Annual Report- 2009

Environment Health Improvement Program

Submitted
to
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1. Summary

Since 2009 was the last year of the three-year EHIP program, completion of construction activities, phasing out from project villages and documentation were the main focus areas of the program. The first year had seen an intensive focus on mobilizing communities through organizing regular meetings, formation and activation of existing village based groups and building their capacities. During the second year the focus was on generating demand for sanitation units, collaborating with Government supported programs such as facilitating TSC program in EHIP villages, encouraging pro- poor strategies and addressing gender-based issues in the program.

On the implementation front, the challenge of reaching out to the residual families was extremely critical. These families either extremely poor, lived in rented houses or had to deal with non-supportive village Panchayats. Another emerging trend especially in Patan District was ongoing government supported housing program for the economically weaker section. These families were excluded from sanitation coverage as they are expected to construct this after completion of housing unit. At the closure of the program, 89% access to sanitation has been achieved. Key Activities planned during the reporting period had high emphasis on awareness generation, capacity building, demonstration of technical designs, support for construction of sanitation units, motivating the households which have not opted for construction of sanitation units and phasing out from select villages.

Documentation and advocacy were focused areas at the project management level. Four documentations with an objective of impacts
(quantative / qualitative), best practice documentation and an EHIP documentary were undertaken. All these documents have scope for wider dissemination in WATSAN sector. End line survey revealed that the program has made significant impacts on most critical parameters of any sanitation program i.e health and hygiene (particularly hand washing practices) and awareness for managing diarrhea.

The overall project cost of EHIP for 3 years starting from January, 07-December,09 was Rs. Rs.1069.05 lacs which includes Rs.662.21 lacs from community and Rs. 406.84 lacs from SDTT. Community contribution was mainly towards cost of construction.. The program has utilized 79% of SDTT funding and mobilized community contribution to the extent of about 61% of overall project cost.

2 . BACKGROUND OF THE PROJECT

Environment Health Improvement Program (EHIP) aimed to establish a sustainable community managed integrated system for water supply, sanitation and hygiene promotion in 50 villages of rural Gujarat. *The Program encompassed an integrated approach to WES with an understanding that while the Government of Gujarat will support the component of water supply, the component of environmental sanitation will be supported by SDTT. In addition, community contributions will constitute an important component of the Program.*

The Program aimed to ensure access to sanitation and hygiene promotion to a population of 83000 residing in 50 villages spread over five blocks in Junagadh and Patan districts of Gujarat. The Program included two key components:

i) Implementation
ii) Research, Documentation and Communication

2.1 Profile of the Program area

The Program has been implemented in two districts of Gujarat, namely Junagadh and Patan districts, covering an estimated 83,000 population. Patan lies in northern Gujarat, while Junagadh district lies in the south-central region of the Saurashtra peninsula, south of the Girnar hills, and is the largest between the two districts chosen for interventions.

Access to sanitation facilities in rural Gujarat continues to be poor; according to 2001 census 21%[1] of rural households had access to sanitation. In most villages, defecation often occurs on open ground. In sparsely populated, arid and semi-arid areas, this causes little environmental damage but has an impact on health status in the form of water borne and other communicable diseases. In more densely populated villages, the absence of household or communal sanitation systems creates significant environmental and health consequences.

Women and children are especially disadvantaged by the absence of adequate household sanitation. Often, women have to wake before sunrise and wait until after sunset to go to the fields to defecate. Restricted toilet opportunities increase chances of urinary tract infection and chronic constipation as well as psychological stress. During menstruation, pregnancy and post-natal period it become more problematic for women if they have nowhere to deal with adequately. The physically challenged feel restricted and are more dependent to meet their basic needs, increasing burden on the care givers which in most cases are women of the household. The absence of adequate sanitation facilities affects children's physical and mental health, preventing them from going to school. Given that men remain the primary decision-makers in most rural settings and do not consider sanitation a problem, the voices of women remain unheard and the expressed demand is not converted into action. However, whenever women are consulted, the demand for safe water and adequate sanitation, including both toilet and bathrooms is strongly expressed. With this rationale, the program goal and objectives have been worked out as mentioned below:

