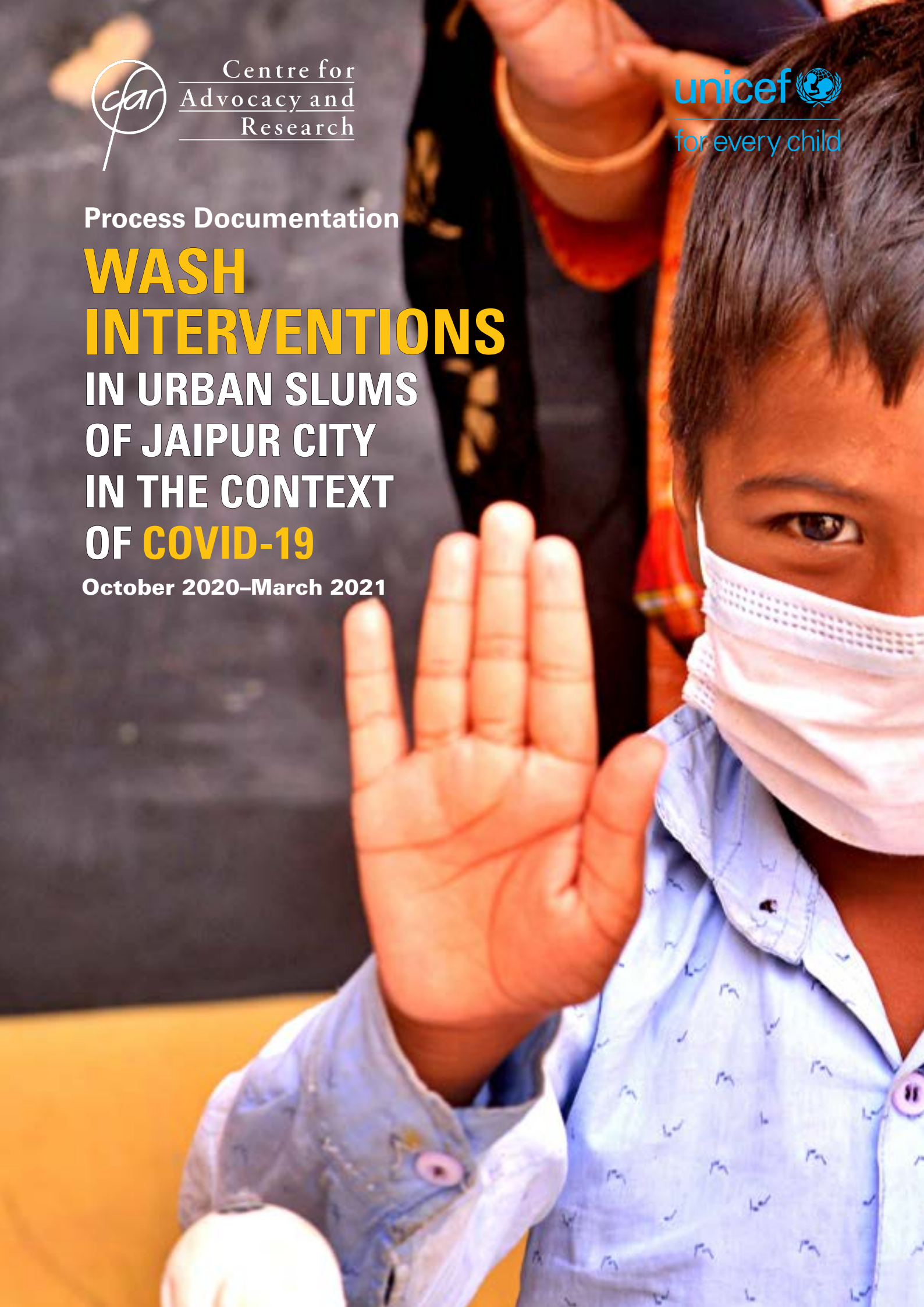


Centre for Advocacy and Research

unicef
for every child

Process Documentation

WASH INTERVENTIONS IN URBAN SLUMS OF JAIPUR CITY IN THE CONTEXT OF COVID-19

October 2020–March 2021

This document has been made possible through the support of the field teams of UNICEF Rajasthan WASH programme and CFAR.

Documentation support: Saheli Khastagir
Design Support: Titash Sen
Published July 2021

Note:
Both UNICEF and CFAR ensures that COVID Appropriate Behaviour (CAB) is followed amongst its team members and promotes it in the communities where they work.

CONTENTS

1

ABOUT THE DOCUMENT

IN 2020, the United Nations Children's Fund (UNICEF) initiated Water, Sanitation and Hygiene (WASH) interventions in the urban slums of Jaipur city in partnership with the Centre for Advocacy and Research (CFAR). This was done in the context of the 2019 coronavirus (COVID-19) pandemic with a threefold objective (see text-box). This document is a culmination of this partnership, capturing the processes followed and learnings under the intervention.

COVID-19 has upended the lives and livelihoods of people across the world. It halted education and careers, and disrupted access to basic services.

Objectives of the Partnership:

- Understand WASH in urban slums in the context of COVID-19, focusing on WASH in institutions
- Strengthen child-friendly and gender inclusive WASH facilities and services in public health/service institutions
- Develop a process document to compile lessons from the intervention

Most importantly, it highlighted the interlinkages between health and hygiene and the vulnerability of the poor and the marginalized. As India battles with the second, and deadlier, wave of the pandemic, the virus has once again reinforced the need to use an equity focused lens to improve

hygiene and sanitation facilities, access to healthcare and vaccination.
In response to the pandemic, the United Nations Foundation (UNF), at the request of World Health Organisation (WHO), established the COVID-19 Solidarity Response Fund in March 2020.

The UNICEF-CFAR partnership was launched as part of the response strategy supported by this fund.
It was **implemented between October 2020 and March 2021, covering 17 settlements and 35 wards in Jaipur.**

The partnership was initiated after a series of external and internal consultations (see Figure 1). This helped in identifying CFAR as a potential partner for entering into urban WASH programming in Rajasthan.

It became evident that to most effectively, equitably and sustainably reach the urban poor communities (particularly children and caregivers of children), it is important to strengthen public health infrastructure and services.

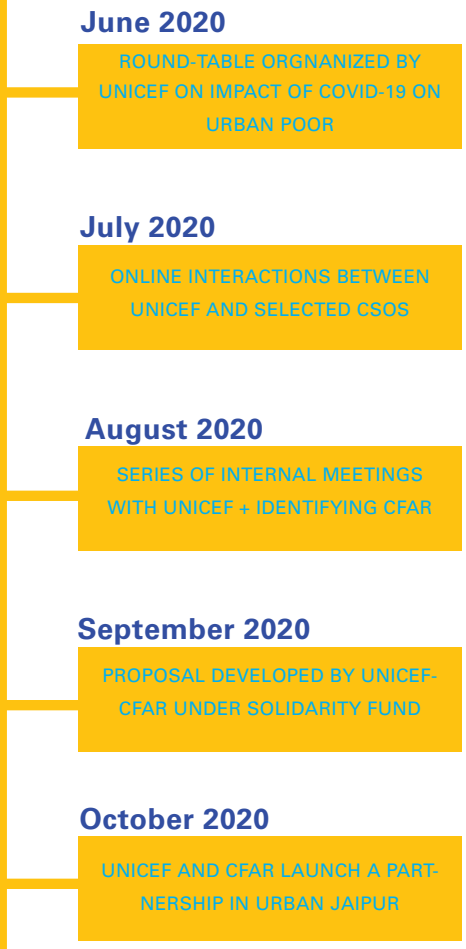


Figure 1: Timeline of activities leading to the partnership

The UNICEF-CFAR partnership, thus, designed and piloted an "Institutions-to-Community"approach under the Solidarity Fund, focussing on institutions that cater to children and women.

The two organisations joined forces to identify the most pressing needs withrespect to WASH programming within urban Rajasthan, and to design and document innovative ways to address them.

This helped in addressing the evidence gap with respect to WASH in urban slums, and model cost-effective and sustainable ways of meeting WASH needs of slum dwellers.

This report describes the partnership process, findings and way forward. It begins with an overview of the operational context of WASH in Jaipur (urban). It then describes the approach, timeline and journey of the partnership and the key learnings in the process.

The document then discusses WASH in each of the targeted facilities separately- health centres, schools, Anganwadi centres (AWCs) and Community Sanitary Compwlexes (CSCs). For each facility, it describes the findings from the gap assessment conducted and the systems strengthening inputs provided to each.

The report was prepared after carefully reviewing all documentation prepared under the partnership, and consulting with team members including the field level mobilizers.

It concludes with a broad blue-print for the way forward with respect to WASH in urban Jaipur. This will help pave the way for UNICEF, CFAR, government departments, other multilateral agencies, civil society organisations (CSOs) and donors seeking to address WASH in urban poor settlements of Jaipur.

2

WASH IN URBAN CONTEXT: JAIPUR, RAJASTHAN

JAIPUR city is one of the fastest growing cities in Rajasthan with a population of 3.1 million[1] – 22.5% (around 0.7 million) living in urban slums. It is both the state capital and the headquarter of Jaipur district which has a total population of more than 6.6 million[2], more than half of which are urban residents.

The city is governed by the Jaipur Nagar Nigam (JNN or Jaipur Municipal corporation) and Jaipur Development Authority (JDA). Within JNN, the jurisdiction for the various wards are divided between the Jaipur Municipal Corporation- Greater and Jaipur Municipal Corporation-Heritage. These work with the concerned line departments, to provide basic services to all in the areas under their jurisdiction.

The city has a total of 211 notified slums, of which 164 are under JNN and 47 are under JDA. In addition, there are non-notified slums in the fringe areas of the city which are not recognized by the government, and there is no reliable data on the exact numbers of them. Access to basic services in the notified and non-notified slums varies greatly, depending on their location, tenancy status, socio-economic composition, local representation in governance, etc. While the non-notified slums are often outside the purview of government programs and frontline workers; in the notified slums, the government programs are irregular, inadequate, mismanaged, and lack coordination with other line departments.

A 2013 Population Foundation India (PFI) report noted that 31% of the households in the urban slums in the city do not have access to piped water connections, 28% do not have access to toilets, and at least 16% of those living in the slums still practice open-defecation. As per the 2016 Urban Statistics Handbook[3], Jaipur town (Municipal corporation) was ranked 370 out of 476 towns on the Government of India's Swachh Bharat Mission indicators.

Over the last decade, there has been various government and civil society interventions to address these gaps, however, they have been implemented in piecemeal manner, lacking coherence and long-term vision. There is an urgent need to address the needs of the urban poor in a holistic manner, with a focus on sustainability, equity and community ownership.

COVID-19 AND WASH IN URBAN CONTEXT

India recorded its first COVID-19 case on January 27th 2020, and the government announced the first lockdown to control the spread of the virus on March 22nd 2020. Soon, the need for individual, community and facility level hygiene took on urgent life-saving proportions. Repeated government and health organisation messaging stressed on the need for regular handwashing with soap and water, for cleaning of surfaces, wearing of masks and maintaining social distancing. These proved particularly challenging

1. Source: 2011 Census
2. Ibid.
3. Handbook of Urban Statistics, 2016. Ministry of Urban Development, Government of India.

for the urban poor, without adequate access to water for handwashing or cleaning purposes or spaces to distance and isolate in. The second wave[4] (currently underway) has become deadlier than the first wave.

The government reported the second wave in Rajasthan to be five times the peak of the first wave.[5] During the first wave, dense urban settlements proved to be disproportionately affected by the virus, which rapidly spreads amongst residents living in close quarters.

> *"Ensuring evidenced-based and consistently applied WASH and waste management practices in communities, homes, schools, marketplaces, and healthcare facilities will help prevent human-to-human transmission of pathogens including SARS-CoV-2, the virus that causes COVID-19."*
>
> *– WHO, Interim Guidance (Water, Sanitation, Hygiene & Waste Management for SARS-COV-2, the virus that causes COVID-19), 29 July 2020.[6]*

The pandemic has both highlighted **the need for WASH** to safeguard health and life of the population, and **the absence of minimum hygiene facilities** amongst the urban poor who are also most vulnerable to it.

In 2020, 68% of the total COVID-19 cases in Rajasthan were concentrated in urban areas, primarily in Jaipur and Jodhpur cities. High density urban settlements are at higher risk of the disease, due to a combination of factors:

(a) ***higher transmissibility*** due to crowding, social mixing, large households living in smaller houses, poor WASH services, community toilets and water points, mass gatherings, etc.

(b) ***higher prevalence*** of severe diseases due to prevalent co-morbidities

(c) ***higher case fatality*** due to inadequate access to care services.

