International Development Select Committee Inquiry into British Aid to India

Written Evidence Submitted by Robert Chambers

Executive Summary

1. This note flags potentials and raises questions concerning rural sanitation and hygiene and nutrition, and then more generally concerning future roles and priorities for DFID in India. Although I have been concerned with rural poverty in India over the years, I make no pretence to the detailed broader and recent experience of others who have given evidence.

2. Rural India has over half the people in the world who defecate in the open. Lack of sanitation and hygienic behaviour is a massive source of deprivation and cause of poverty, with high human and economic costs. The current large-scale efforts of the GOI have been disappointing. This sector therefore presents vast potential. Community-Led Total Sanitation (CLTS) is a promising way forward. It is an example of the sort of innovation where DFID could make a contribution to reducing deprivation and poverty out of all proportion to the costs involved.

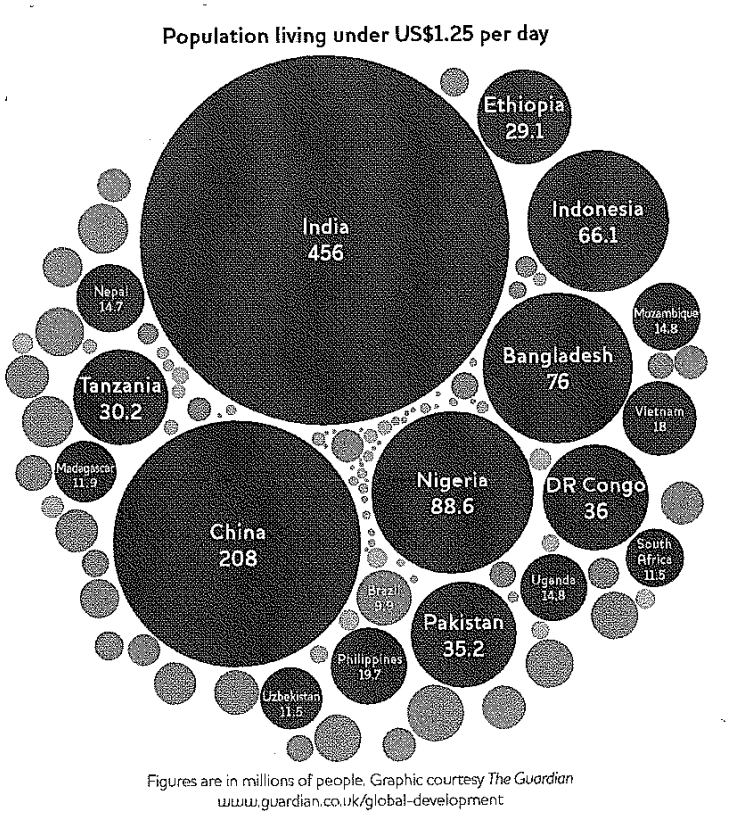
3. More than finance, it is relationships, committed professional specialists, and introducing and supporting innovations and innovative programmes, that may be key for continuing and future acceptability and additionality of DFID's partnerships in India. High return activities are staff-intensive. Restricted staff numbers may be the biggest constraint on anti-poverty cost-effectiveness. More programme and technical staff are implied, with continuity in post and a higher staff to funding ratio.

Context

4. Some of the context is well known. India has far more poor people than any other country, some 450 million living on less than $1.25 a day (see figure 1). Bihar alone has some 4 per cent of the world's poor. In the most recent (2005-6) survey, 46 per cent of Indian children were undernourished, a third of those in the whole world, a figure which has been obstinately stable for decades. As is very well known and recognised, the Indian Government is very serious

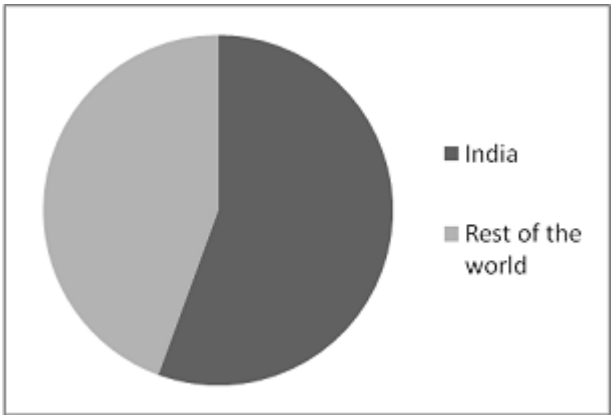
about the reduction of poverty and has pioneered direct anti-poverty programmes and implemented them on a vast scale, most remarkably in recent years through the National Rural Employment Guarantee Act, and with school feeding and food subsidy programmes. At the same time, with rapid economic development, inequalities of wealth and income have become ever more marked and much poverty remains stubbornly resistant. India still has a third of the poor people in the world.