[1] Rural coverage as per Govt of Gujarat's latest data is 59%

2.2 Program Goal and Objectives

The overall goal of the program was to improve the quality of life of rural communities through increased access to sanitation infrastructure, promotion of environmental sanitation, appropriate hygiene practices and behavioral change focusing especially on women in their reproductive years, children under five and socially disadvantaged groups in the intervention areas'

The specific objectives of the program were to:

- Promote positive sanitation and hygiene practices among individuals and households for better health status, and increased security, privacy and dignity of women and girls;
- Build capacities of community based organizations to manage and advocate for sustained water supply and sanitation infrastructure, and strengthen internal systems of democracy, equity, inclusion and governance;
- Increase the institutional capacity of AKPBS,I to implement Program, conduct research, and advocate for sustainable community-managed water supply and environmental sanitation policies and practices;
- Conduct sector specific and village-based research studies that contribute to innovations, new learning and policy related dialogue,;
- Document best practices in the sector and share experiences at state and national levels; and
- Advocate and communicate widely to influence public opinion and policy reforms related on sanitation and/or water.

3. REPORTING FOR THE PERIOD **– January - December, 2009**

3.1). Summary of fulfilment of the objectives: Analysis based on revised log frame work

2009 has been a crucial year of the project being last year of the project cycle. With the critical mass remaining to be addressed, much more efforts were exerted for targeting them through interpersonal communication, focus group discussion and by working on individual beneficiary specific problems and offering appropriate solutions. Apart from this, awareness drives with communities with an aim to reinforce the learnings of previous two years were undertaken. Observations during these awareness drives were: declining level of cleanliness among the villages, attributed to reduced support from *'Taluka Panchayat'*. Non-receipt of prize money of 'Nirmal Gram Puraskar' from government leading to reduced motivation of *'Panchayats'* and *Sarpanchs*.

Access to sanitation by end of the program has reached 89%. Out of remaining 11% families, 10% were planning to construct sanitation by themselves as a part of their housing improvement which was undergoing at the end of the project.

Table: 1 Log Frame work – Cumulative update from January,07- December '09[2]:

Objectives:	Expected Outcome	Output	Accomplishment	Rating	Remarks
1) Enable and mobilize rural communities to establish operate and maintain water supply, excreta disposal and environmental sanitation infrastructure in a sustainable manner in 50 villages.	Water supply systems are installed / rehabilitated in villages covering the entire population with a supply point located not more than 500 meters from all the communities.	Mobilized communities in WASMO-villages (32), facilitation of construction process in the year 2006 and 2008.	Handed over completed schemes/ estimates to Govt as per plan in the year 2007	Satisfactory	83% families have access to regular potable water. Non-availability of water for 10-14 days during summer is a critical issue. Project identified water sufficient villages [3]
	All families have access to and regularly use latrines, bathrooms and other environmental sanitation facilities by the end of 30 months of Program implementation.	89% households have access to sanitation units)	7864 households have access to sanitation	satisfactory	89% families have access to sanitation and the remaining11% are motivated to construct on their own.
2. Promote positive sanitation and hygiene practices among individuals and households for better health status, increased security, privacy and dignity of women and girls.	One worker per village trained in promoting hygienic & sanitation practices in all intervention villages.	50 anganwadi workers and Gram Mitra trained and mobilised.	2 persons/ village trained and mobilized (Anganwadi workers and Gram Mitra)	Very satisfactory	EHIP project aimed to make these extension volunteers as leaders in sanitation promotion. They will continue to take up the cause of 'health and hygiene' after completion of the project.

