[MUSIC PLAYING] ROHAN SANDHU: Welcome back to The Harvard Center for International Development's weekly speaker series podcast. My name is Rohan Sandhu, and I am a CID student ambassador. This week we are joined by Diane Coffey, assistant professor of sociology and population research at the University of Texas at Austin. She is also the co-director of r.i.c.e-- a Research Institute for Compassionate Economics-- discussing why child health remains an enduring challenge for the Indian population.

Today I'm sitting down with Diane after her appearance in the CID speaker series at the Harvard Kennedy School on October 4th, 2019. Diane, thank you for being with us today. Before we dive into the content of your research, tell us why and how you got interested in India and on issues concerning health and sanitation.

DIANE COFFEY: Sure. Thanks so much for having me. So I first went to India in 2005 as a college student and I just kept wanting to go back. It's a place where there's a ton of diversity, there's a ton to learn. And so I kept finding excuses to go back and eventually got together with a really fantastic team of both Indian Americans and Indian citizens who are all interested.

We really came together around questions of health in India, and I think one question that's really motivated us is why Indian children are less healthy than you might expect them to be based on India's economic progress. And that led us down roads looking at sanitation and down roads looking at maternal nutrition, increasingly also at air quality and social inequality.

ROHAN SANDHU: Mm-hmm. So let's dive into your research. And, you know, one of the things you mentioned is India's growth versus its inequalities in health. A lot has been said about how India's growth has actually translated into massive reductions in poverty over the last three decades, but why do you think this has failed to improve health indicators, especially for children?

DIANE COFFEY: Yeah, no, that's a great question. There have been really important reductions in poverty in India even in the last decade, too. And it's not that health hasn't improved. There have been really important improvements in health. It's just that some of the indicators are not improving as quickly as we might expect. And so I think there are a few things going on, but they're tied together by the theme of social inequality.

So if you have a situation where you need maternal health to be at a certain level before children are going to survive, you know, even if a family gets richer they may not invest it in the woman's pregnancy, they may invest it in other things that make their lives better.

Or if we think about the issue of sanitation, you know, people may be now in a situation where they could afford a 5,000 or a 10,000 rupee latrine, but because the forces of caste and untouchability make that a less attractive option than it is in other countries that use these sorts of affordable latrines, people wait until they have 40,000 or 50,000 rupees to spend on a latrine before they invest. So that's just a couple of ways that we see social inequality getting in the way of

translating economic progress into health progress.

ROHAN SANDHU: Mm-hmm. And given the situation, where do you think policy can actually help? Because I mean, you know, we've seen newer interventions in India recently focusing on insurance or focusing on conditional cash transfers. But clearly that only addresses a part of the problem if that. So what is the most important aspect of this problem actually that policy can help address?

DIANE COFFEY: That's a really great question. You know, you point out that many of the health policies that exist are about getting people to access the facilities in various ways, whether that's a cash transfer to encourage them to go or health insurance that's meant to, you know, reduce the costs that people need to pay when they're there.

But if we think of health problems as not just something that can be solved by a clinic but by something that can be solved by cleaning up the environment and by investing in women's nutrition, then we realize that there needs to be a whole other set of health policies that are outside of health clinics and hospitals.

ROHAN SANDHU: Mm-hmm. Let's dive a little deeper into what's happening in Uttar Pradesh and Bihar, which are two states that you talked about today as being the worst outliers as far as progress in India was concerned. Maybe pick one of those states and tell us, you know, the two or three things that are happening there that concerned you specifically with this problem.

DIANE COFFEY: Yeah, so an issue that I've thought quite a bit about and worked on quite a bit is that of neonatal mortality in Uttar Pradesh in particular. So this is the fraction of babies who are born alive who die in the first month of life. And as we saw earlier, that neonatal deaths are often caused by either lack of care at birth or by poor health during pregnancy.

And Uttar Pradesh is a state where both of those are relatively big problems. A large fraction of women-- around 30%-- are underweight before they begin pregnancy, and they're not gaining enough weight in order to have babies that are born large enough to have healthy childhoods.

And then on the side of hospital care at birth we see both public and private facilities not providing a great quality of care. There's often problems of abuse of patients, poor hygiene in hospitals. And we really need those hospital experiences to be much better in order to, in some sense, make up for the poor health in pregnancy.

ROHAN SANDHU: Mm-hmm. So I want to also shed some light on some of the good findings you found. We were just talking about how there actually might be some good news in terms of the survival of baby boys versus baby girls in India. Tell us a little more. What are your latest findings on this front?

DIANE COFFEY: Great, yeah. So the National Family Health Survey is India's demographic and health survey, and it was last done in 2015. And so there have been three prior demographic and health surveys starting in 1992. And in each of those three prior surveys, under five

mortality was higher for girls than it was for boys.