Figure 1. Population living under US$1.25 per day[1]



[1] Reproduced from Andy Sumner *The New Bottom Billion* In Focus, IDS Sussex 2010

Figure 2. Open defecation. India and the Rest of the World[2]



5. Less well known, India has 58 per cent of the 1.1. billion people in the world who practise open defecation. The latest estimate is 638 million in 2008, more than twice as many as in the whole of Sub Saharan Africa. Of the India total, 578 million were rural, making rural India alone over half the global total. Moreover, a further 70 million rural people had sanitation classified as unimproved, meaning that it did not meet very basic standards and so was a threat to health[3].

6. To make things worse, access to improved sanitation in rural India is sharply skewed. In the poorest three quintiles only 2, 7 and 14 per cent respectively have improved sanitation, while the two upper quintiles have 30 and 78 per cent respectively. Open defecation is practised by 97, 89, 81, 66 and 21 per cent[4] of these quintiles. Gains over recent years have been strongly skewed to the upper quintiles, with little improvement among the poorer. An exception is the rural areas of Himachal Pradesh which has had a successful programme of Community-Led Total Sanitation (CLTS).

[2] Source: WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation, 2010 update page 22. All figures in this paragraph are from that source, based on 2008 data

[3] I have used the past tense because the data are two years old. Between 2008 and early 2011 there will have been some changes in totals, but the proportions are unlikely to have changed significantly.

[4] The numbers do not sum because there is a smaller category of sanitation which is unimproved

7. The main large scale efforts of the Government of India have had disappointing results. Since 1999 the Total Sanitation Campaign (TSC) has sought to provide hardware subsidies to BPL (Below the Poverty Line) families so that they can have toilets[5]. It has also sought to educate people about the importance of safe confinement of faeces and hygienic behaviour, especially handwashing, through a programme of IEC (Information, Education, Communication). Large budgets have been passed by the Federal Government to the States for these purposes. In recent years a special effort has been made through the NGP (Nirmal Gram Puruskar) programme which has rewarded communities that successful claim to have achieved ODF (open defecation free) conditions and to have cleaned up in other ways. Progress has been disappointing, and there have been many false claims[6]. Exaggerated reports of achievement have given a misleading impression. As the quintile figures above show, the intention of helping the poorest people has quite starkly not worked. Even when toilets are constructed, they are notoriously often not used or used for other purposes. Indeed programmes of individual household hardware subsidy (IHHS) like the TSC have not to my knowledge worked anywhere in the world.

8. The costs of OD and lack of hygienic behaviour are high. A recent World Bank Report has come up with the astonishing estimate that in 2006 inadequate sanitation and unhygienic behaviour cost India US$53.8 billion, equivalent to 6.4 per cent of GDP[7]. Of this total, $18 billion was associated with diarrhoea among children. India compared unfavourably with other countries: per capita losses in India were $48 compared with $28.6 in Indonesia and US$9.3 in Vietnam.

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[5] The terms latrine and toilet are often used interchangeably. I am using toilet because it is more inclusive. Many people start with a simple pit latrine with a cover over the hole. UNICEF and WHO classify this as improved sanitation.

[6] A UNICEF survey found only 4 per cent of NGP communities were open defecation free.