It is pertinent to note that during the second wave of COVID-19 infection since March 2021, the spread has also reached rural parts of Rajasthan, as is the case across India. This is being dealt by the Government through a differential approach. The infection in urban areas have also shifted from high density settlements to high-rise buildings, necessitating wider approach to deal with the challenge including home isolation and strengthening health infrastructure both in urban and rural areas. However, the vulnerability of high density settlements in urban areas continues to remain high for any such infection, hence learnings from this engagement will be useful for future initiatives in slums.

4. https://cmo.rajasthan.gov.in/cmoadmin/Program/Pdf/7a5a3528696a4eb5a8625f1cc68ea588_CM_Press_Note_Covid_03-04-2021.pd
5. https://indianexpress.com/article/india/coronavirus-india-live-updates-vaccination-drive-oxygen-shortage-7293259/
6. https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC-WASH-2020.

OVERVIEW OF RECENT GOVERNMENT INITIATIVES

IN recent years, there have been various flagship programs and initiatives by the governments at the national, state and city levels to tackle WASH related issues.

The largest of these was the **Swachh Bharat Mission (SBM)** launched by the Government of India in 2014 ***to eliminate open defecation and improve solid and liquid waste management in the country.***[7] In urban areas, it was implemented by the Ministry of Housing and Urban Affairs (MoHUA).

Similarly, to ***improve access to water,*** the Government of India launched **Jal Jeevan Mission (JJM)** in 2019. This aimed to provide Functional Household Tap Connection (FHTC) to every household in rural India; more recently the government announced its extension to urban areas.

For ***menstrual hygiene management (MHM),*** the state government of Rajasthan launched a free sanitary napkin distribution scheme called **"UDAAN"** in 2015. It covered both school and non-school going girls from slums areas. In 2018, the then Chief Minister of the state announced a budget of INR 760 million for MHM. This resulted in the Menstrual Hygiene Scheme, expanding the reach of the programme to include all girls and women in the age group of 15 to 45 years. The scheme was visualized to be implemented in two stages, with stage two reaching urban and semi-urban population.

In Jaipur, the city administration has implemented the **Solid Waste Management Rules (2016)** for ***proper segregation and disposal of solid waste.*** The government (in 2017) launched door to door collection of waste in the city and mandated segregation of solid waste at source by citizens.

However, in the 2020 sanitation survey undertaken by the MoHUA[8], **Jaipur ranked 95 out of 100** urban local

7. https://swachhbharatmission.gov.in/
8. https://swachhsurvekshan2021.org/ImpDocs/SS2020fullreport.pdf

bodies (ULBS), underscoring the need to prioritize sanitation programming in the city.

Government response to COVID-19 in Rajasthan. In Rajasthan, the state government took measures for the prevention, testing, treatment and isolation of COVID-19 cases, as per the guidelines of the central government, with need-based adaptation to suit the local context. Based on the joint advocacy by UNICEF and WHO, the state adopted broad principles in containing transmission and mitigation measures for saving lives and livelihood, which entailed (a) classification of the cluster and outbreaks (b) perimeter control (c) geographic quarantine (d) active surveillance and contact tracing (e) testing (f) treatment and mitigation (g) isolation and (h) quarantine risk communication.

The state government employed a communication strategy as a core component of the initial response to dispel myths and promote COVID-19 prevention behaviours. In addition, an innovative approach called **Mission Life Saving (LiSa)** was adopted, based on the technical inputs from **WHO, UNICEF** and United Nations Population Fund (**UNFPA**). In the urban slums (especially those in major cities like Jaipur), the state government used its network of frontline workers for active surveillance of COVID cases, and conducted awareness generation activities.

BRIEF OVERVIEW OF CFAR AND UNICEF'S APPROACH

CFAR has been working in urban areas of Jaipur since 2006. Initially, the focus was on supporting the urban poor and marginalized communities living in slums to access basic entitlements.

It began addressing WASH in urban poor settlements starting from 2012, with the help of a three-year Bill and Melinda Gates Foundation funded project.

Subsequently, between 2016 to 2019, CFAR expanded its reach by implementing an urban sanitation intervention across 55 informal slums of Jaipur. Under this, it facilitated the community to form collectives called Community Management Committees (CMC) at the settlement level and Single Window Forum (SWF) at the ward level to articulate its demands to the government bodies.

CFAR thus brings its extensive experience and familiarity with the WASH situation amongst urban poor in Jaipur to this partnership, and its expertise in community engagement.

UNICEF, on the other hand, has been working with the Government of Rajasthan to provide technical assistance for strengthening WASH policies and guidelines and advocate for the rights of the most marginalized, particularly children and caregivers of children. UNICEF through its WASH programming has worked closely with the Government of India as well as the state government in Rajasthan to improve WASH in schools, Anganwadi centres and health facilities, especially within the context of COVID-19.

However, UNICEF has primarily worked in rural areas with engagement at state and district level and did not have prior engagement with urban settlements. Similarly, CFAR had not focused on WASH in institutions previously.

COVID-19, and its predominance in urban hotspots, highlighted the need to initiate work in the urban high density areas, primarily focusing on vulnerable and poor population residing in slums using the approach of "no one left behind".

UNICEF thus partnered with CFAR to complement its expertise in the institution-to-community approach and its focus on children in its programming, with CFAR's familiarity and existing rapport with urban poor communities in Jaipur.

By joining forces, the partnership helped both organisations to gain new insights and expand their reach and knowledge that will have implications on their future programming.

The program offered an entry point to UNICEF to work in urban poor settlements, and to CFAR to work with institutions and service providers in its programming.

3

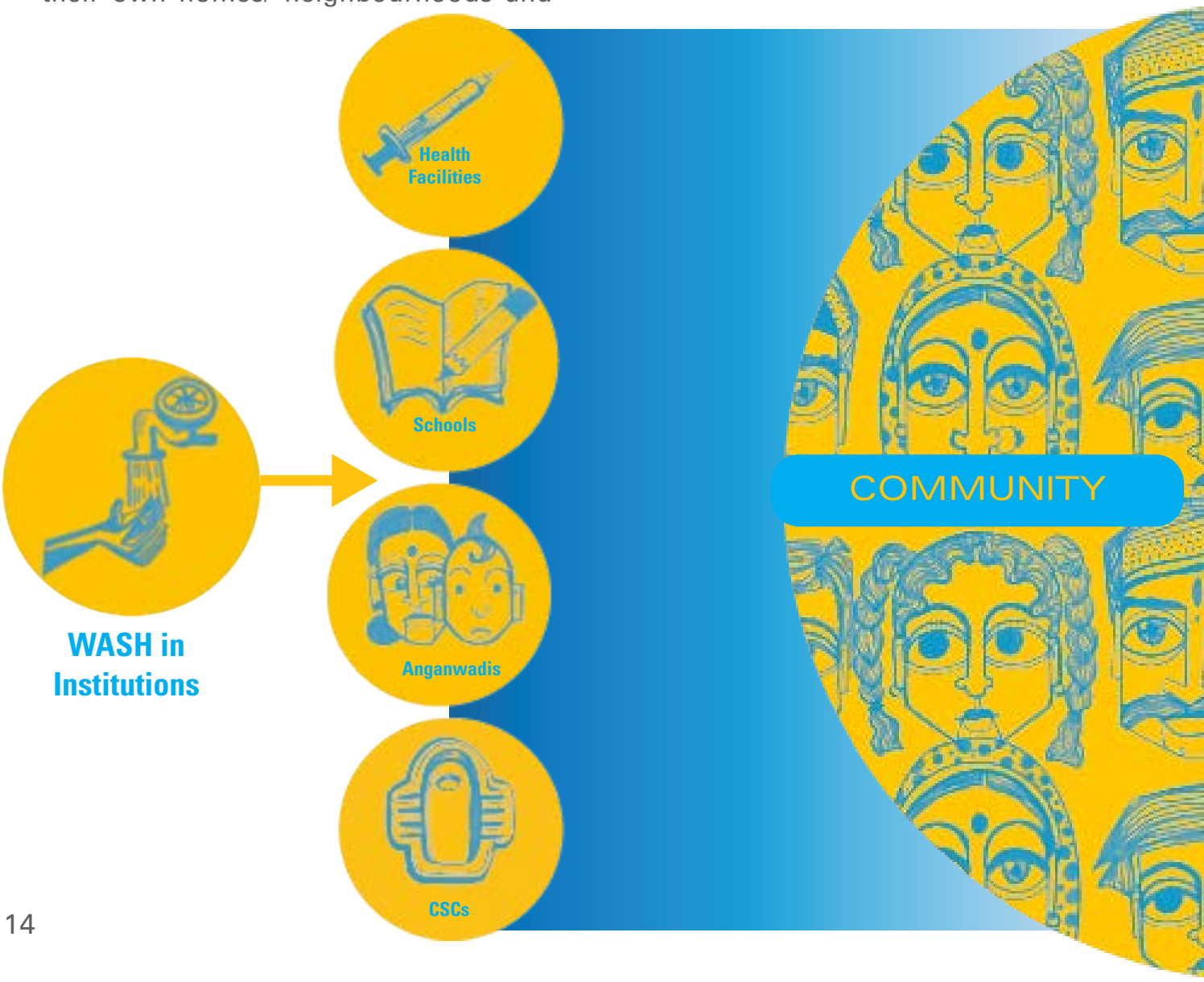
INSTITUTIONS TO COMMUNITIES APPROACH: JOURNEY OF THE PROJECT

A key component of this project has been the use of "institutions to communities" approach. This approach is premised on the rationale that public institutions can be a gateway to the larger community, and provides the most efficient way to reach a wide range of community members. The role of public institutions for providing safe WASH services has become even more paramount during the pandemic.

In urban poor settlements, where many people don't have access to adequate water and hygiene facilities within their own homes, they depend on those that are available in these public institutions. The facilities thus model best practices for the community to carry forward in their own homes/ neighbourhoods and impacts the community's ability to avail services within the facilities. A school that does not have adequate WASH facilities affects its students' attendance and participation rate, impacting their education. Similarly, a hospital without clean toilets, will not be able to provide the healthcare relief that the public seeks from it.

With these considerations in mind, this intervention sought to

(a) understand the gaps in WASH in facilities, and
(b) improve WASH services for the urban poor in Jaipur by using systems-strengthening approach in public facilities frequented by these communities.



JOURNEY OF THE PARTNERSHIP

ORIENTATION STAGE

THE inception of the project involved a series of orientation sessions, visits to the slums and trainings for the field team. These activities helped the project team get acquainted with the target locations and the rights holders.

The orientation included discussion on the following:
I. Key components of Water, Sanitation & Hygiene (WASH): (a) safe handling of drinking water; (b) safe disposal of wastewater; (c) safe disposal of human waste; (e) household sanitation ; (f) personal hygiene; and (g) overall cleanliness in slums and institutions

II. Role of WASH in COVID-19 response

III. Jal Jeevan Mission during COVID-19 and its role at district and village levels

IV. Sanitation practices and protocols in institutional facilities like Anganwadi centres (AWCs), schools and health centres.

V. Orientation on Government checklists for assessment of AWCs, schools and health centres as well as community sanitary complexes

GAP ASSESSMENT

A key component of the partnership was the gap assessment. The findings from this will help fill in the evidence gap with respect to access to WASH in urban settlements. In addition, the findings from the assessment will be helpfulin showing the way forward for urban WASH programming in Jaipur. The assessment used an "evolving and adaptive" approach, and the methodology was adapted and fine-tuned over the course of the intervention period.

Table 1: Methods Used for Gap Assessment

Method Used	Sample Size
Household Survey	115
Community/Stakeholder Consultations	27
Gap Assessment of institutions (schools, health facilities, AWCs) and CSCs	40
Institution to Community outreach	400

EARLY ASSESSMENT AND OBSERVATIONS.

The preliminary assessment was conducted in 11 settlements in Jawahar Nagar. This involved conducting a household survey in two wards of Jaipur, along with community and stakeholder consultations and visits to facilities used by the community. This helped the team identify the ***main institutional facilities used*** by the community, namely – schools, AWCs, health centres and community sanitary complexes (CSCs).