[2] Source of data, EHIP end line survey
[3] Water sufficient villages indicate access to sustainable potable water

Objectives:	Expected Outcome	Output	Accomplishment	Rating	Remarks
	Safe hand-washing practices adopted by 70% of adults, especially women, and 70% of children in the intervention villages.	Orientation of adolescent girls and women on health and hygiene conducted	83%[4] families adopting safe hand washing practices against	Satisfactory	We have emphasis on these issues during our campaign for school children. One of the aims of Child to Child approach is to increase awareness about hand washing. Children will act as a promoters of hand washing practices within the family and at school.
	22% children (11% families having children below 6year) in past 1 month suffering incidence of diarrhea	Assessment of Health and Hygiene system established through base line study	Marginal Reduction of diarrhea from 22% to 21% (1% reduction)	satisfactory	Base line and end line data
3. Build capacities of community based organizations to manage and advocate for sustained water supply and sanitation infrastructure, and strengthen internal systems of democracy, equity, inclusion and governance.	Village Development/ Swacchata Committees) formed with representatives from all sections, including women.	50 village committees formed	50 (406 members)VSC formed /strengthened with 35% women, 21% belonging to marginalized communities, 34% Panchayat members .	Very Satisfactory	'Village Swachhata Samiti' is taking active interest in village governance specifically for 'water and sanitation' issues.
Conduct sector specific and village-based research studies that contribute to innovations, new learning and policy related dialogue	Lessons documented for "100% Coverage Approach", 1 technological innovation of prefabricated unit documented and disseminated.	2 village based studies done under the program	Base line and end line survey end term evaluation completed	Satisfactory	Innovation in low cost pre-fab sanitation was hailed as one of the most appropriate technologies in Lok-Awas Yatra organized by leading NGOs at Regional level.

[4] Endline survey carried out by CORT

Objectives:	Expected Outcome	Output	Accomplishment	Rating	Remarks
Document best practices in the sector and share experiences at state and national levels			Best practice document done	Very Satisfactory	
Advocate and communicate widely to influence public opinion and policy reforms related on sanitation and/or water	2 state level workshop	2 state level workshop	1 state level workshop done. AKPBS,I was invited as a member of CMSU and as a member of Nirmal Gram Puraskar assessment team.	Satisfactory	Presented the EHIP program at two international workshops to deliver the concept of "100% approach to sanitation".

4) Program Design and Implementation:

Program design was developed in 4 phases along with respective activities. Community Management and Health and Hygiene promotion activity was interlinked with all the phases as described in the table below:

Table-2: Phases of the program

Phase	Main Activities	Main Outputs in three years
Phase I: **Preparation (3 months to 6 months)**	• Community dialogue and agreement • Community mobilisation • Participatory Rural Appraisal • Base line survey focusing on existing water supply and sanitation access and of existing hygiene practices	• Villages identified and were later changed as per their emerging needs. • 50 Village Swacchata Committees formed/ strengthened • 50 Village Action Plans developed • Strategy on health and hygiene developed
Phase II: **Implementation (18 months cycle)**	• Sanitation Promotion. • Mobilising Community Contribution • Construction of Sanitation units • School Sanitation Program • Hygiene promotion	• 50 Gram Mitra/ Anganwadi workers • Health promotion drives undertaken with school children • Construction of 7864 toilets with bathrooms.
Phase III: **Commissioning**	• Training in operation and maintenance and system management • Hygiene promotion • Monitoring and Research	• 50 Masons trained • End line survey reports • Trained human resource in villages ensuring sustainability.
Phase IV:	• Links with other agencies • Monitoring and Research	• End of project documents (3) • Evaluation study done

Handing-over	• Advocacy and Policy Influencing • Project Documentation	

4.1 Phase 1- Preparatory Phase

Community Mobilisation is the main focused area during preparatory phase. This has been done in coordination with Gram Panchayat and Village Swacchata Committee (VSC) Being last year of the project, focus remained on capacity building of 'VSC' for future actions particularly for general cleanliness and hygiene awareness. During various meetings at the village level, emphasis was on following issues:

- 100% utilisation of toilets and zero open defecation
- Safe disposal of solid waste.
- Promotion of hygiene habits (Hand washing, covering drinking water, safe water handling practices)

4.1.1 Village Swacchata Committee:

Project has strengthened / formed 50 *Village Swachhata Committees* within the EHIP project. As anticipated, these committees have played a role for total cleanliness. Project team ensured for developing network within *VSC* and 'Panchayat' for future sustainability. It provided enabling leadership within village. Most of the VSCs contributed towards construction and use of toilets for containing open defection at village level.

