success of the campaign,<sup>46</sup> ensuring total community participation and increasing the chances of sustainability.

Despite the strengths of community-based approaches, there has been some criticism, too. Literature notes that, often, behaviour change for something as fundamental as health can only be achieved through structural forces and coercion.<sup>47</sup> It challenges the fundamental principle of 'community-based interventions' being driven by the locals. However, removing all structural forces in interventions will undermine the government's role in the endeavour. The Indore example cited above supports this, as the intervention was initiated by an executive diktat and executed by community members. The Commission on Social Determinants of Health (CSDH) has called for public financing of action across social determinants as part of one of the principles for action.<sup>48</sup> Public financing of latrines (government subsidies for latrine construction, in this context) being a structural intervention itself, the

community-based approaches versus the use of structural forces argument becomes another debate. Poverty is one of the most important social determinants in India, and thus, structural interventions and/or interference cannot be completely ruled out.

Shaming and punitive tactics involved in many community-based approaches are not only inadequate but also coercive and race-based, akin to colonial public-health practices.<sup>49</sup> Moreover, CLTS being a radical form of behaviour change could contribute to new forms of social control which, in turn, can marginalise certain groups.<sup>50</sup> Shaming as a tool for behavioural change has been criticised as unethical and, in certain cases, has been found to violate human rights.<sup>51</sup> While CLTS was effective in Indore, the campaign itself must be scrutinised: it was executed by community members but initiated by a government body, and an element of coercion was indeed used by government officials and politicians. Collecting monetary fines, photographing people defecating in the open and getting children to shame defecators loudly using whistles and kicking their water containers may be defined as violations of their human rights. These tactics cannot guarantee the sustainability of the results. However, Indore does continue to top the clean-city rankings.

Another popular debate revolves around the sensitivity of the facilitators. Although NLs are mostly locals, they come with their own social and political baggage, often disregarding the physical, social, historical and economic conditions of the people.<sup>52</sup>

The Behaviour Centred Design (BCD)—a non-CLTS approach—has emerged as a new effective paradigm for behaviour change that uses psychosocial theory. A behaviour change communication campaign based on BCD principles overcomes the limitations of CLTS, since it does not use shaming tactics and thus avoids potential failures. The



‘SuperAmma’ project in Southern India used BCD and successfully changed the unhygienic behaviours of the target population.<sup>53</sup> Recently, its use in Gujarat has shown positive impact on defecation behaviours of the population.<sup>54</sup>

## **SBM-Gramin**

The SBM-G guidelines highlight the importance of creating demand and motivating communities for sustainable social and behavioural changes. According to these guidelines, “BCC [Behaviour Change Communication] is not a ‘stand-alone’ separate activity to be done as a ‘component’ of SBM-G, but about mobilising and nudging communities into adopting safe and sustainable sanitation practices through effective BCC.” The guidelines also suggest adopting community approaches to sanitation by focusing heavily on triggering entire communities and achieving collective behavioural changes. This reinforces the significance of awareness creation to incentivise community behaviour change and generate demand for sanitary facilities.<sup>55</sup>

The centre-approved budget for IEC activities (a key component of the BCC) is eight percent of the total budget for the SBM-G, out of which three percent is to be used at the central level for a pan-India campaign.<sup>56</sup> *Prima facie*, these numbers seem insufficient, since behaviour change has been the key differentiator of the SBM. Moreover, the actual utilisation of these funds is even less and has declined from four percent in 2014–15 to just two percent in 2017–18.<sup>57</sup> Despite the SBM’s failure to spend its earmarked budget, there has been significant private investments made into the sector through another component of the SBM: the Swachh Bharat Kosh (SBK). The SBK was started to encourage individuals and corporate companies to spend money on sanitation initiatives to help the SBM. Over INR 670 crores have been collected by the SBK.<sup>58</sup> Organisations such as Tata Trusts have sponsored



consultants, NLS and trainers to facilitate the work by local governments. Development-sector giants, such as the Bill and Melinda Gates Foundation, World Bank, UNICEF and Aga Khan Foundation, by way of collaborating with the government, have been instrumental in providing technical support to the cause of making India ODF. By investing in large-scale media campaigns to create awareness, Reckitt Benckiser Group plc continues to make huge contributions through its “Swachh Banega India” campaign. It attempts to fill, to some extent, the gap created by lack of expenditure by the SBM on IEC. Over 95 percent of the total expenditure of the SBM has been on individual household latrines,<sup>59</sup> a subsidy-centric approach. As earlier evidence suggests, this becomes a major contributor towards the failure of community-centric approaches to solve India’s sanitation riddle.

General observation shows that a lot of the communication material that is disseminated focuses on promoting SBM and financial subsidies, instead of creating awareness to change sanitation behaviours. Promoting financial subsidies (incentives, as referred to in various government documents) has proven a barrier to the uptake of latrines, not a facilitator. While the community demand for sanitation infrastructure has increased from before, people still tend to rely solely on the government to construct latrines for them. Government officials see the promotion of subsidy as ‘incentive’, but the onus being on the government hinders community mobilisation, acting as a deterrent for the community to realise its own potential. This was the biggest challenge to a community-based intervention in Haryana. The rural population in Haryana was used to receiving big subsidies from governments for water, electricity and other developmental work. Over the years, this environment created a psyche of complete dependence that undermined community solidarity as there were few issues on which people would agree.<sup>60</sup> A similar observation has been made in a qualitative study on the coastal villages of Gujarat.<sup>61</sup>