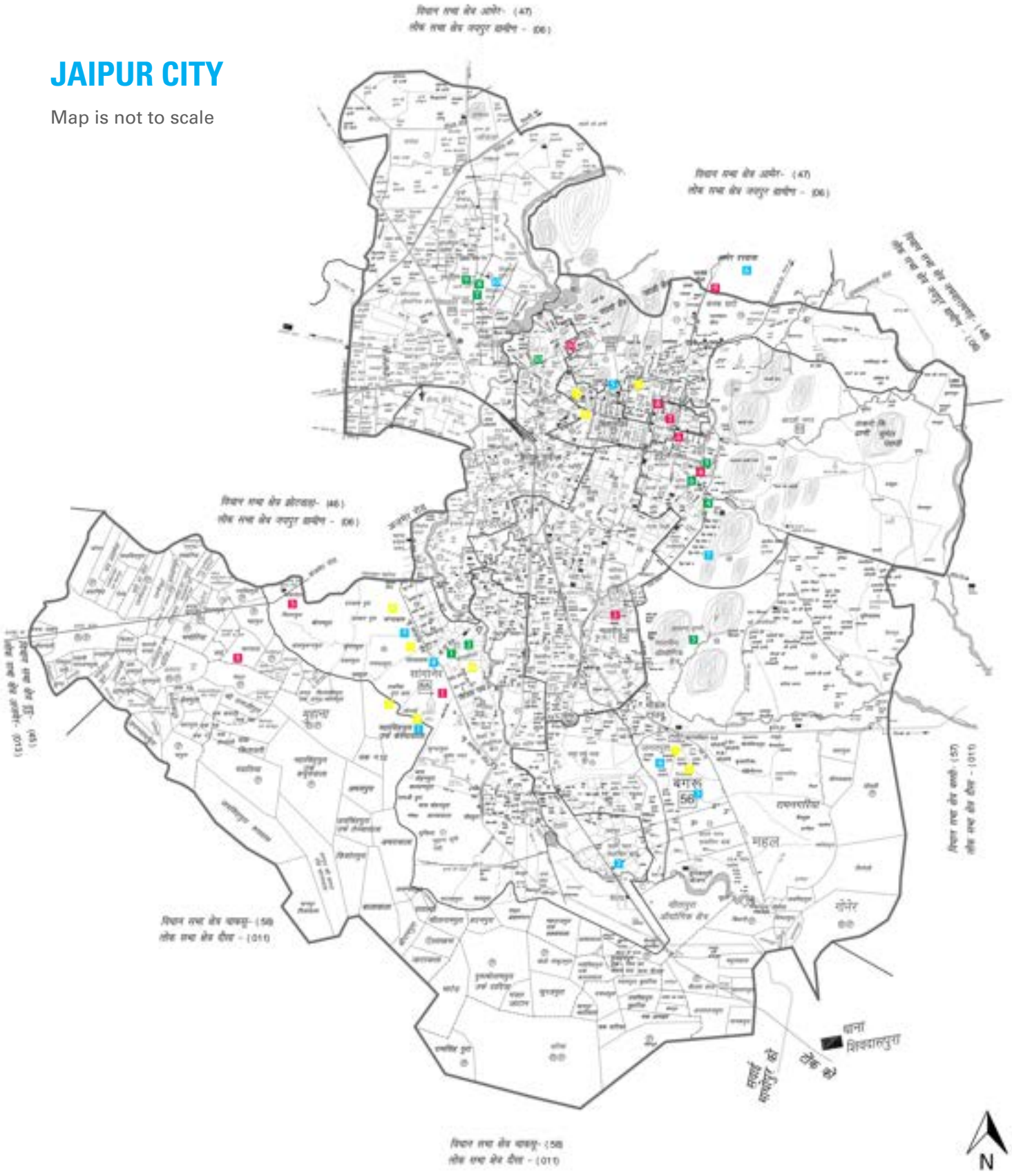
This exercise also made the team realize that they will have to expand the settlements covered so as to cover a wider range of facilities and to reach the most marginalized and vulnerable amongst the urban poor. The findings from the survey drove home the need for an "institution to communities" approach in reaching the community for the gap assessment study, as community members were found to use a wide range of facilities from public to private which were not necessarily in the same settlement or ward as their residence.

PROCESS FOLLOWED

- Orientation of team on using existing Government checklists for assessment
- Interactions with local stakeholders – ASHA, Anganwadi worker, SWFs, CMCs, Slum Development Committees-to assess community efforts and seek their support
- Building Partnerships with Government Stakeholders- Municipal Corporation, Public Health and Engineering Department (PHED), Zonal and Ward Officials

JAIPUR CITY

Map is not to scale



Anganwadi

1. Jagatpura Fatak
2. Jagatpura Gator
3. Madram Pura
4. Tejaji ka Bada, Sanganer
5. Shastri Nagar, Shivaji Nagar
6. Gangauri Bazaar, Bharmpuri Road
7. Bhatta Basti
8. Mangyawas, Mansarovar
9. Pratap nagar, Sector 8
10. Vadh Devari, Mansarovar

Hospital

1. Community Health Centre, Sanganer
2. Rukmani Devi, Jaipuriya Hospital
3. Urban Primary Health Centre, Bhankrota
4. Satellite Colony, Sethi Colony
5. City Health Centre, Sirsi
6. Women Hospital, Sanganeri Gate
7. Jawana Hospital
8. Pandit Deendayal Upadhyaya Hospital, Gangauri Bazaar
9. Community Health Centre, Amer
10. Hari Baksh Kawatiya Hospital

School

1. Govt. Sec. School, Madrampura
2. Govt. upper Primary School, Pratap Nagar, Sec. 8
3. Govt. Middle School, Jagatpura Fatak
4. Govt. Sec. School, Jagatpura, Gator
5. Govt. Sec. School, Badh Deveri
6. Govt. Girls Sr. Sec. School, Amer
7. Govt. Primary School, Tila no. 4
8. Govt. Primary School, Sundar Nagar, Mansarovar
9. Govt. Sec. School, Mansarovar
10. Govt. Girls. Sen. School, Shastri nagar, Shivaji Nagar

Community Toilet

1. Sector 12, Mansarovar
2. Gujjar ki Thadi, Mansarovar
3. Jhalana Dungri
4. Tila no. 6B, Jawahar Nagar
5. Tila no. 4, Jawahar Nagar
6. Lal Dungri, Transport Nagar
7. Bapu Nagar
8. J.D.A Colony, Vidyadhar Nagar
9. LankaPuri, Vidyadhar Nagar
10. Shastri Nagar

Table 2: Selection criteria for the facilities

Health Facilities	» Multi-speciality government hospitals » Must cater to a large population with multiple services » Must have the capacity to handle institutional deliveries, and have labour rooms » Prioritization of facilities that are most frequented by slum/ vulnerable » population
Schools	» Inclusion of at least one each from Primary, Upper Primary, Secondary and Senior Secondary schools. Ensuring coverage of students of all age groups. » Inclusion of at least one exclusive girls' school
AWCs	» Must be located in a government building. » Must be within selected schools' premise or adjacent to it.
CSCs	» Must be located within the same settlement as that of the other facilities » Must be accessed by the local community members » Must be used by both women and men » Must not be managed by a private individual or organisation

Thereafter, a ***list of minimum criteria*** was developed for selection of the four institutions, listed above.

INSTITUTION TO COMMUNITY ASSESSMENT.

Based on the criteria, CFAR identified 40 facilities- 10 each of schools, AWCs, health centres and CSCs. Starting from the two wards (11 settlements) that the household survey was undertaken in, the team concentrically expanded the search and reached out to wider area to cover 17 settlements in 10 zones across 35 wards.

In each facility, a need assessment was undertaken by using or adapting government approved checklists. This was essential for ensuring usability of the findings and for coordination or advocacy with the government. Within each institution, the field team undertook ***observation as well as discussion with the service providers or front line workers*** to take a comprehensive assessment of the situation.

CHECKLISTS USED IN EACH FACILITY:

- **Health Facilities:** The Kayakalp guidelines was translated in Hindi and adapted for the gap assessment.
- **Schools:** The Swachya Vidyalaya Puraskar (SVP) or Clean School Award checklist was used for the gap assessment.
- **AWCs:** The AWC checklist piloted by UNICEF in Dungarpur (2018) and subsequently scaled up across Rajasthan by the DWCD (2019) was used for the gap assessment.
- **CSCs:** The Google tool based CSC checklist developed by UNICEF for Garib Kalyan Rojgar Abhiyan (2020) was used for the gap assessment.

From each facility then, the field team identified and reached out to 10 community users of the facility.
Care was taken to cover a wide range of community members, with particular focus on children and women.
400 community members were covered in these interviews which covered 63% or 252 women and 37% or 148 men.
With each community beneficiary then, in-depth qualitative discussions were undertaken.

The purpose of these were to:
- Verify the findings of facility level need assessment.
- Attain deeper insights on challenges faced by the community in accessing WASH in the respective institutions
- Identify local leaders in the settlement.
- Understand and present a holistic picture with respect to overall gaps in WASH access faced by the community.

INSTALLATION OF GROUP HAND-WASH STATIONS AND INCINERATORS

UNDER this intervention, the team provided two key WASH related inputs in the facilities: low cost COVID-19 appropriate hand-wash stations and incinerators. Although it was not possible to address all the needs assessed during gap assessment owing to the short timeline and scope of project budget, these two inputs helped meet some of the pressing needs expressed by the community and service providers.

Disposal of menstrual waste was found to be one of the main concerns in schools and hospitals - it contributed to the solid waste generated, and impacted the students' and patients' participation in these facilities. Similarly, water scarcity was one of the most common concerns across settlements and public facilities, due to which most service providers and community members prioritised water for drinking over washing. Availability of dedicated hand-washing space was a big need across facilities, particularly in the context of COVID-19.

HAND WASH STATIONS

30 foot-operated handwashing stations were installed in 27 facilities- nine health facilities, nine schools, seven AWCs, and another two at the level of the settlements. The team used a "trail, error and adapt" approach to develop innovative stations that can be replicated across other facilities.

A ***design plan was developed*** for the units (see text-box on page 20). Based on this plan, a vendor was identified to work with the team in designing a customizable hand-washing unit.

The project team worked with the vendor to develop, test and adapt different design protypes. Two different prototypes were developed based on the group handwashing units design.
However, there was a felt need for further improvisation as they were not COVID-19 appropriate and did not meet the space constraints of the institutions.

Figure 2: Final design of the handwash station installed

Criteria to select facilities to install handwash stations:

- Availability of continuous water supply
- Ability & willingness of institution's management to take up O&M of the units

Key design principles:

- Child-friendly: appropriate height and safety of structure
- COVID-19 appropriate: distancing of users and minimum touch points
- Sturdiness & Mobility: to avoid vandalism of structure.
- Cost-efficiency, scalability & replicability
- Proper water drainage system

Based on the learning from these two prototypes, the team developed the third and final design.

The final design (see Figure 2) had the following ***innovative features:***

- It consisted of ***one tank surrounded by three washbasins*** on three different sides. Two out of the three sinks in each unit had ***a foot-operated tap and soap dispenser,*** and the remaining one had a plastic tap with a hand soap tray. By having a single washbasin on each side, the unit ensured social-distancing and foot-operated tap/ dispenser helped avoid unnecessary touch as per COVID-19 prevention protocol.

- The ***height of the tap was customized*** based on the type/ age of end users- lower placement of tap for the young children in AWCs and pre-primary grades, medium placement for the primary and secondary school children and higher placement for senior-secondary school children/ and the adults in hospitals/community.

- The tank had a capacity of 300 litres/ 300 users or 500 litres/ 500 users (depending on the footfall of the different facilities).

- The unit had ***smooth edges to ensure that it did not hurt the end users*** and a belt with clamp on all four sides to ***hold the tank in position.***

- It included a high quality drainpipe, which is easily available in the market and is cost effective. The installation ensured that the waste water gets released in the soak pit, or facility/ kitchen garden.

- On three sides of the installation, a soft board was fixed with simple pictorial messages on handwashing

After the installation of each station, the ***team demonstrated how to use it,*** and shared information on best practices around hand-washing. Messaging and demonstration was linked with information on COVID-19 prevention. In every facility, the project also distributed two units of hand-wash soap, and stressed the importance of using soap for hand-washing.

INCINERATORS

10 incinerators are installed across four schools and four hospitals.

The incinerators installed had the following innovative features:

- Digital LED display which showed the temperature and status.
- Capacity to burn 50 pads at a time (within 30 minutes).
- Customized heavy pipe material for exhaust (based on the need in the installation sites)
- ISO and the Pollution Control Board certified.

Criteria to select facilities to install incinerators:

- Schools with adolescent girls (secondary, senior-secondary schools)
- Hospitals that undertake institutional deliveries

Key design principles:

- Value for money
- Easy and convenient to use
- Environment friendly

After the installation in each facility, the field ***team demonstrated how to use the unit***. The demonstration was done with the facility staff as well as the rights holders, responding to any questions raised. ***To ensure ownership*** of the unit, each facility was asked to provide a letter of acknowledgement for receiving the incinerator. ***To ensure sustainability,*** each facility was given one year replacement warranty and an additional year of free service for the maintenance and repair of the incinerator units.