The Swachhata samitis performed the following functions under EHIP:

- Take the overall responsibility of managing the project in the villages.
- Actively participate in the project and contribute to raising general awareness amongst the community for toilet construction
- Maintain contacts at the individual HH level and motivate them to contribute and construct latrines.
- In some cases, they also served as guarantors to individual members to get credit for toilet construction materials from suppliers.
- Raise monitory contribution for community based activities
- Creation of revolving fund for purchasing construction materials particularly for poor families.
- Supporting awareness drives for safe waste water disposal and solid waste management.
- ***Falia (Hamlet)*** *committees* to check open defecation.

Table No 3: Composition of VSC members

District	VSCs	Total Members	SC/ST	Women	Panchayat members	General
Junagadh	27	260	50	88	92	30
Patan	23	244	73	87	44	40

Total	**50**	**406**	**86**	**145**	**126**	**49**

4.1.2 Awareness Generation:-

Intensified efforts were undertaken in project villages for *"Nirmal Gram Puraskar" as NGP status to the village acts as a motivation to the community. At the same time, NGP has become a bench mark for a clean village.* The main emphasis was on proper use of toilets and promotion of hygienic behavior including hand washing pratctices.

Table No. 4: Awareness Generation undertaken in 2009

	Types of meetings	Total
1.	**Group Meeting**	72
2.	**General Meeting**	15
3.	**Gram Sabha**	21
4.	**VSC Meeting**	23
5.	**Woman's Special Meeting**	15
6.	**Health and Hygiene Promotion**	20
	Total Meetings	166

4.1.3 Capacity Building: The last year of the EHIP focussed more on health and hygiene promotion at village level. Extension volunteer became the extending arms of the organisation in this regards. To start with, orientation training were organised for EVs to explain importance of health and hygiene issues. They visited 'Environment and Sanitation Institute (ESI) – *Safai Vidhyalay"* to understand different options for the sanitations

Table No. 5: Capacity building activities

Topics	No of trainings	Male	Female
Orientation of VSCs	1	16	10
Exposure-trip	1	6	31
Women Rally	1	0	15
School Program – Drama/Play	5	503 Students	
Improved Chulha Training	3		46
Charcoal Brequetting Training	1	18	7
WSO-WSP Training (EV meetings)	2	18	3
Total	**19**		

School Health and Hygiene Promotion: Project team was trained by Chetna, an Ahmedabad based NGO for promoting Child to Child Approach which is considered very effective for motivating children towards safe water and sanitation practices. Followed by this training, a series of awareness programs were undertaken as follows:

Team organised first meeting for policy advocacy with principles, selected teachers and representatives of parents. Subsequently trainings for the teachers and students were

conducted in their respective schools. Potential students were identified (Mostly from the 5th and 6th Standards) and their groups were formed. Teams worked with these groups to take up sanitation and hygiene issues at village level. The team aimed at leadership development within C2C groups.
These teams were involved in 'Promotion of Hygienic habits' through exhibitions cum rallies Details of Child to Child activities

Table No. 6: School Level Intervention

Topics	No	Male	Female
Policy advocacy meeting	1	14	10
Students – teacher Training, Ankvi, Kot and Meloj villages	1	19	18
Students – teacher Training , Kanesara village	1	13	12

4.1.5 Hygiene promotion & School sanitation activity

As per the base line survey, hand washing practices and water storage methods emerged as weak areas which needed to be addressed. Accordingly, health and hygiene strategies were developed, focusing around following behaviors changes.