While there is evidence against financial subsidies, it is also important to acknowledge that historically, poverty has been one of the major barriers to behavioural change through community-based approaches and, subsequently, to the uptake of sanitation infrastructure and its use. Difficulty in buying soaps and the inability to construct latrines due to poor economic status hindered behaviour change, despite the desire to do so.<sup>62</sup> Some families in India had to abandon latrine construction due to unaffordability.<sup>63</sup> Although financial assistance contradicts the guiding principles of CLTS, some Asian interventions that incorporated this component observed that financial incentives and latrine-building helped habit formations.<sup>64</sup> According to the suggestions of CSDH regarding public financing of action, this approach seems justified. It is also vital to take into consideration the varying degree of economic disadvantage in the country. The SBM-G, in its guidelines, states that an incentive amount of up to INR 12,000 is to be provided to Below Poverty Line/identified Above Poverty Line households to construct one unit of individual household latrine and to ensure water availability, including for storage, hand-washing and cleaning of the toilet. However, it is difficult to identify such households given old policies, flawed data, and corruption.

An interesting angle in the subsidy debate is that while it is important to think of equity-focused actions in economic terms, disadvantages are not necessarily limited to monetary reasons and extend to knowledge, awareness and access to information, social and environmental barriers etc. Considering the diverse causality of OD in India, proportionate distribution of efforts becomes key to equitable actions. Therefore, it is vital to have balanced approaches that take into consideration these seemingly contradictory factors while formulating policies.

## Centralised Policies

India's first nationwide village-level sanitation programme—Central Rural Sanitation Programme—was launched in 1986. Multiple approaches and methodologies have been tried to reduce OD in the country since then. Emphasis on community-based approaches started in the early 2000s, when small-scale community interventions showed promising results.

On a national scale, hands-on training for CLTS was initiated for two sets of government officials from each of India's 611 districts. This, in turn, created a demand for further training in some districts in 2008.<sup>65</sup> The effects, however, if any, have not been documented. Moreover, despite such training, CLTS never became a mainstream government policy; the India Country Paper<sup>66</sup> to the third South Asia Conference on Sanitation (SACOSAN III) in 2008 did not mention CLTS.

The SBM-G guidelines clearly spell out the role of community-led approaches in government policies. While the 2014 SBM-G guidelines give no strict directives on what must be done, it suggests triggering communities, involving community-based organisations and self-help groups, and encouraging community-led monitoring and community incentives.<sup>67</sup> On the other hand, the new 2017 SBM-G guidelines strongly recommends the Community Approaches to Sanitation (CAS).<sup>68</sup> The guidelines also instruct states to take on the responsibility of deciding and implementing interventions based on the SBM-G recommendations as applicable,<sup>69</sup> allowing states the autonomy to spend money and implement locally relevant actions.

A decentralised approach to governance in sanitation has been successful, as evidence suggests. For example, the Madinapur model in West Bengal inspired the demand-driven, community-led approach of

the Total Sanitation Campaign (TSC).<sup>70</sup> Additionally, the WaterAid's study of TSC in five states concluded that in states and districts where Panchayati Raj institutions are involved in TSC, the results are quicker and more sustainable.<sup>71</sup> However, the decentralisation of governance so far seems selective and not uniform. In some states, e.g. Bihar, the sanitation initiatives have been primarily state led and supply driven, with poor results. In other states such as Haryana and Tripura, active community participation, encouraged by local governments, has yielded positive outcomes.<sup>72</sup> Additionally, some geographical areas demand more investments for constructing latrines, such as the coastal villages in Gujarat. In such cases, states must use their autonomy to implement locally effective interventions that cater to specific needs.


A decentralised approach is more feasible and effective, considering the diversity in communities across the country. However, strict adherence to guidelines framed under a policy framework that covers the whole country—without considering other determinants that influence interventions—has led to inconsistency in the success of policy implementation and its impact. There is evidence that decentralised governance of sanitation investment can create stronger incentives for, and accountability in, pro-poor investment.<sup>73</sup>

In a country as diverse as India, where sanitation practices are largely driven by social norms, a one-size-fits-all approach is unlikely to yield significant results, as evident from past efforts. States, districts and Panchayati Raj institutions must now take up the challenge and transform the situation locally to produce results at a national level.

## CONCLUSION

There is hardly any argument that open defecation is largely a behavioural issue, exacerbated by structural challenges. Tackling this

issue at an individual level has proven difficult and time-consuming. Community-based innovative approaches have been effective in many rural regions across the world. However, such programmes must be tailored to different communities. Standardising these programmes will make processes top-down, negating the core principle of community mobilisation through people-centric and people-driven interventions. No programme fits all, and theories keep changing. Therefore, more research is needed to help develop these approaches and, in turn, reduce the practice of OD.

Additionally, alternative approaches must be adopted by states, who can make decisions at the local level. The subsidy component—a primary focus since the inception of national-sanitation policies—must also be revisited. However, it is unwise to completely do away with subsidies or incentives, considering the importance of universal actions in tackling OD and the discrepancy in the levels of social advantage across the country. Therefore, to reduce the steepness of the social gradient in health, the scale and intensity of measures must be commensurate to the level of disadvantage in a certain region or community. This is called “proportionate universalism”, an approach that can be helpful in revising policies and interventions.<sup>74</sup> Such equity-focused measures also call for the decentralisation of policymaking processes, which can be tailored for better results through locally appropriate, culturally sensitive and community-monitored interventions. 

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20, Rouse Avenue Institutional Area, New Delhi - 110 002, INDIA

Ph. : +91-11-35332000 Fax : +91-11-35332005

E-mail: [contactus@orfonline.org](mailto:contactus@orfonline.org)

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