[7] *The Economic Impacts of Inadequate Sanitation in India*
http://www.wsp.org/wsp/featuresevents/features/inadequate-sanitation-costs-india-equivalent-64-cent-gdp

9. The more obvious human costs are appalling. Most spectacularly, child deaths from diarrhoea in India are estimated at 362,000 per annum[8]. This often quoted figure is bad enough but there is much else. It does not take account of the effects of the very much larger number of cases of diarrhoea which are now sublethal because of oral rehydration treatment. Nor does it take account of many other faecally related infections. It also does not include the extreme discrimination and deprivations experienced by women without toilets who are compelled by custom and shame to defecate only in the hours of darkness, bearing at those time also risk of assault, snakes, accidents and trampling on fresh faeces, and being forced to abstain at other times. There are deep issues here of shame, humiliation and lack of dignity as well as many of women's and girls' physical illbeing and ill-health.

10. Less obvious and gravely underestimated costs are links between OD and child illbeing and undernutrition. Prime Minister Manmohan Singh has said that the high level of undernutrition in children is 'a curse we must remove'. To overcome this, food supply and access programmes are important. However, the link between between sanitation and hygiene on the one hand, and nutrition on the other, is neglected. We have to ask how much of this undernutrition, this curse, results from insanitary and unhygienic conditions and practices.

11. The five As of nutrition and physical wellbeing are relevant. The first two concern food and are visible, obvious and commonsense: **A**vailability – good food must be there; and **A**ccess – people, especially poor people and children, must be able to obtain it. These two As have been the main focus of interventions in India through school feeding programmes, fair price shops, and other measures. But three other As are less visible and less obvious. These are associated with faecally-related infections: **A**bsorption – food which is ingested is not absorbed because of infections in the gut, damage to the wall of the small intestine, theft by worms and other parasites, and diarrhoeas and their effects; **A**ntibodies – nutritional energy is consumed by the manufacture of antibodies to fight infections in the blood stream and the gut; and **A**llopathogens – other faecally-related pathogens such as hepatitis,

[8] www.WASHwatch.org

schistosomiasis, typhoid, hookworm, liverfluke, trachoma, polio and some epilepsy. Hookworm alone is estimated to infect 200 million people in India, and 60-80 per cent of the population in some areas of Bihar, Orissa and West Bengal.

12. The impact of faecally-related infections appears to have been underestimated[9]. Let me explain why I think this is so. The diarrhoeas are dramatic, episodic, measurable and treatable. So they receive the bulk of the attention. Many of the other infections are continuously debilitating but do not show up in the same way. Tropical enteropathy, a condition where there are long-lasting infections in the blood stream, is subclinical without marked symptoms. However, it is quite possible that it alone has a bigger adverse nutritional impact than diarrhoeas[10]. And this is without taking account of worms or allopathogens, which also debilitate, weaken and steal food but often without dramatic symptoms. The questions then are: how much food is lost through malabsorption, through feeding worms and other parasites, and through producing antibodies to fight faecally-related infections, and through allopathogens? How much does child undernutrition in India result from combinations of faecally-related infections? If all the infections could be caught during their life cycles just below the anus and safely confined, might the impact be dramatic, and would child undernutrition be sharply reduced and even largely eliminated?

Towards Total Rural Sanitation and Hygiene

13. The Total Sanitation Programme (TSC) relies on individual household subsidy, and the Nirmal Gram Puruskar relies on rewards. Such subsidy programmes have struggled and failed in all the countries and contexts of which I am aware. The subsidies go to the wrong people. There is corruption (as so often when hardware is involved). The toilets are built but not used or used for other purposes (storing fuel or equipment, or a shrine …) or

[9] I need to warn the Committee that I am not an expert in this area, but have been drawn into it through work on sanitation. To date, no one has seriously questioned these arguments and I am becoming less diffident in putting them forward.

[10] Jean Humphrey 'Child undernutrition, tropical enteropathy, toilets and handwashing' *The Lancet* 19 September 2009

dismantled and the materials used elsewhere. Open defecation continues. The response has been brickwallitis (if you bang your head against a brick wall and it does not fall down, bang harder). The subsidies have not been abandoned but raised, most recently from Rs 2,200 to Rs 4,000. Nor to my knowledge have reward programmes a record of much success. They can lead, as they have done in India, to false claims and exaggerated achievements. The NGP has been now been tightened up, but can only apply to a small minority of communities[11]. To tackle rural sanitation and hygiene cries out for a different approach and a breakthrough at scale.