1. Washing hands with soap, before cooking, before serving, before eating and after defecation.
2. Covering food and stored water , Use of ladles and use of tap-matka for storage.
3. Proper disposal of children (below 3-4 years) excreta and washing hands after cleaning child.

Village level workers such as Asha Workers under 'National Rural Health Mission', Anganwadi workers were involved for collective efforts. The teams coordinated with Asha Worker to spread awareness about 'health and hygiene'. Networking with Asha workers led to considerable success in dissemination and also led to direct contact with pregnant women, whose families were then sensitized towards the need of sanitation.

Women were motivated to be health guardians of their families and thus adopt hygienic habits to keep diseases at bay. Women were also trained for use of ORS during diarrhea incidence.

Child to child and child to parent communication of health messages were found to be effective tools for behavior change. The project helped primary schools to setup and run health corners on regular basis. With active participation of teachers, health and hygiene session were organized for students. Participatory methodologies such as games, story telling, essay writing and quiz competition were used to enhance understanding of students.

Stage Play for promoting change:

As a part of "Nirmal Campaign", schools in project villages were asked to present plays on health and sanitation. Students worked out scripts and also acted in play. Teachers provided able support to students in their efforts. Some themes were particularly interesting:,

a) Visit of mosquito to healthy person – Explaining causes of malaria and prevention measures.

b) Discussion among flies – Explaining dirty habits of human and their relation to diseases

c) Rejection of marriage proposal due to lack of sanitation unit

Motivated principal directs a stage play for promotion of sanitation.

Principal of Nagalpur Primary school (Junagadh) was impressed with the concept of the play. He motivated students to develop a skit on sanitation and provided necessary guidance to them. The message of the skit motivated many villagers in the village to construct toilets immediately. AKPBS, I helped students to stage the same play in near by schools for motivation of others. The group has performed in six villages and received appreciation.

Environmental Sanitation Institute (ESI), Gandhinagar has developed a mobile van named *NANDINI* for village level awareness on 'Health and Hygiene'. It has various audio –visual materials for 'Water and Sanitation' and rural development. AKPBS,I organized visit of *NANDINI* van to six villages. These villages had low coverage and showed slow progress. The *NANDINI* team organized awareness drives within the village, which comprised of role play exhibitions, songs, and video show. It was a right blend of knowledge with entertainment. Followed by this, visible improvement in village level cleanliness was witnessed.

4.1.5 Gender Participation:

EHIP adopted a two pronged approach for promoting gender equality. It involved integrating gender equality across project activities as well as designing and implementing specific initiatives that benefit women. 36% representation of women in village based organization reflects gender participation in the project.

The project has promoted good leadership within village women. One of the women from Junagadh district area deliberated on her view for 'Sustainable Sanitation' during state level workshop organized by the project.

One of the appointed women extension volunteers, Mrs. Deepikaben in Kanesara Village – Sidhpur project area was instrumental in negotiating with *'Panchayat'* and NREGA staff for availing maximum financial assistance for construction of toilets. Because of her efforts, poor communities were able to avail labour charges through NREGA scheme. She also advocated 'solid waste management' at village level.

4.1.6 Networking:

Government of Gujarat is proactively following up on the implementation of Nirmal Gram Puruskar Policy with active involvement of "District Rural Development Agencies". EHIP program played a complementary role to achieve this objective in both project districts. Field teams were invited to be part of district level evaluation teams district for screening NGP applications. Teams contributed to the screening process in their respective districts. During the closure of project,

- Water Management Project:

AKPBS,I signed an agreement with WASMO for Roof Rain Water Harvesting Project in Junagadh District. Under the agreement, 100 units of RRWHS were facilitated in EHIP project villages. Role of AKPBSI was to facilitate community driven process for demand generation and technical support during the construction. This program was initiated in March,09 and was completed by December,09.

- Prefabricated structure: for details see (Annex 1)

The organization continued to promote use of prefabricated toilet structure for construction of sanitation units. A new manufacturer of prefabricated structures was identified and trained in Patan District. As the production started, more and more villagers began to use prefabricated structures for construction of toilets and bathrooms.