And this is something that's a bit surprising because in other developing countries boys actually have higher mortality rates than girls because girls are more biologically robust. And so the fact that we were seeing girls having higher mortality rates than boys is indicative of severe discrimination against girls and neglect, not feeding them as much, not taking them to the hospital when they're sick.

So the 2015 data was the first time that we saw equal mortality rates for girls and boys. Now, this is still indicative of discrimination against girl children because their mortality rates should be lower, but it's certainly indicative of important progress on this front.

ROHAN SANDHU: Mm-hmm. Speaking of progress, we've also seen some improvements in states such as Madhya Pradesh, Chhattishgarh, Maharashtra, West Bengal. I know we don't have conclusive answers on this, but for other researchers potentially listening in, are there some hypotheses you're working with that maybe others can also help find answers to?

DIANE COFFEY: Yes, definitely. You know, I always encourage folks to go out and do field work and have a conversation between the big data sets and what's going on the ground. So let what's going on the ground inspire you to look for something in the data, and let a puzzle in the data inspire your field work.

But one thing that I think might be useful to understand in Madhya Pradesh, Chhattishgarh in particular is why it at least seems to be the case that being born in a hospital is protective against neonatal death. So what are the folks in hospitals there doing that folks in hospitals in Uttar Pradesh and Bihar might not be.

ROHAN SANDHU: So you're saying that the supply side of hospitals in these states might be better than UP and Bihar?

DIANE COFFEY: It seems like it may be. At least we see an association there between being born in a hospital and surviving the first month of life. Those babies that are born in hospitals in those two states are more likely to survive than babies that are born at home. So it's at least suggestive that hospitals are doing something good.

ROHAN SANDHU: Mm-hmm. I do want to make a transition a little to your research methodologies and also how do you see the field of economic research more generally.

DIANE COFFEY: Sure.

ROHAN SANDHU: A lot of your research has, you know, been about the variety of linkages between a range of stubborn social issues. Your paper written with Melissa Lopalo and Dean Spears, for instance, is about an association between the health of children, casteism, rural open defecation, and so on. Tell us a little bit more about the complexities of conducting research on such profoundly interlinked themes, and also walk us through how your own assumptions as a researcher and your own methodologies that you employ have changed over

these years.

DIANE COFFEY: That's a great question. I love to talk research methods. So I think that part of the strength that we have as a team at r.i.c.e-- Research Institute for Compassionate Economics-- is that we have people from lots of different backgrounds across the social sciences. So people who are really skilled at collecting survey data, people who are skilled at analyzing large data sets with causal identification strategies, others who are excellent at doing face-to-face interviews. Many of us have also spent months on end just observing what happens in villages.

And so when you sort of put all of these methodologies towards a question like why do people in India continue to defecate in the open when they can afford a latrine, you're able to get at an answer that's really a broad answer and a broader understanding than you could get if you just picked one of these methods and pursued it that way.

ROHAN SANDHU: Mm-hmm. And also a lot of these concern, you know, some very culturally sensitive areas. How do you keep this in mind whilst conducting such research while surveying such people, and how does this align with what you are trying to do with r.i.c.e?

DIANE COFFEY: Great, great. So I'll start by talking about, you know, what sort of sensitivities one needs when actually collecting data. So in a lot of our work we've asked people about their defecation practices, whether they use a latrine or whether they don't. And so very often we'll have surveyor, maybe an upper caste person from an urban area, asking this question.

And so the person needs to be trained and sensitized that, you know, you don't go wearing your rings, you may not give your last name when you introduce yourself to the person you're to be interviewing-- all things to try to decrease the social distance between the person who's asking the question and the person who's answering it. So that's one thing about collecting data.

And then I think as a team when we think about the advocacy that we're doing and what sorts of sensitivities do we want to bring to that, one thing that we've noticed over the years is that there are many Dalit scholars and activists who have been talking about issues around sanitation and finding the same sorts of things that we're finding for many years. And due to structural issues in academia, often their voices are not heard very loudly, and so part of what we try to do is amplify those voices as much as possible.

ROHAN SANDHU: Mm-hmm. I know you're trained in policy. What are some of the biggest challenges you've faced in translating some of this complex research into policy prescriptions? And also what are the challenges you've found in thinking from a policy lens but then, you know, finding these complex issues of not being able to translate that thinking from a policy lens into that.

DIANE COFFEY: That's a really great question. So I think that we should wear multiple hats. As social scientists, we should try to understand issues deeply and broadly. As folks who are interested in policy, it's helpful to understand the issues, but often you have feasibility

constraints.