14. Here Community-Led Total Sanitation (CLTS) offers a solution. Where it has champions, it has had remarkable success locally, even in spite of the subsidy policies. It relies on no subsidy but instead on facilitating communities to appraise and analyse their shitting [sic] habits (the crude word is always used[12]) and to recognise for themselves that they are 'eating one anothers'shit'. Done well in favourable conditions, this provokes immediate action to dig holes, build toilets and collectively move towards becoming ODF which is in the collective interest of rich and poor alike. This has been most successful so far in Himachal Pradesh, thanks to outstanding leadership and commitment of senior officers and the Chief Minister. In that state, through a sustained Government campaign with CLTS, those not practising open defecation have risen in only five years from 2 million to 5.4 million out of a rural population of 6 million. One key element has been that in the common interest other community members have helped those who are poorest, weakest or least able to dig and construct toilets for themselves.

15. CLTS faces obstacles. The deeply entrenched subsidy programme inhibits the self-help on which CLTS depends: people wait for what they may get free. Vested interests in subsidised hardware oppose change. Professionals prefer pucca designs. NGOs argue that the poorest cannot afford sanitation and need help from outside: however, a survey of 7 districts found over twice as many households with televisions as with toilets and the same proportion with

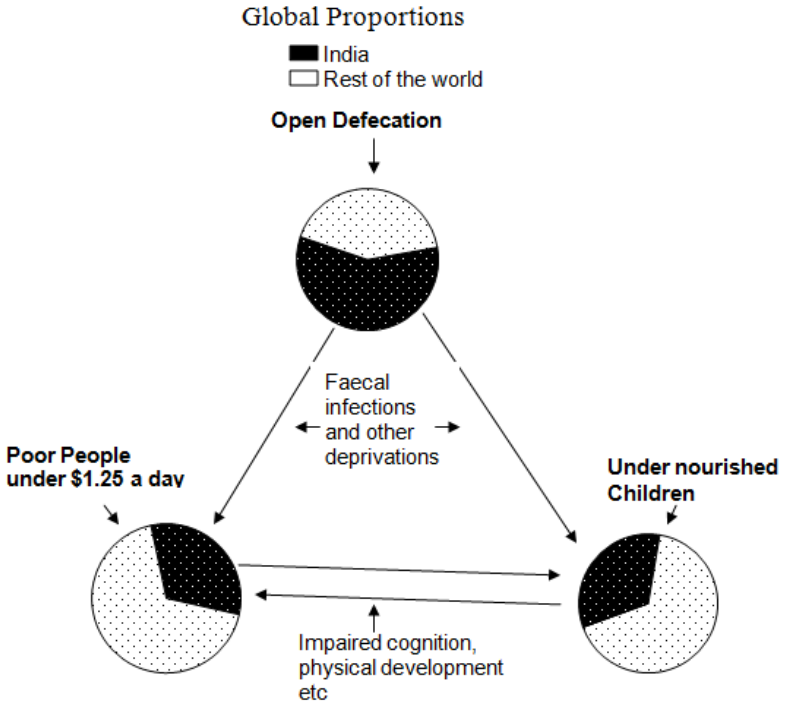
[11] It remains to be seen what difference will be made by the tightening of verification in the NGP

[12] For an international glossary with over 100 words for shit and other information about CLTS visit www.communityledtotalsanitation.org That website has much information on CLTS.

mobile phones, indicating that for many households sanitation has been a low priority rather than unaffordable. Another constraint is that not everyone can be a good CLTS trainer or facilitator. And pervasively, mindsets, habits and budgets all have their own momentum and inertia hindering change.