Figure 3: Demonstration session with health facility staff on using the incinerator.

The team developed and distributed ***various communication materials*** (Hindi pamphlets and video demonstration) explaining how to use the machine. These were distributed in each facility to the rights holders as well as the staff. The pamphlet included "Dos and Don'ts" as well as a customer care number that can be called for any questions related to the machine.
The team also developed a short 3-minute video for circulation through social media platforms such as WhatsApp for the facility in-charge and school students.
The field mobilisers undertook follow-up visits to collect feedback and clarify doubts on using the units.

COMMUNITY ENGAGEMENT PROGRAMS

ALONG with the facility level efforts, the program also executed community engagement programs to inculcate best practices around hygiene and sanitation practices and to create ownership of the program's inputs by the community.

In each of the 17 settlements covered, the field mobilizers organized at least one group activity with each of the following three groups: women, adolescent girls and children.

During these, the discussion was customized as per the needs identified during gap assessment, but generally included a combination of these topics: (a) COVID-19 precautions, (b) MHM, (c) hand-washing, (d) solid and liquid waste segregation, (e) hygiene and sanitation, (f) open defecation.

Some noteworthy national/international days were also observed with the community, such as

the Global Handwashing Day (when the project began), World Toilet Day on 9th November 2020 and Menstrual Hygiene and Awareness day (India) on 5th February 2021. These were used as an opportunity to build momentum around issues relevant to the day, and encourage community and government participation and dialogue. For instance, during the menstrual hygiene day, a wall-painting program was organized around menstrual issues on the wall of a community health centre (see figure 4); health officials from the centre were invited to participate in the event, who then gave their commitment to proactively address any MHM related issues or complaints that the community brings to them.

In some of the settlements, the field mobilizers formed small community platforms like adolescent or kishori groups and women's groups who then took forward the information on MHM to their households and neighbours. During one of the community activity, these groups were asked to write a letter to their father / brother / husband / other male member in their family, seeking their support or dispelling myths around menstrual hygiene,
Some other community awareness activities undertaken within the settlement were:

- **IMAGINING GREEN SETTLEMENT WITH CHILDREN.** A poster making activity where children imagined an ideal green settlement, and were sensitized on their role in improving the community's hygiene and sanitation.

- **GLITTER ACTIVITY** in which the trail of glitter on the hands of the children were used to raise their awareness on the presence and spread of germs from their hands. This activity was then used to discuss hand-washing practices with the children.

- **RED-DOT CAMPAIGN** with menstruating women to dispel shame and secrecy associated with menstruation and to normalize discussions around it amongst the community. This was then used to raise awareness on menstrual hygiene practices.

Figure 4: Wall painting on Menstrual Hygiene Awareness day

KEY TAKEAWAYS FROM THE COMMUNITY ENGAGEMENT SESSIONS

THE community engagement sessions along with the interviews and consultations with the community also sought to further understand the gaps in WASH faced by the urban slum residents. Most of these will be discussed in Chapter 4, as we speak of each facility separately. But some of the most pressing takeaways that was common across all settlements covered are discussed below:

- Most community members are fearful of the COVID-19 pandemic. But they are also wary of public health guidelines on handwashing with soap due to water scarcity.

- Water scarcity is one of the biggest concerns of the community in urban slums of Jaipur. This has always been a pressing issue, but more so with the pandemic. As a result, they have to repeatedly prioritize water for drinking over washing, and compromise on their hygiene habits.

"I wake up in the morning at five in the morning every day to fill buckets with water. I borrow water from the neighbour's house which we then use for bathing and drinking purposes. We can't afford to waste water! So we don't wash our hands too much, just after taking our meals."

– Female community member, Tila No. 4

- In the absence of household toilets (because of space and resource constraints), and the overcrowding and poor maintenance of CSCs, community members opt for open defecation. This has increased during the pandemic, when they are fearful of crowds and closed spaces.

- This lack of access to functional and well-maintained toilet facility has become an additional burden for the differently abled, women, children, elderly and transgender community members. In addition, many of the toilets are not accessible to these groups. Where the toilets are segregated for the differently abled and the women, they are either not well-maintained or used by the male and abled bodied counterparts (due to over-crowding of the other toilet-units). Maintenance of personal hygiene thus becomes particularly difficult of these already marginalized groups, increasing their vulnerability to diseases (including COVID-19).

- Community members are wary of using public health facilities, and prefer to use private facilities if they have the means. Many of them worry that they will get sick, or their health will deteriorate due to the unhygienic and overcrowded spaces of the public health facilities.

- Community members expressed willingness to pay a reasonable amount for the maintenance of CSCs and to contribute for household toilet (if space allows for it).

- Some mothers in the community were worried about the health and well-being of their children when they return to schools and AWCs after (pandemic-related) lockdown, due to inadequate WASH infrastructure (toilet, drinking water, hand-washing units) in these institutions.

- Most community members are not aware of the linkage between hygiene and health outcomes. Those who are aware of it, lament the lack of access to hygiene facilities.

- Adolescent girls and women lack access to proper information and products for menstrual hygiene management.

- The community don't have access to/ information about grievance redressal processes for solid and liquid waste management.

> *"The wastewater from the resident on top hills run down and fills up the open drain causing blockage."*
>
> *– Female community member, Azad Nagar*

PROCESS DOCUMENTATION

THE process documentation is an important component of this intervention. This will document the processes, learnings and successes of the partnership, and identify emerging actions for future WASH program interventions in the identified urban slums of Jaipur. By documenting the processes, it will act as a useful resource that other organisations can use when designing their own WASH in urban slums in program. It will also act as an advocacy and learning document for CFAR and UNICEF to use in their future programming.

CHALLENGES

IMPLEMENTING a WASH program in highly dense urban settlements in the middle of a pandemic is no easy task, the team faced various challenges in the process. Some of them were:

- INITIAL RESISTANCE FROM HEALTH FACILITIES.
  In many health facilities, entry of outsiders were prohibited during the pandemic. The health officials in the facilities were overworked and reluctant to engage with outsiders in the middle of the pandemic.

  To address this, the field team began a careful process of rapport building and explaining the purpose of the project. Over the course of the project, the team was able to build improved relations with the health centres, and to smoothly continue with its activities even in the midst of COVID related restrictions.

- FACILITIES VS. CHECKLISTS/ GUIDELINES.
  In the beginning of the project, the team found that the Kayakalp checklist was not applicable to most of the health centres visited (as they were smaller in size and scope). Similarly, many of the AWCs were being run in private buildings, which were often not fixed and CSCs were managed by private bodies/ individuals – this made any assessments or any program inputs difficult, as there would be no institutional buy-in for it. This led to the development of the criteria for the selection of institutions (see table 2), and expanding the scope of the project to cover a larger number of government facilities that meet the requirements of the project.

- HIGH TURNOVER of field team due to the challenges of working in the field during COVID. To address this, the project prioritized the safety and comfort of the team, and worked closely with the field mobilizers to motivate them for their task.

- DISCOMFORT WITH TAKING RESPONSIBILITY OF THE PROGRAM INPUTS. Many service providers were initially uncomfortable taking on the responsibility of the handwash stations and the incinerators as they were unsure of their safety and worried about vandalism from the community

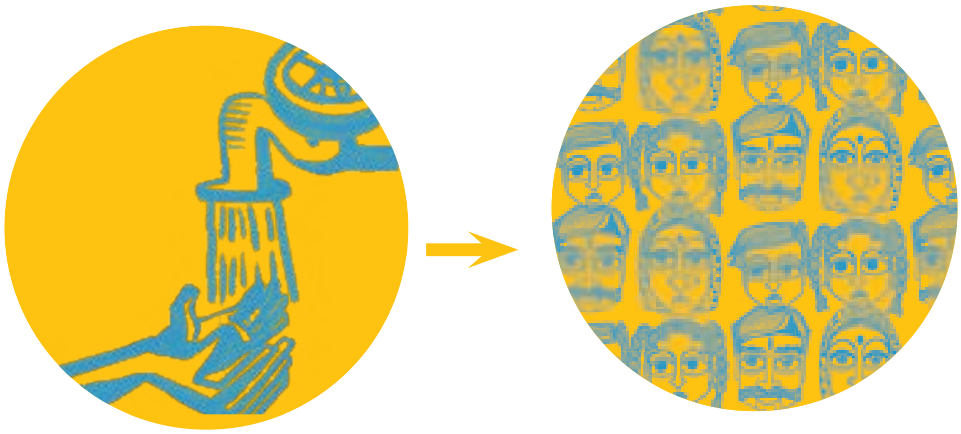
around them. The team thus tried to address issues of safety and mobility when designing these units, and also worked with the community and service providers to build trust around the safety and ownership of facilities.

- RESISTANCE FROM THE COMMUNITY.
  The mobilizers also faced resistance from the community, where many of them were at first reluctant to speak to them, due to fear of interactions posed during the early wave of the pandemic.
  The community were also wary of messaging around hand-washing (as mentioned before). The field mobilizers had to slowly win them over through repeated engagements, and interactive activities.

4
WASH IN INSTITUTIONS

This section describes the process and findings from the engagement with each of the four facilities separately.

As mentioned before, the project team reached out to 40 facilities and 400 community end users of these facilities.



Institutions
{40= 10 health facilities + 10 schools + 10 AWCs + 10 CSCs}

Community End Users
{400=100 of health facilities + 100 of schools + 100 of AWCs + 100 of CSCs}

This section describes the findings from each facility- summarizing the gap assessment findings against the government indicators, and then providing a more detailed overview of the key bottlenecks faced by each facility with respect to WASH. This includes the findings from both the need assessment in the facilities, and the interviews and consultations with the community.

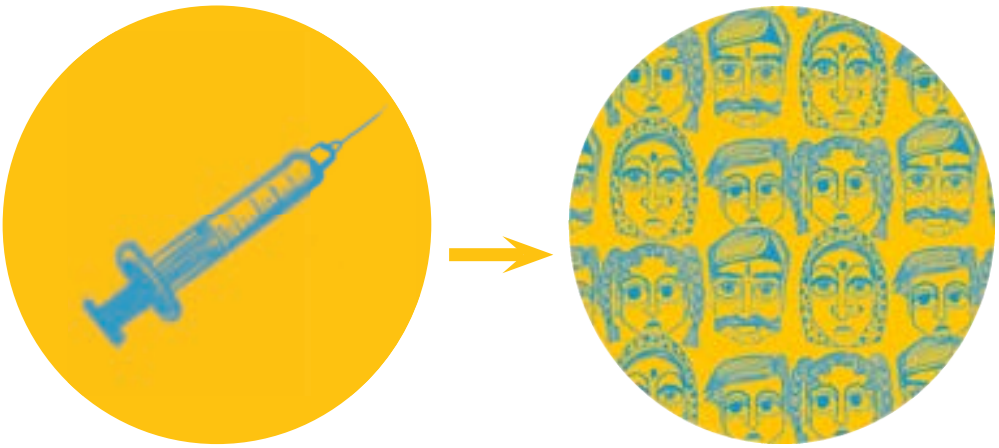
WASH IN HEALTH CENTRES

In May 2015, the Ministry of Health and Family Welfare (MoHFW) launched the **Kayakalp initiative** to promote cleanliness and enhance the quality of public health facilities. Under this, it released the **Swachhta Guidelines for Public Health Facilities**.[9]
These guidelines were adapted for the gap assessment of the health facilities under this engagement. As shown below, it reached out to 10 health facilities and its 100 community end users for the same.

SERVICE DELIVERY INDICATORS FOR HEALTH CENTERS (AS PER KAYAKALP GUIDELINES):

I. Hospital/ Facility Upkeep
II. Sanitation & Hygiene
III. Waste Management
IV. Infection Control
V. Support Services.
VI. Hygiene Promotion

9. Source: http://qi.nhsrcindia.org/swachhta-guidelines-public-health-facilities. Description: These guidelines provided detailed instructions on the upkeep and maintenance of sanitation and hygiene in health facilities, including for bio-waste management.