The organisation also demonstrated this prefabricated structure at various public events like cultural fairs. The structure was also demonstrated at the venue of government's Block level review meetings organised by the state government and UNICEF. The manufacturers are now receiving orders from faraway states like Karnataka due to efforts made by the organisation in promoting this technology.

5 Implementation Phase:

Construction of Infrastructure :

5.1 Sanitation units:

During the year, a total of 2174 units of sanitation units were constructed against the target of yearly revised target of 3046[5] units. (Village wise details –enclosed in Annex 2) Overall target achievement is less by 30 % due to multiple reasons such as rental, Illegal land, hard rock strata and new housing programs. (annex-3 village specific reasons and village coverage) Overall project has constructed 7864 units if toilets and 7478of bathrooms.

Table No. 7: Construction of Physical Structures

District	Total Villages	Project Target	Total target -09		Achievement (Jan- December, 09)		Cumulative achievement (w.e.f 2007)	
			Toilet	Bathroom	Toilet	Bathroom	Toilet	Bathroom
Junagadh	27	4339	1600	1600	1038	983	3760	3598
Patan	23	4270	1517	1517	1186	1140	4104	3880
Total	50	8609	3117	3117	2224	2123	7864	7478

(Pl. note- Financial Reporting presents average of toilet and bathroom units)
(Pl Note- approved target as per SDTT revised proposal was 8818. However, during the implementation of program. few villages were changed, resulting in reduced targets)

Village Wise Coverage: Out of 50 villages, 24 villages have achieved 100% coverage, 18 villages within the range of 80%- 99%. 8 villages were within the range of 60%-79%. 87% of villages have achieved satisfactory target, out of remaining 13 %, 10% families are planning to construct on their own and 3% families owing to hard strata, lack of land ownership and space were not able to receive project benefits.

Table 8: % age coverage

District	100%	80-99%	<80
Patan	12	9	2
Junagadh	12	9	6
	24	18	8

[5] Cash flow for year 2009 was based on revised target

5.2 Community Based Activities:

46 community based activities were completed against the project target of 50 units. These small scale activities were found extremely useful by community. Community based water management interventions though done on very small scale, helped in providing safe water by supporting rejuvenation of defunct water systems such as hand pump, improving washing platforms. For detail community- infrastructure, refer to annex- 4

6) Commissioning and Handing Over :

By end of December,09, EHIP was handed over to respective village Swacchata committees and to the individual beneficiaries. In 8 villages, where 100% coverage could not be achieved, a dialogue with village leaders and VSC was undertaken. Organisation will continue monitoring their progress and will liaise with DRDA team for achieving the objective in one of the project areas i.e. Junagadh.

7) . Program Review and Monitoring:

Program Review Committee Meeting: 1 PRM was organized with the entire committee members in the month of May,09. Key discussions were regarding village specific coverage and issues, future plans, end term evaluation and plans for documentation. (Annex 2- minutes of the meeting)