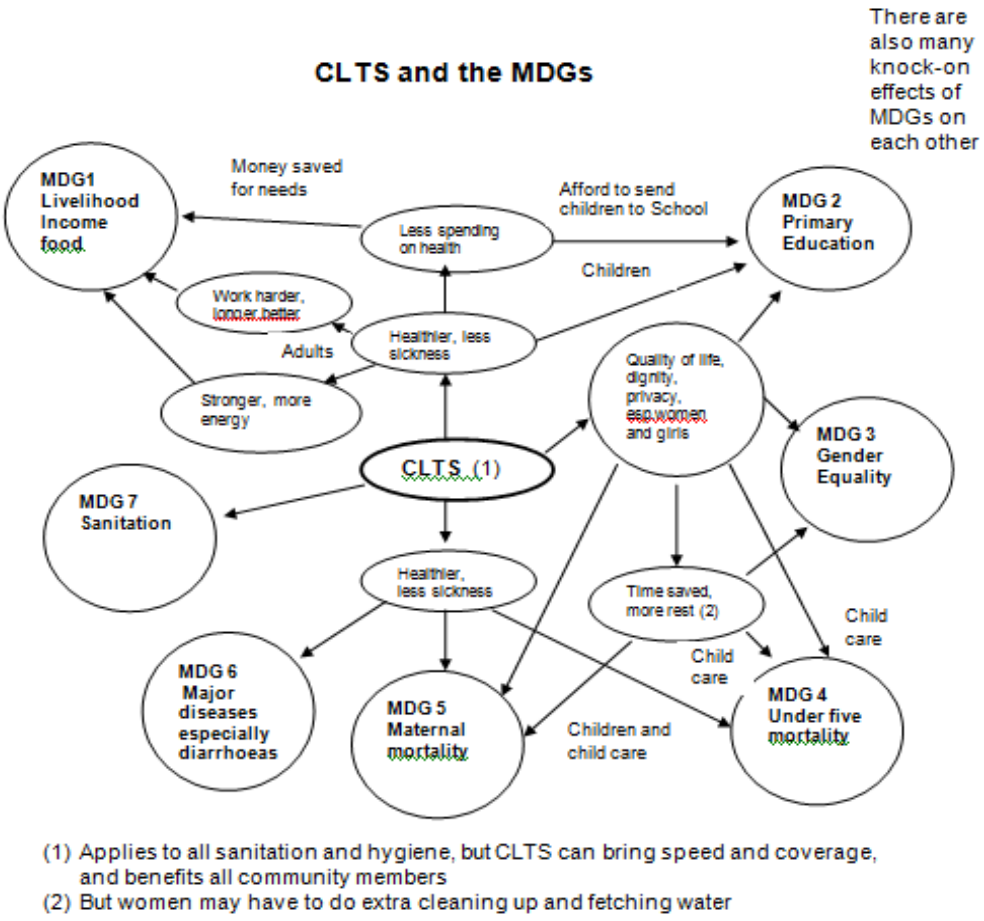
16. The scale of the current syndrome of open defecation, poverty and undernutrition in India is indicated in Figure 3 with the coexistence of 58 per cent of the open defecation, a third of the poor people, and a third of the undernourished children, in the world. I would argue that the links between open defecation and poverty and child undernutrition are likely to be more significant that has been generally recognised.

Figure 3.



17. This is even more marked when the links between sanitation and hygiene (part of MDG 7) and the other MDGs are recognised, as summarised in figure 4. CLTS is in the centre where it is also a proxy for improvements to water, sanitation and hygiene whatever their provenance. The diagram traces the multifarious links from effective CLTS as driver to the first seven MDGs.

Figure 4 CLTS and the MDGs



(1) Applies to all sanitation and hygiene, but CLTS can bring speed and coverage, and benefits all community members
(2) But women may have to do extra cleaning up and fetching water

18. The huge potential of CLTS is now evident. The challenge and opportunity are to enable it to spread and spread well, especially in the States where there are the largest numbers of poor people in rural areas. If the TSC could be progressively transformed, and good CLTS practices introduced, open defecation in rural India might be largely eliminated in a decade. But if the TSC continues in its present form, this seems unlikely. Without CLTS, an outcome could be foreseen of stark and tragic contrasts between India as a prospering Middle Income Country, and many, perhaps most, Low Income Countries. For in many LICs, CLTS has already taken root and is spreading[13].

[13] It is a sad irony that in many of these CLTS has been introduced by its Indian originator, Kamal Kar

19. Taking DFID's focus states, there are small bridgeheads of CLTS in Madhya Pradesh and Orissa, nothing yet in Bihar[14], and apart from the exceptional slum of Kalyani on the outskirts of Kolkata (where DFID was involved), nothing to my knowledge in West Bengal.