Health Facilities
{10 = 6 hospitals
+ 3 PHCs + 1 CHC}

Community End Users
{100 = 79 women (inc. 19 pregnant
women) + 16 men + 5 children}

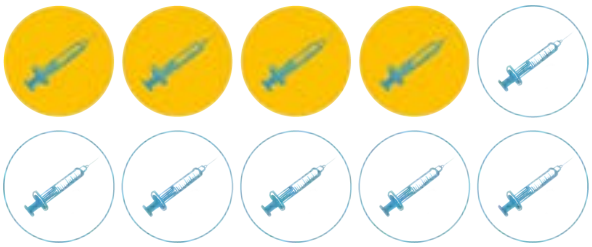
Gap Assessment Findings: Health Facility

The findings from the gap assessment will help in highlighting the areas to prioritize for any future WASH programming in urban health facilities. The graph below (Figure 5) summarizes the findings against the assessment criteria. As shown, the facilities assessed scored the poorest on "support services" and the "hygiene promotion" criteria.

The assessment highlights are further shown in Figure 6 and discussed in the text below.

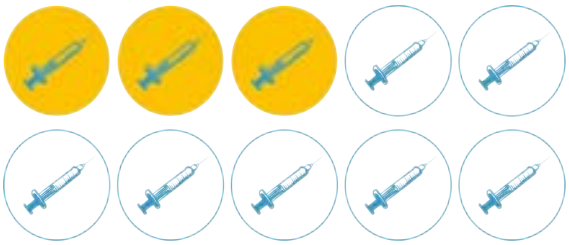
Go to Annexure (Table 5) for facility wise score and observations against these criteria.

Figure 5: Summary of Gap Assessment Findings: Health Facilities



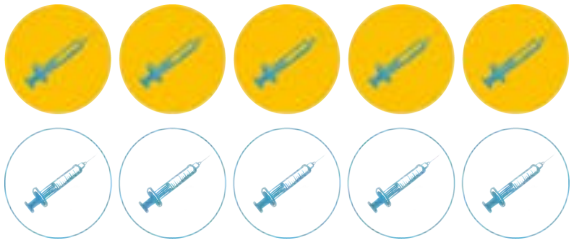
HOSPITAL UPKEEP

4 out of 10 facilities meet 67% or less of the basic upkeep requirements



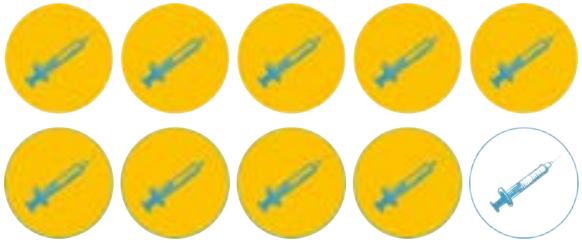
WASTE MANAGEMENT

3 out of 10 facilities meet less than 80% of the requirements



INFECTION CONTROL

5 out of 10 health facilities meet 77% or less of the requirements



COVID-19 PROTOCOLS

9 out of 10 health facilities were not following the protocols

SANITATION & HYGIENE

1 facility scored 48%, all others meet more than 75% of the requirements

HYGIENE PROMOTION

All facilities meet less than 50% of the requirements

Figure 6: Key Bottlenecks for WASH in Health Facilities

- **COVID-19 PROTOCOLS NOT BEING FOLLOWED.** Although most of the health centres displayed messages on COVID-19 prevention (distancing, use of masks, handwashing with soap), most facilities were not following them. This included mandatory use of masks by patients and their attendants, sanitizing hand or hand wash, and social distancing. This was mainly due to an extremely high footfall in the centres where maintenance of distance or regulation of hygiene and mask-wearing practice could not be enforced. The hospital staff were also over-burdened due to the additional hygiene and safety requirements during the pandemic, and there was fear of infection amongst both the staff and the patients/ visitors-but both blamed the other for lack of maintenance of protocols.

- **TOILET SURROUNDINGS ARE UNHYGIENIC.** The toilets in the health centres were cleaned at fixed intervals- either once a day, or twice a day. But this was found to be inadequate considering the high footfall in the facilities. The toilet often stayed dirty and unhygienic through most part of the day, until the next scheduled cleaning took place.

- **DUSTBINS ARE NOT EMPTIED ON TIME.** The assessment found overflowing and stinking dustbins around many of the health centres.

- **INADEQUATE MHM.** In many of the centres, the women admitted in the wards were provided with rolls of cloth for menstrual management, and did not have access to disposable sanitary pads. In the absence of clean, accessible and private spaces for cleaning of these cloth pads, these were often found thrown in the hospital toilets, adding to the lack of hygiene of the space. Both cloth and disposable used napkins were found tossed around windows of the toilets.

- **INADEQUATE HYGIENE PROMOTION ACTIVITIES.** Hygiene promotion was one of the main gap areas identified through both quantitative and qualitative interaction. This is because of the absence of the requisite community monitoring mechanisms or training of staff to undertake hygiene promotion.
  - Rog Kalyan Samities (hospital management societies) mandated under the National Health Mission were not functional
  - Counselling of patients on hygiene and cleanliness were not taking place
  - There were no feedback mechanisms in place for cleanliness or hygiene promotion
  - Insufficient and inadequate messaging and information, education and communication (IEC) materials on hygiene promotion
  - The staff (health as well as cleaning staff) were not being trained for hygiene promotion, as per the Kayakalp guidelines

Overall ***most community members prefer to go to a private hospital, if they have the means.*** Some of them even save up over months to afford treatment in a private facility, instead of availing free treatment in the nearby government ones. Many of them fear that they will get sicker if they go to the government hospital due to the unsanitary conditions – this fear was heightened during the pandemic.

Based on the findings of the gap assessment, handwashing units and incinerators were installed in the facilities identified based on the selection criteria (see Section 3, for criteria for selection).
Six incinerators were installed across four public hospitals with the potential of reaching 300 adolescent girls and women in a day (or 36000 girls/women in a month). 13 handwashing stations were installed which are being accessed more than 1000 end users every day.

The experience with the health facilities underscored the need for system strengthening approach to improve WASH infrastructure in public health facilities of Jaipur, particularly for hygiene promotion. The need for MHM facilities and training of staff on government WASH protocols was also highlighted through the assessments and facility/ community engagements.

Figure 7: An incinerator being installed at Women's Hospital, Jaipur.

"These (the incinerators) would be very useful for us...they will help in controlling pollution and the garbage that used to be thrown here and there will not be done anymore."

– Dr. Renu Meena, In-Charge Bio-Medical Waste Management, Women's Hospital

WASH IN SCHOOLS AND ANGANWADI CENTRES

IN 2014, 'Swachh Bharat Swachh Vidyalaya' (SBSV) or "Clean India, Clean School" campaign was initiated by the Ministry of Human Resource Development, as a prelude to SBM. In 2016-17, the Swachh Vidyalaya Puraskar (SVP) was instituted by the Department of School Education and Literacy, MoHRD to recognize and award schools who have performed exceptionally well in bringing sanitation and hygiene practices in the school. Under this intervention, the targeted schools were assessed against the SVP guidelines.

Similarly, the Women and Child Department (WCD) has clear guidelines for WASH in the Anganwadi centers (AWCs). These guidelines were used by UNICEF to develop and pilot an AWC checklist with 40 AWCs in Dungarpur in 2018. Since then, this checklist has been scaled across Rajasthan.

Under this intervention, the SVP guidelines and the AWC checklist were used to assess and reach selected schools and AWCs respectively. It reached out to10 schools and 10 AWCs, and 100 urban poor end users of each, to identify gaps and strengthen

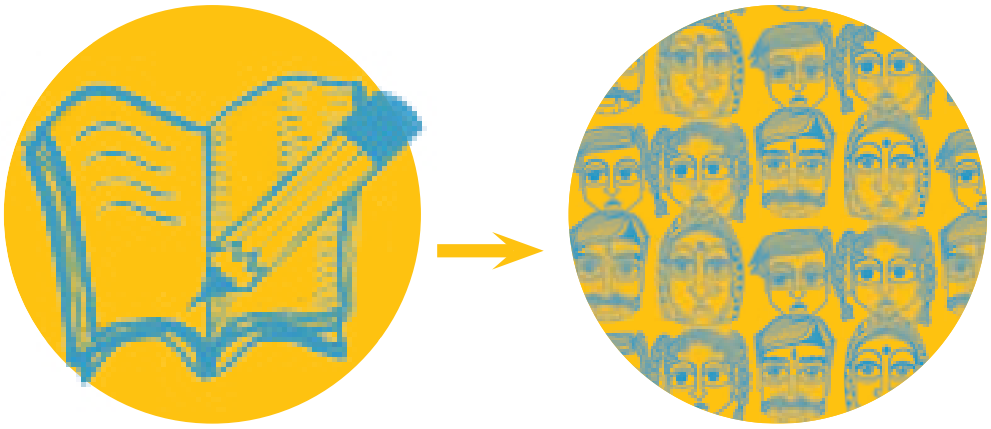
KEY WASH CRITERIA FOR SCHOOLS AS PER SVP GUIDELINES

I. Water (Availability of safe + clean drinking water and water for handwashing/ toilets)
II. Toilet
III. Handwashing with soap
IV. Operation & Maintenance
V. Behaviour Change & Capacity Building

KEY WASH CRITERIA FOR AWCS AS PER THE AWC CHECKLIST:

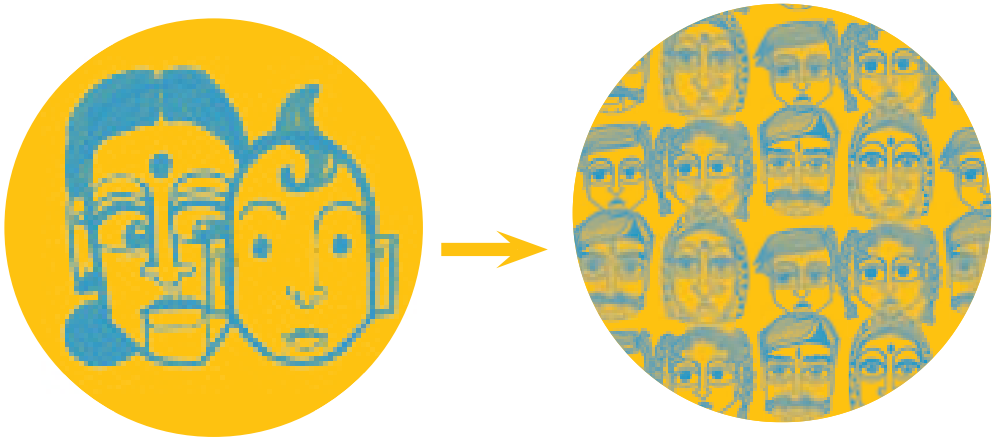
I. Water
II. Cleanliness
III. Health
IV. Behaviour Change
V. Solid and Liquid Waste Management

All the AWCs covered were running in the same premise as a government school, and therefore both schools and AWCs are being covered together in this sub-section.



Schools
{10 = 2 primary + 1 upper primary+ 3 secondsary + 4 senior secondary}

Community End Users
{100 students}



Anganwadi Centres
{10}

Community End Users
{100+ = 41 women (inc. 17 pregnant women, 8 mothers) + 59 children}