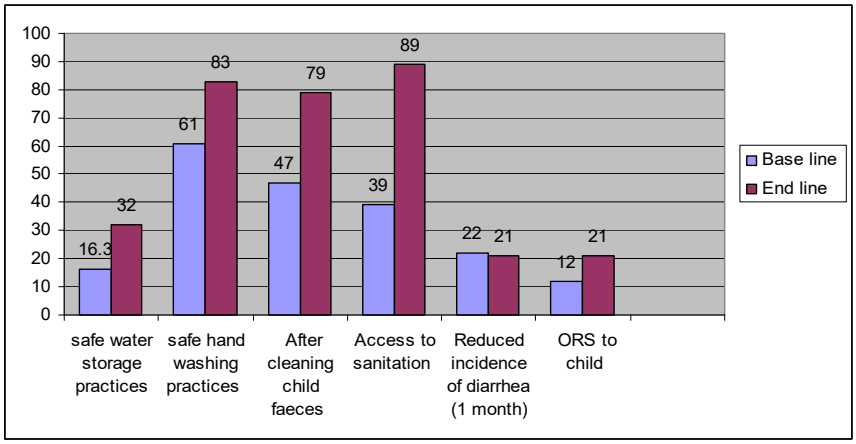
8) OVER ALL ASSESSMENT AND IMPACT

Impact of EHIP has been evaluated through three studies undertaken by external consultant i.e i) End Line Survey by CORT ii) End term evaluation by Mr. Satish Mehdiratta and iii)EHIP Program Documentation by Ms. Mamita Thakkar. Some of the key highlights of each document are reproduced as follows:

8.1 End Line Survey: It was a detailed data collection report on 10% sampling report and gives a complete scenario vis-à-vis base line survey. End line survey of the project reveals that project has been successful in developing awareness for hygiene promotion and awareness among mothers for managing diarrhoea. There is a marginal reduction by 0.5% for prevalence of diarrhoea. Following table gives overall changed scenario in project villages in 3 years:

Table No 8 :Impact assessment (Figures in %age)

Main Indicators	Base line	End line	Increase/ Decrease
safe water storage practices	16.3	32	96
safe hand washing practices	61	83	36
Hand washing after cleaning child faeces	47	79	68
Access to sanitation	39	89	128
Reduced incidence of diarrhea (1 month)	22	21	0.5
Awareness of mothers regarding ORS to child in case of diarrhea	12	21	75



8.2 End Term Evaluation has documented following achievements:

- 20 EHIP Villages awarded Nirmal Gram Puraskar and 11 more villages expected by 2010.

- Privacy, safety, security, convenience and dignity of women has been increased due to the provision of household toilets and bathrooms. Visibility and credibility of AKPBS,India and AKF,India has been enhanced at the Gram Panchayat, Taluka, district and state levels. Women are articulating about their own problems and accomplishments related to water and environmental sanitation. Men are also advocating for the household toilets and bathrooms for the dignity of women.

- Village based water management interventions though done on very small scale, helped in providing safe water to the communities.
- Linkage of the project with the Government has strengthened especially DRDA,TSC cells and WASMO are strong.
- Trained local masons are available for building toilets for TSC in their own villages as well as neighbouring villages.
- Low Cost Pre-cast (LCP)RCC toilet developed and tried out successfully though on a small scale in some of the project villages .The cost of LCP RCC toilet is Rs 2800/= as compare to Rs 7675/= of conventional toilet constructed from lime stones.
- Information, Education and Communication material on environmental sanitation such as pamphlets, brochures, comics, posters etc developed and utilized for creating awareness and generating demand for toilets and bathrooms in the project villages could be utilized under TSC.

8.3 EHIP Documentation:

1. The achievements of project targets in a relatively narrow time frame have been demonstrated in EHIP. This success can be attributed to, besides other factors:

    - Definition of clear and focused objectives and planning timelines

- Constant monitoring, assessment, and reassertion of planning targets
- Professional and knowledgeable local staff committed to programme outputs.

2 One of the lessons learned from the beneficiary perspective was that household visits, including a one-on-one interaction, appeared to be the most effective instruments in delivering and reinforcing messages conveyed, through other modalities, such as informal talks aimed at knowledge transfer. The household visits allowed for a "personalization" of the hygiene messages and reinforcement of key positive behaviors according to the circumstances of each individual or family.

3 The EHIP implementation also has build institutional capacity of AKPBS,I to manage and implement large project without compromising on community participation and quality of construction.

4 EHIP implementation has yielded following impacts at the village levels.

- Community awareness about collective cleanliness within the project villages, which culminated in voluntary ban on open defecation. The project is more becoming demand driven and the organization is facilitating implementation.

- Timely payments of incentives resulted in building image of the organization. Now villagers are also pressing for similar actions from Panchayats and government schemes.

- The concept of EV has worked satisfactory at village level. Some of the EVs are now sanitation champions of the village and also extend their services to nearby villages.