Opportunities, additionality, staff and relationships

20. I have elaborated on CLTS for two reasons. First, substantially, it could be transformative in many dimensions through many linkages to the MDGs and to child and other nutrition. And second because it is an example where DFID could explore small or medium scale initiatives with high additionality and cost-effectiveness. Low key interventions by DFID could be welcomed locally in States and at national level, to further introduce, test and spread CLTS, with well directed interventions to support and strengthen key organisations and programmes. DFID staff and resources judiciously and professionally linked might have exceptionally high additionality through supporting action and learning on CLTS and research on faecal-infection links with undernutrition.

21. As other evidence to the Committee has stressed, DFID has a good track record of introducing and supporting innovation. I would argue that this should be built on and intensified in fields of competence and concentration - health, governance, education, civil society, social movements and other domains. More focus on sanitation and hygiene could be part of this. The current DFID budget share for water and sanitation is about 1 per cent. With CLTS as in other fields quite small fine-pointed sums can have big impacts and large sums can sometimes paradoxically do harm. Where promising innovations can be found, either in India or elsewhere, DFID can facilitate their piloting in partnership with the Indian Government, civil society, movements and the private sector. They may require a higher proportion of small actions. There are implications too for sponsoring research.

22. These activities are not new but are open to being extended and deepened. They require high levels of professionalism, originality, being alert for

[14] However, in late January, Kamal Kar, the Indian pioneer of CLTS, conducted a one-day workshop in Patna with the District heads of development from all the districts. I understand that DFID was associated with this workshop.

innovations and proactive, and strong and positive relationships and trust. They are staff-intensive. They require more professional staff.

23. DFID generally has been criticised for what can be termed the 'capital trap', the way in which staff are trapped by emails, meetings, visitors, negotiations and harmonisation with other donors so that they spend little time outside the capital city. Badly managed, more professional staff could make this worse. Well managed, it should liberate all staff so that they can spend more time in the States, in the field, and with poor people.

24. In this scenario, even more than now, DFID staff would be professionally in touch and up-to-date, able to identify and pursue good initiatives. They would have time to make adequate and unrushed field visits. To achieve high additionality funding needs to be sensitive, flexible and exploratory and experimental. Rather like the Ford Foundation, relationships between DFID staff and Indian partners and colleagues would shift in balance more to professional substance compared with the transfer of funds.

25. Three potential innovations can illustrate the sort of thing DFID staff might introduce and pilot:

    a. Reality Checks. These have been evolved by a British consultant and ex- DFID Social Development Adviser in Bangladesh for Sida. A team of 15 go annually at the same (for poor people most difficult) time of year to 15 representative locations and stay for five days with a poor family. They wander around and talk and observe what is happening in the two sectors of Sida concern – primary health care and primary education. Their findings are then consolidated and reported. The insights into rapidly changing conditions are an invaluable contribution to policy. Reality checks introduced in Indian States could have major impacts in updating and influencing policy and practice.

    b. Immersions with their counterpart colleagues. DFID staff could not only emulate the immersions of the Secretary of State and the Permanent Secretary but make a regular practice of immersions for longer periods like three days and nights, together with their Indian

colleagues. This could form relationships and shared understandings grounded in field realities.

c. Methodological innovation as with participatory statistics. Many DFID staff have already had brief exposures to these. Statistics are generated by people themselves, empowering them, giving them voice, and informing policy and practice. The Statistical Services Centre at Reading University are pioneers in this emerging field, usually a win-win which empowers local people while generating insightful and accurate statistics.

These are illustrations to make the point that there is much that proactive professionals in DFID can do through quite small actions if they have the time.

26. All this points to a need for increasing the numbers and continuity in post of committed professional staff and giving them space. I agree with the Secretary of State's repeated observation before the election that increasing the DFID budget while reducing the staff was ridiculous. But much more than that, with the staff-intensive and professional strategy that I have argued makes sense in India, a higher staff to budget ratio should be more cost-effective in achieving the poverty reduction objectives shared by DFID and the Indian Government and in giving better value to the British taxpayer. For this, DFID's already good relationships at the personal and professional level are a precious asset. Money matters, but for good influence on policy and practice, those relationships are more significant than money.

30 January 2011