Gap Assessment Findings: Schools and AWCs

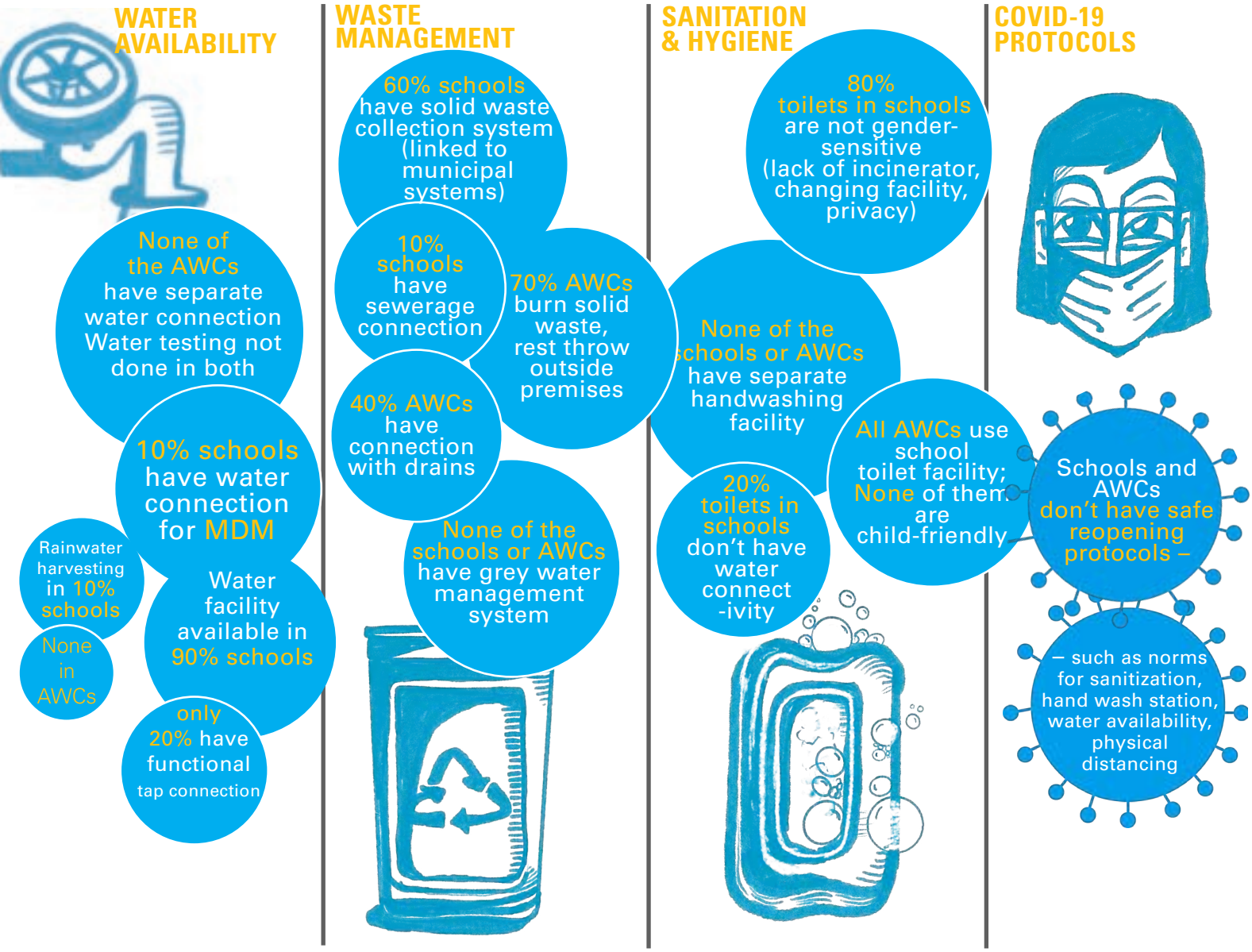


Figure 8: Key Bottlenecks in Schools and AWCs

As with the health facilities, the findings of the gap assessment will be useful in highlighting the areas to prioritize for any urban WASH programming in schools and AWCs. The graph (Figure 9 on Page 36) summarizes the findings against the assessment criteria.

As shown, the AWCs perform worse than the schools on most criteria, particularly with respect to availability of water. Both perform poorly in terms of hand-washing facility.

The assessment highlights are further shown in Figure 9 and discussed in the text below.

Go to Annexure (Table 6 & 7) for facility wise score and observation for the 10 schools and 10 AWCs.

- **DRINKING WATER IS NOT TREATED ADEQUATELY (IN AWCS) AND QUALITY NOT REGULATED (IN BOTH).** In four out of 10 AWCs, children and staff brought their own water bottles or water campers.

Note that since (as discussed before) water scarcity is one of the main concerns expressed by the community, this requirement to bring their own water bottles was a big drawback for many households.
In many centres, the staff and children fetched water from the neighbours.
In 90 percent of the schools and AWCs, there is no process for water testing. ***None of the AWCs practiced boiling of water before drinking it.***

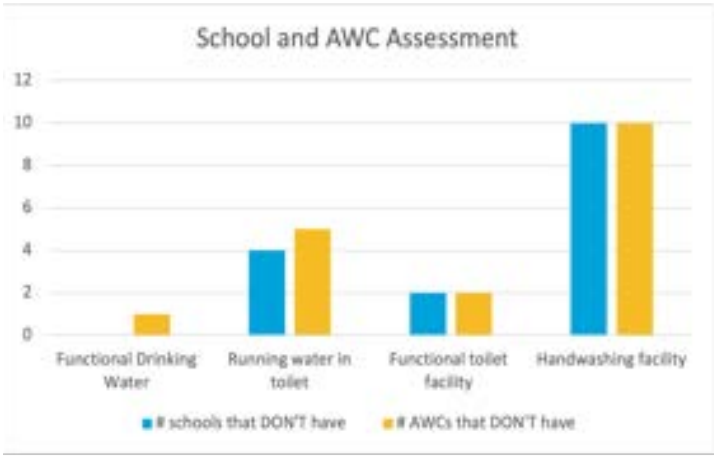


Figure 9: Summary of Gap Assessment findings:Schools and AWCs

- **LACK OF WATER FOR CLEANING/WASHING PURPOSES.** Two out of 10 schools visited did not have a water source in toilet for handwashing. In most schools (six out of ten), a cement tank or drum with the plastic mug is placed for handwashing after toilet use and before eating meals. Almost all the schools (nine out of 10) did not have a clean water supply for the kitchen.

Since the AWCs don't have their own water connection- three out of 10 use the water connection of the school on the premises, and the rest collect from nearby sources.

- **TOILETS ARE NOT CHILDREN OR WOMEN FRIENDLY.** None of the AWCs had their own toilets, they used the ones of the schools on the premises. However, half of the AWCs visited did not have access to any functional toilet. Out of the five that did have access to a toilet, only three had water facility and soap, and only three were child and women-friendly. ***Only one of the AWCs had access to toilet that was cleaned regularly.*** As a result, most of the children and staff defecate or urinate in the open as a practice.

The situation is slightly better in schools where all of them have a functional toilet, However, two out of 10 are not gender segregated, and eight of them do not have a sanitary disposal system. In five of the schools, teachers and students share the same toilet. Similarly, in two of the AWCs, there is a single toilet that is used by staff, parents/visitors, as well as by children. ***In most schools, the toilet surrounding was dirty*** – only two had surroundings clean.

In addition, some of the Anganwadi workers (AWWs) also mention ***discrimination in use of facilities in the school.*** In some schools, the AWWs were not allowed to use the toilet or water facility in the school on their premises. As a result, they had to resort to asking a neighbour for the same.

- **DESPITE HAVING INCINERATORS** in seven out of 10 schools, most of them were either not functional or the staff/ students ***did not know how to use them.*** The staff/ students did not receive any demonstration or information on how to use them.

  "The toilets are not clean and we don't even have any place to throw the pads we use. We are uncomfortable throwing it outside the campus. We usually have to bring the dirty pads with us home, and then dispose it."

  - Female student (Class 8th), Government Secondary School Mangyawas.

- **INADEQUATE HANDWASHING FACILITIES.** In the absence of enough water supply in the centres, AWWs, like the community members in the surrounding settlements, often prioritize water for drinking over washing. 30 per cent of the schools do not have any washing facility in the kitchen and 60 per cent kitchens do not have dishwashing soap/ powder to wash utensils with.

- **NOT ENOUGH RESOURCES FOR OPERATION AND MANAGEMENT (O&M).** Four out of 10 schools do not receive any government funding for maintenance and repair.

- **INADEQUATE BEHAVIOUR CHANGE ACTIVITIES WITH BENEFICIARIES OR CAPACITY BUILDING OF STAFF TO UNDERTAKE THEM.** Six out of 10 of schools have teachers assigned for hygiene and sanitation education and a student council to promote and manage school sanitation, but as many of seven of the schools do not organize any programs on the theme of hygiene and health safety.

Inaccessible toilets stalls Upasana's education and aspirations in Bapu Basti

Upasana is a young girl who lives in Bapu Basti, Vidhya Nagar. At 15 years of age, she is the eldest daughter in her family, and lives with her parents and three younger siblings. Her father, a daily wage laborer, is the sole earner in the family and struggles to meet the basic needs of his family.

Upasana has multiple disabilities, and repeatedly finds herself in spaces which are not able to accommodate her needs. Every day Upasana watches as her younger siblings go out to study at the nearby Government Upper Primary School. But the schools don't have disabled friendly toilet, forcing her to drop out of school before she could even complete grade 3. Similarly, her small house in the slum does not have a toilet, so her family has to use the CSC in their settlement. But the CSC is neither disabled nor child friendly, so her siblings defecate in the open and she defecates on a paper which is later disposed by her mother. Her mother having to take care of a disabled girl in a disabled inaccessible environment, is unable to go out to work to add to the family income.

Like any young girl, Upasana also has dreams and desires, but nobody has the time to know of them, and she is repeatedly disenfranchised even from the basic right to access a school and a functional toilet.

Table 3: Human Interest Story from the field #1

The intervention highlighted the need for advocacy and system strengthening to improve WASH in AWCs, with separate provision for child friendly water and toilet facilities. Separate handwashing facilities are required in both schools and AWCs and MHM facilities in senior-secondary schools.

Based on these findings, schools and AWCs were identified (see Section 3, for criteria for selection) to install the handwashing and incinerator units in. ***Four incinerators were installed in four schools reaching 730 adolescent girls and 17 foot-operated handwashing units were installed in nine schools and seven AWCs reaching 105,500 students/ children and staff.***

It is important that such installations are replicated and scaled up to other schools and AWCs serving the urban poor in the region. In addition, staff-training and funding should be prioritized to ensure compliance of the facilities with the WASH standards of the government.

WASH IN COMMUNITY SANITARY COMPLEXES

THE construction of community sanitary complexes (CSCs) forms an important component of the SBM, recognizing that not every household have resources or space to construct individual toilets. This is particularly relevant in urban dense settlements, where most dwellers do not have enough space to construct toilets.

During the initial household survey, the project team found that CSCs are the most commonly used institutional facility by the community Therefore, to better understand and serve the WASH needs of the urban poor community, the field team reached out to 10 CSCs and 100 urban poor end users of the CSCs. Mixed-method approach was used to assess the key WASH gaps faced by the community with respect to the CSCs.

CSCs
{10 }

Community End Users
{100 = 30 women + 63 men + 7 children/ adolescent}

KEY WASH CRITERIA USED FOR ASSESSING CSCS

I. Water
II. Design and Functionality
III. Safety/ Security
IV. Waste Management
V. Operation and Maintenance

Gap Assessment Findings: CSCs.

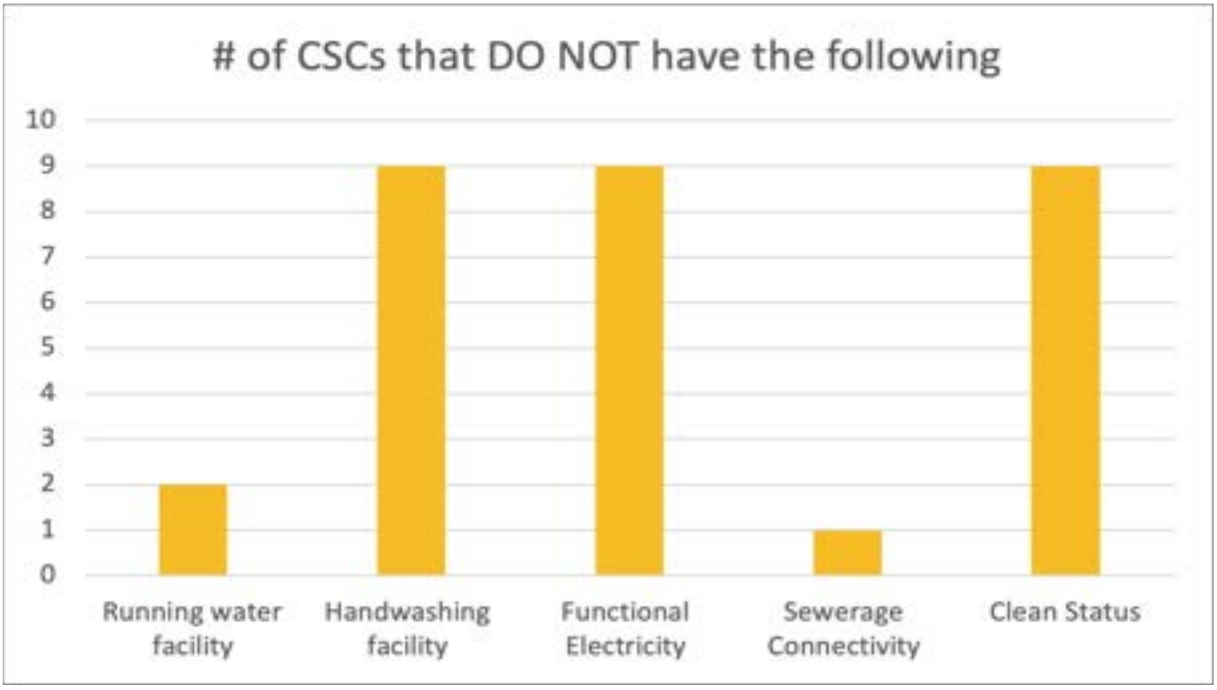
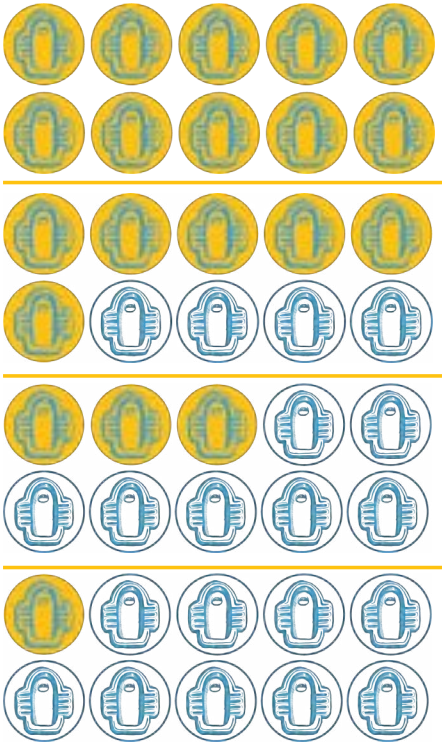


Figure 10: Summary of Gap Assessment findings: CSCs

The assessment findings will be useful in improving the WASH infrastructure of the CSCs, with the potential to impact most of the urban slum dwellers in the city. The graph on the side (Figure 10) summarizes the findings against the assessment criteria.