What is it that a government could do or an organization could do in this situation? And often the policy prescription is about making something a little bit better than it otherwise is. And you're not going to solve everything with one particular policy, but you're saying, is this going to be an improvement?

ROHAN SANDHU: In your book, Where India Goes, you talk about open defecation being the consequence of the caste system, untouchability, ritual purity, and so on. Tell us a little more about these intersections. Help unpack, you know, what this means for policy making and whether you think the Swacch Bharat Mission has been able to consider these profound issues while designing these interventions.

DIANE COFFEY: So I was surprised, like many people were, when the prime minister stood at the Red Fort and announced that sanitation and increasing latrine use was going to be a policy priority of the administration. And I think that there's much to applaud about a central government in India saying, we really need to focus on this issue of sanitation.

Unfortunately, it's really tough to work on sanitation in India. So what we were showing in the book is that unlike most of the rest of the developing world where people can build a socially acceptable latrine for, say, 5,000 rupees, that turns out to be not an acceptable option to many rural Indians.

So the way that rural sanitation technology works is it's on site, you would dig a hole, line it either with rings or with bricks, defecate in the hole, and eventually it will fill up. And so that pit will need to be emptied. And in places that don't have a history of manual scavenging and untouchability, it's relatively straightforward to send for somebody to either do this to him or herself or hire another person to do it.

Ideally the pit would be allowed to decompose so that the faeces were less dangerous to interact with. Often, both in India and in other countries, they're not. But nevertheless, it does provide health benefits that people are using latrines in the first place.

Unfortunately in rural India, people associate that act of emptying a latrine pit with manual scavenging and the worst forms of social exclusion for Dalits. And so the sorts of affordable latrines that the Swacch Bharat Mission was looking to pay for and that are often built through contractors are not socially acceptable to people. They want to build expensive latrines with these large underground tanks that either never have to be emptied or can be emptied by a machine.

So the Swacch Bharat Mission, it had a really, really big challenge. So I'm lucky enough to be part of a team that did longitudinal survey, meaning it revisited households in 2014 and 2018 really right over the period that Swacch Bharat was operating. And so we were able to see pre-SBM that about 70% of folks in the four states that we were studying-- Madhya Pradesh, Rajasthan, Bihar, and Uttar Pradesh-- defecated in the open.

By 2018 there were big impacts of the SBM. That 70% had been reduced to about 45%. This was much faster than open defecation had been reduced in the past. This was mostly driven by latrine construction. So latrine ownership increased from a little bit less than 40% to about 70%.

One interesting thing that we found was that there was not a change in the percent of people who defecate in the open if they had a latrine. So amongst latrine owners, open defecation was about 25% both in 2014 and in 2018. I'm hopeful that there will be another post-SBM sanitation policy to address the remaining open defecation. I'm concerned that the fact that many local officials have used coercion and threatened people's public benefits in order to facilitate latrine construction may have adverse consequences for future sanitation policies.

ROHAN SANDHU: A question across all of your research-- what are the big differences you see between the interplay of these different social and cultural factors between rural India and urban India? Is that a difference? Are there similarities?

DIANE COFFEY: There are both differences and similarities. That's right. So I'm lucky enough to be a part of a group of researchers that does a mobile phone survey about discrimination and social inequality. We try to measure prejudices-- gender prejudice, caste prejudice, also anti-Muslim sentiment. And we do see relatively big differences on some questions between rural and urban India where rural India tends to be more conservative. But there are also large state variations.

ROHAN SANDHU: Mm-hmm. Finally, what are your current research priorities, and what are the next steps you and your team is undertaking in terms of advancing the calls of compassionate economics, as you call it?

DIANE COFFEY: Thanks. So just because we were talking about it on the last question I'll talk a little bit more about where we're hoping to go with our mobile phone survey. So this survey, which we called SARI-- Social Attitudes Research India-- it's a partnership between r.i.c.e and my colleague Amit Thorat, who is at JNU, a university in Dehli. And so there what we're trying to do is measure social attitudes over time, and we're hoping that casteism, sexism, patriarchy, we'll see these things declining.

And we're also considering the idea of having other researchers contribute to the survey. So if there's something that you're interested in and you want a representative sample of adults and it has to do with social inequality, please consider taking a look at our website, riceinstitute.org. The data tab has all of the data sets from SARI and the longitudinal study on sanitation that I was telling you about free for download. And if you get in touch, you know, we may just be able to put a question on a future survey.

ROHAN SANDHU: Great. Thank you, Diane. As Diane said, you can find more information about her work at UT Austin and r.i.c.e at riceinstitute.org. And to learn more about CID's research events and upcoming speaker series seminars, visit us at CID.Harvard.edu. Thank you for listening in, and we'll see you back next week.

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