- The needs of women, children and other disadvantaged groups are recognized at village level and are addressed appropriately.

- The primary observation indicates about the reduction of medical expenditure within the project villages as per discussions by Panchayat members.

9 Problems faced, action taken and challenges:

- Sanitation Coverage: With ever changing situation at the village level, 100% sanitation coverage had been a critical challenge due out-migration/in-migration, splitting of joint families.

- User friendly appropriate technology for hard strata was not worked out. Though project demonstrated eco friendly ECO-SAN unit which is ideal for hard strata. However, due to non acceptance from community, this technological option was not propagated.

- Project was unable to find a doable solution for rental/ illegal land holding / hard rock strata. Though there are certain cases where such families were recipient of sanitation unit in coordination with village Panchayat.

Barriers to achieving 100% sanitation coverage

- The barriers to achieving 100% sanitation in villages can be distinguished into two types. The first type includes generic factors which are applicable at large and the second type are factors that are localized and involve members of a particular group or community. Some of these barriers are described below
- Political instability and rivalry in the village is one of the main barriers to sanitation coverage. For example in village Samoda in Patan district, sanitation coverage has been extremely slow mainly due to political infighting and has till date achieved only 51% sanitation coverage. In village Rajesar in Junagadh district also took a long time of more than 30 months to achieve 80% sanitation coverage.

Local barriers

Local barriers are issues unique to individual or a few villages. Some of these issues are mentioned below

- Unavailability of land/space within own premise, as in the case of Samoda and Chandesar village in Patan.
- Households on illegal land as in the case of Akwin in Patan District
- Perception of water contamination due to pit latrine as in the case of Maghavada village in Junagad district
- Nomadic communities , which do not feel the need for sanitation
- Temples in front of house as in the case of Patni Community inhibit the construction of a sanitation unit in the same space.
- Hard strata of land making it difficult to dig the sanitation pit
- In some cases some households want to reconstruct their houses, so they plan to build the toilet and bathroom during the reconstruction process

10 : Financial Summary:

Total budget under SDTT for 2009 was Rs. **152.56/-** lacs of which Rs. **106.86/-** lacs has been utilized (70%). Community contribution is in line with the expected i.e. 82.46 % contribution toward of the total construction cost.

Budget and expenditure -2009

Line items	Budget	Actual	%age utilization
Construction Cost (SDTT)	**8,967,750**	**6,205,941**	**69.2**
Personnel and Consultants	**4,004,331**	**2,986,928**	**74.6**
Capacity Building	**255,000**	**160,096**	**62.8**
Documentation & Communication	**1,290,000**	**661,478**	**51.3**
Programme Operating Cost	**739,236**	**672,399**	**91.0**
Total Project Cost (SDTT)	**15,256,317**	**10,686,842**	**70.0**

Community Contribution	**25,759,250**	**17,794,793**	**69.1**
Total	**41,015,567**	**28,481,635**	**69.4**

Variance Explanation :

1. Construction of sanitation units: overall sanitation coverage in EHIP project villages was 89%. Therefore, balance 11% sanitation target has contributed for underutilization upto 30%.
2. Personnel and Consultant Cost: As per the organizational policy, annual staff increments were at the rate of 4% instead of projected 10%, leading to 7% variance. Also, Area Manager's position at Sidhpur remained vacant for 4 months.

3. Capacity Building: staff training was arranged at very reasonable cost at Uttranchal Academy. This training institute arranges free boarding and lodging and organisation has to bear only the travel cost.

4. Program Operating Cost: Negligible variance of 9%.

Consolidated Financial Summary:

Overall project cost of EHIP for 3 years starting from January, 07-December,09 was Rs. Rs.1069.05 lacs which include Rs.662.21 lacs from community and Rs. 406.84 lacs from SDTT. Community contribution was mainly towards construction component. Project has utilized 79% of SDTT funding and mobilized community contribution upto 61% for overall project cost. Consolidated report attached as annex.-5