As shown, functional electric equipment, regular cleaning of toilet/ toilet surroundings and availability of handwashing facility were the biggest gaps in the CSCs impacting the hygiene and safety of the facilities.

Water Connectivity, Drainage and Use



100% toilets have overhead water tank (water gets filled once in a week by Jaipur Nagar Nigam)

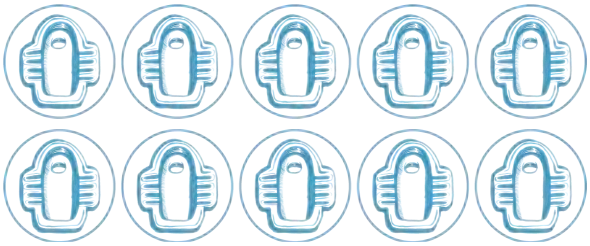
60% toilets are connected with municipal sewerage network

30% are connected with soap pits/septic tanks,

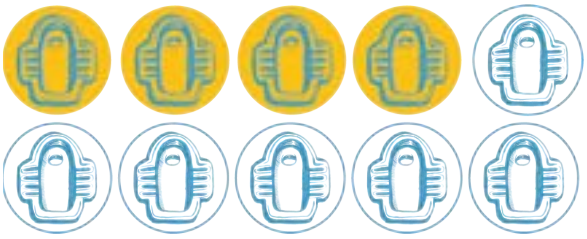
10% are connected to single leach pits

Figure 11: Key Bottlenecks in CSCs

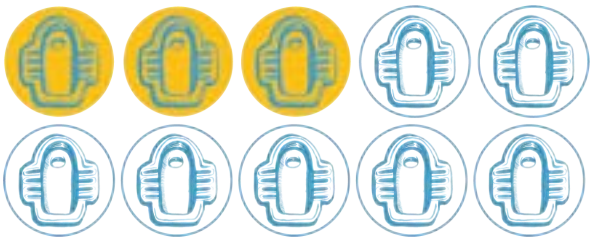
Functionality



No CSC had functional electric connection



40% facilities had proper ventilation

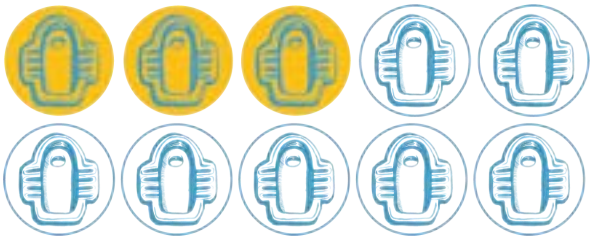


30% toilets have functionality issues (breakage, leakage, clogging of toilets)

Only 10% have functional hand wash facility (soap availability varying)

Inclusivity and Use

90% CSCs are used regularly by slum population



30% facilities had separate units for differently abled, but only 20% were functional

Toilets are gender seggregated

Figure 11: Key Bottlenecks in CSCs

The assessment highlights are further shown in Figure 11 and discussed in the text below. Go to Annexure (Table 8) for school/ AWC wise score and observation against these criteria.

- **WATER AVAILABILITY IS A BIG CHALLENGE AND DETERRENT TO COVID-19 PREVENTION.** In a water scarce area like Jaipur, availability of water is the biggest challenges faced by the community, more so for the urban poor. During community interactions around hand-washing, there is the repeated refrain that "there is no water to drink, and you are talking about hand-washing!" With the pandemic now in its second wave, the need for water for hand-washing, cleaning and hygiene maintenance is especially urgent.

  There are no hand-washing facility in the CSCs and with Corona spreading, we are always scared of infection!

  – Male community member, Tila No. 7

- **TOILETS ARE NOT DISABLED FRIENDLY.** Only two CSCs had functional disabled-friendly units. Most do not have ramps or railings to make them accessible for people with physical disabilities.

- **TOILETS ARE GENDER SEGREGATED BUT NOT GENDER SENSITIVE.** While the toilets were gender segregated, the team observed that men often used the women's toilets- mainly due to overcrowding in the men's ones. There were also no system for menstrual hygiene disposal for the women; as a result, sanitary pads or cloths were found thrown on the floor or inside the toilet blocking its drainage and worsening the hygiene of the place.

- **OVERCROWDING OF CSCS.** The number of toilets available in the complexes were too few to cater to the large population of the urban poor in these settlements. This lead to overcrowding and long queues. Some of the women community members time their visits to the CSCs during the afternoons when there is less rush for the toilets.

Figure 12: Mobilizers interact with community end users of CSCs

Overcrowding also makes it difficult to maintain social distancing, due to which many community members prefer open-defecation over compromising their health in the toilets.

- **TOILET MAINTENANCE AND CLEANING IS THE BIGGEST CHALLENGE.** Toilet units faced regular functionality issues like breakage, leakage or clogging. In the absence of regular cleaning and maintenance, this makes many of them unusable for long periods of time, further adding to the over-crowding mentioned above.

- **LOCATION AND LIGHTING OF CSCS MAKE THEM UNSAFE.** Some of the CSCs have been constructed across a road with heavy traffic making is unsafe for elderly or the children. Further, five out of 10 CSCs do not have proper electricity connection. ***Not a single CSC was found where all electric equipment was in working condition*** – most of the bulbs, fans and electric point were found dilapidated. This further adds to the lack of safety experienced by the community members, particularly women and children.

- **LACK OF COMMUNITY OWNERSHIP OF THE CSCS.** Although most of the community residents in the slum settlements use the CSCs, there is no community ownership of the complexes. All the CSCs are maintained by the Jaipur Development Authority (JDA) and in nine out of 10 of them the community does not participate in the O&M.

WOMEN FEEL UNSAFE GOING TO THE CSCS ON THEIR OWN IN JAWAHAR NAGAR

In one of the slums or bastis of Jawahar Nagar, the CSC is far away from the settlement, and across a big road with heavy traffic. The community members have to walk through long empty stretches surrounded by wilderness, without adequate street-lighting and then cross this heavy trafficked road to reach the toilet. Many of the women expressed feeling unsafe, especially at night to use the toilet, and to prefer defecating/ urinating in the open instead of risking any harassment on the way. Those who are able, take a male family member with them, to go to the toilet. Some of them also mention instances, where they found themselves locked in the toilet by pranksters who then proceeded to laugh and harass them from outside. Such instances scare them even more, and discourage the usage of the complexes.

Table 4: Human Interest Story from the field #2

The gap assessment highlighted the need for regular cleaning of the CSCs, and access to handwashing and MHM facility in the units. Based on these findings the project team identified ***two settlements to install the handwashing and incinerator units*** – these have the potential to reach 2.76 lakh adults per month in the settlement.

This experience with the urban poor settlements highlighted the need to have more CSCs that are functional, gender and disabled segregated to avoid overcrowding of the existing ones. In addition, it underscored the need for community ownership, to improve its upkeep and maintenance.

Figure 13: Community member uses the hand-wash unit outside Janana Hospital

5 Conclusion

WITH the help of the Solidarity Fund, UNICEF and CFAR tried to both understand the needs of the urban poor in Jaipur, and to demonstrate innovative ways of addressing them.
The text-box below lists the key deliverables under the intervention.

KEY DELIVERABLES UNDER THE PARTNERSHIP:

- Gap Assessment Report and presentation
- Hindi translation of Kayakalp Report
- CSC Assessment Format
- Cost-effective & customizable model of hand-washing station
- Cost-effective model of incinerator
- Behavior change IEC materials
- Process Documentation report

This intervention used a "institution-to-community" approach to reach a wider range of urban poor, and provide a holistic picture of their WASH related concerns. The gap assessment helped to address the evidence gap with
respect to updated and reliable data on the needs of the urban poor.
The innovative WASH installations demonstrated cost-effective and replicable ways to address the needs identified.

Using a "learning by doing" approach, the project team adapted, innovated and tested new ways of working with the urban poor. The team found that the use of "system strengthening" approach is the most effective and sustainable way to impact the community.

The biggest learnings from this engagement are the following:

- Water, sanitation and hygiene needs of the urban poor should be prioritised, particularly with the pandemic.

- Working with service providers provides a gateway to reach a wider circle of the community, and to create partnership between the government and the community.

- In Jaipur city, the urban poor have very limited access to water for washing and cleaning purposes, which needs to be addressed for the community to meet basic hygiene needs.

- Service providers need training and support to meet the government WASH guidelines.

- Both the community and the service providers want public health and hygiene messaging to be accompanied with the necessary resources/ training to practice them.

- There is need for a spirit of partnership and trust between government and community, to ensure mutual ownership and trust of any WASH program.

This process document aims to share the learnings and experiences of this engagement with the wider development community to employ in their own programs.

6
WASH IN URBAN RAJASTHAN: WAY FORWARD

Building on the learnings from the UNICEF-CFAR partnership, this section highlights the key areas within WASH in urban settlements that requires greater attention in the future.

This will not only guide the work of UNICEF and CFAR, but also other UN agencies, CSOs and government departments that choose to refer to this document when executing WASH programs in urban Rajasthan.

- **CAPACITY BUILDING:**
  (a) Roll out of capacity building programmes through government – non-government organization (GO-NGO) partnership for key service providers working in public institutions, focusing on planning, ownership and O&M;
  (b) Align capacity building with government guidelines/ protocols;
  (c) Develop appropriate IEC or social and behaviour change communication (SBCC) materials suitable to the urban high density settlements, with a focus on personal hygiene and COVID-19 protocols
  (d) Enhance role of CSOs in building capacities of the communities, especially women, children and differently abled on key WASH behaviours

- **STRENGTHENING COMMUNITY PARTICIPATION TO ENHANCE OWNERSHIP OF WASH INFRASTRUCTURE:** Establish a flexible and evolving GO-NGO coordination mechanism to strengthen community participation and facilitate ownership of public WASH infrastructure by the community.

- **PRIORITIZING FUND ALLOCATION FROM EXISTING GOVERNMENT PROGRAMMES FOR ENHANCING WASH IN URBAN SLUMS:**
  (a) Enhance equitable water supply to urban poor residing in high density settlements through existing flagship programmes such as Jal Jeevan Mission;
  (b) Fund allocation for hand wash stations, household toilets to reduce open defecation;
  (c) Increase fund allocation for O&M in schools and AWCs

- **MAKING WASH INFRASTRUCTURE IN SLUMS CHILD-FRIENDLY, GENDER-SENSITIVE AND CLIMATE RESILIENT FACTORING THE DISASTER PREPAREDNESS:**
  (a) Promote innovative design for WASH infrastructure particularly in schools, AWCs and health facilities to make them appropriate for use by children, women, elderly and differently abled;
  (b) Identify localized and alternate solutions suitable to the urban high density settlements (addressing issues such as space and resource constraints, issues of upkeep and ease of maintenance) for narrowing the WASH gaps in immediate and short term through active participation of government and community;
  (c) Advocate to linking WASH infrastructure in urban settlements with existing water supply and sewerage network of the city; (d) Address the interlinkages of gender and disability inclusion, WASH and disaster planning

- **STRENGTHENING O&M AND SUPPORTIVE SUPERVISION:**
  (a) Strengthen community participation to improve maintenance of public WASH facilities and narrow gaps in the existing government programs;
  (b) Provide periodic supportive supervision and capacity building for frontline workers, teachers, supervisors working in the health facilities, AWCs and schools for O&M of WASH in these facilities

- **USING EVIDENCE BASED ADVOCACY:**
  Strengthen existing systems by using evidence based advocacy that identifies and targets the relevant line department for the specific advocacy areas:
  (a) Advocate with the PHED and local administration for regular and equitable water supply in the notified slum areas;
  (b) Advocate with the JDA to address gaps identified in the CSCs;
  (c) Advocate with the DWCD and municipal authorities to address gap identified in the AWCs.

- **COORDINATION AND SYNERGIES WITH ALL STAKEHOLDERS INCLUDING UN AGENCIES, CSOS, COMMUNITY ORGANIZATIONS, LOCAL LEADERS AND GOVERNMENT BODIES:**
  (a) Map the existing actors, resources and data bases covering the urban slums of Jaipur;
  (b) Identify gaps and establish synergies;
  (c) Create a platform and organize round-tables for periodic sharing of findings, establishing partnerships, developing/ refining guidelines and planning for the future.

ANNEXURE:
GAP ASSESSMENT FINDINGS FOR THE FACILITIES

TABLE 5: ASSESSMENT FINDINGS OF 10 IDENTIFIED HEALTH FACILITIES AGAINST THE KAYAKAP GUIDELINES

Sl. No.	Name of Hospital	Hospital Upkeep	Sanitation & Hygiene	Waste Management	Infection Control	Support Services (laundry)	Hygiene Promotion	Overall Rating	Observations
1	Pandit Dindayal Hospital, Gangauri Bazar	67		91	90	38	42	82	• Overall well maintained facility • High footfall /OPD • Challenge of regular cleaning
2	Women's Hospital, Sanganeri Gate	66	75	69	73	27	40	70	• High delivery load, high footfall (OPD) • Cleaning not appropriate (management a challenge) • Gap of MH disposal, hand wash facility
3	Rukmani Devi beni prasad jaipuriya Hospital (COVID-19 centre)	86	90	100	99	45	49	94	• Currently a dedicated COVID-19 facility • Facility is good and meets most of the criteria except support services, hygiene promotion
4	Janana Hospital	87	90	100	99	45	47	94	• High delivery load, High footfall (OPD) • Gap of MH disposal, hand wash facility • Cleaning (management a challenge) • Heritage building (upkeep a challenge)
5	Urban Primary Health Centre, Sirsi	79	89	93	82	42	45	86	• New building • Cleaning management a challenge • Complex cases referred to District hospitals • SWM – dependence on Nagar nigam
6	Urban primary Health Centre, Bhankrota	83	96	96	86	29	40	86	• Cleaning management a challenge • SWM – dependence on Nagar nigam • Complex cases referred to District hospitals"
7	Satellite Hospital	62	76	74	69	19	35	67	• High footfall / OPD • Challenge of regular cleaning
8	Hari Baksh Kanwatiya Hospital	79	85	79	73	27	40	77	• High footfall / OPD • Cleaning (management a challenge)
9	Community Health Centre, Sanganer	43	48	91	69	17	38	61	• Poor housekeeping cleaning • Stray animals in campus • Water availability is a challenge (drinking water through camper) • Toilet facility not clean •Labor room needs improvement"
10	Urban Primary Health Centre, Amer	73	87	95	77	25	44	80	• Cleaning management a challenge • Complex cases referred to District hospitals • SWM – dependence on Nagar nigam"

TABLE 6: ASSESSMENT FINDINGS OF 10 IDENTIFIED SCHOOLS AGAINST THE SVP GUIDELINES

Sl. No.	Facility Name	Drinking water	Functionality of drinking water facility	Source of water	Running water in Toilet	Toilet Facility	Toilet Functionality	Handwashing facility
1	Government Girls Senior Secondary School, Amer	Y	Y	PHED	Y	Y	Y	N
2	Government Upper Primary school, Bhatta Basti, Shastri Nagar	Y	Y	PHED	N	Y	Y	N
3	Government Upper Primary school, Teja ji ka Bada sector 8, Mansarovar	Y	Y	PHED	Y	Y	Y	N
4	Government Secondary School, Madrampura	Y	Y	PHED	N	Y	Y	N
5	Government Upper Primary School, Pratap Nagar, Sector 8	Y	Y	PHED	N	Y	Y	N
6	Government Secondary School, BadhDevari, Mansarovar	Y	Y	PHED	Y	Y	Y	N
7	Government Secondary School Mangayawas	Y	Y	PHED	Y	Y	N	N
8	Government Senior Secondary School, Jagatpura, Getor	Y	Y	PHED	Y	Y	Y	N
9	Government Girls Senior Secondary School, Shastri Nagar, Shivaji Nagar	Y	Y	PHED	Y	Y	Y	N
10	Government Senior Secondary School, Jagatpura Fatak	Y	Y	Bore well	N	Y	N	N

TABLE 7: ASSESSMENT FINDINGS OF 10 IDENTIFIED AWCS AGAINST THE AWC CHECKLIST

Sl. No.	Facility Name	Drinking water	Functionality of DW	Source of water	Running water in Toilet	Toilet Facility	Toilet Functionality	Handwashing facility	Additional remarks
1	BadhDevari(GS.S.BadhDevari, Mansarovar)	Y	F	PHED	N	Y	Y	N	School & AWC both are in same budling . The water facility in the school is not accessible for the pre-primary students of the AWC.
2	Mangyawas(G.S.Sc.Mangayawas)	Y	F	PHED	Y	Y	N	N	The toilet in the school is not functional; therefore, the AWC children practice open defecation
3	BhattaBasti(G.U.P.S, Bhatta Basti,Shastri Nagar)	Y	F	PHED	N	Y	Y	N	The center runs in the same building as an upper primary school, which the AWC children are able to use.
4	Shivaji Nagar(G.G.S.S.S, Shastri Nagar, Shivaji Nagar)	Y	F	PHED	Y	Y	Y	N	
5	Madrampura,Sanganer (G.S.S. Madrampura)	Y	F	PHED	N	Y	Y	N	
6	Teja Ji Bada, Sector 8(G.U.P.S., Teja ji ka Bada sector 8, Mansarovar)	Y	F	PHED	Y	Y	Y	N	Both AWC and school are running in same building but because of the partition between them, the Angawadi children are not able to use the school facilities.
7	JagatpuraFatak(G.S.S.S, Jagatpura Fatak)	Y	NF	Bore well	N	Y	N	N	
8	JagatpuraGator(G.S.S.School, Jagatpura, Getor	Y	F	PHED	Y	Y	Y	N	
9	Pratap Nagar (G.U.P.S, Pratap Nagar, Sector 8	Y	F	PHED	N	Y	Y	N	
10	Gangauri Bazar, Bhrampuri Road (GSSS Gangauri bazar)	Y	F	PHED	Y	Y	Y	N	The AWC runs in the same building as the school, but the school is senior secondary and its facilities are not child friendly.

TABLE 8: ASSESSMENT FINDINGS OF 10 IDENTIFIED SCHOOLS AGAINST THE SVP GUIDELINES

Sl. No.	Name of the facility	Water Source	Running water facility in Toilet	Toilet Male	Sheet Female	Total sheets							Clean-ing status
1	Bapu Nagar, Vidyadhar Nagar	PHED/JMC	Y	3	3	6	Y	N	y	N	Y	N	Nil
2	Tila no. 4 Jawahar Nagar	PHED/JMC	Y	4	2	6	5 F	N	y	N	Y	N	Nil
3	Jawahar Nagar 6B	PHED/JMC	Y	3	3	6	Y	N	y	N	Y	N	Nil
4	Transport Nagar	PHED/JMC	Y	5	5	10	Y	N	y	N	Y	N	Nil
5	Sector 12, Mansarovar	PHED/JMC	Y	1	3	4	Y	Y	y	Y	Y	N	Clean
6	Bhatta Basti, Shastri Nagar	PHED/JMC	N	5	5	10	Y	N	y	N	Y	N	Nil
7	JhalanaDungri	PHED/JMC	N	3	3	6	N	N	y	N	Y	N	Nil
8	Gujjar kiThadi, Mansa-rovar	PHED/JMC	Y	12	12	24	22 F	N	y	N	Y	N	Nil
9	Sector 3, LankaPuri, Vidhyadhar Nagar	PHED/JMC	Y	3	2	5	Y	N	y	N	N	Y	Nil
10	JDA Colony Vidyadhar Nagar	PHED/JMC	Y	3	3	6	Y	N	y	N	Y	N	Nil

Toilet Functionality

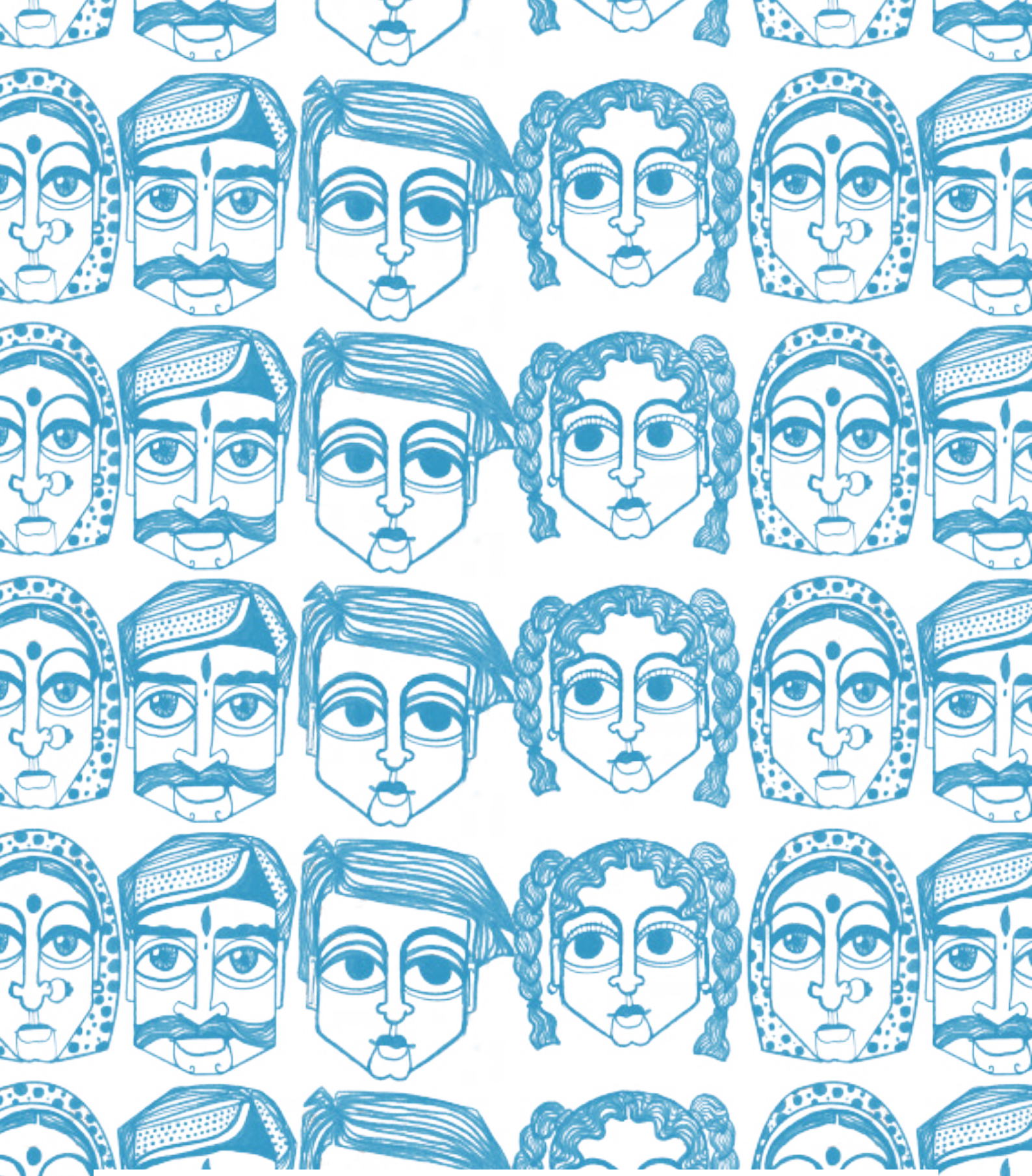
Handwashing Facility

Electricity

Electricity Functional

Sewerage connectivity

Twin pit



For more information contact:

1. Rushabh Hemani, WASH Specialist,

UNICEF Office for Rajasthan: rhemani@unicef.org

2. Juhi Jain, Sr. Programme Manager,

CFAR: juhi.j@cfar.org.in


हाथों का पानी से अनेक
4
5
6
अंगूठा के रगड़ें