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# **Towards Total Sanitation and Hygiene: A challenge for India**

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**Government of India**

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## Abbreviations and Acronyms

CCDU	Communication and Capacity Development Units
CRSP	Centrally Sponsored Rural Sanitation Programme
DALY	Disability Adjusted Life Years
DPEP	District Primary Education Programme
GDP	Gross Domestic Product
GoI	Government of India
HRD	Human Resource Development
IEC	Information, Education, and Communication
IMR	Infant Mortality Rate
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
NCAER	National Council for Applied Economic Research
NDC	National Development Council
NFHS	National Family Health Survey
NGO	Non-governmental Organisation
NSS	National Sample Survey
PC	Production Centre
RGNDWM	Rajiv Gandhi National Drinking Water Mission
RSM	Rural Sanitary Mart
SHG	Self-help Group
SSA	Sarva Siksha Abhiyan
TSC	Total Sanitation Campaign
UN	United Nations
UNICEF	United Nations Children's Fund

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# Introduction

## Overview

This paper is broadly divided into three sections. An introduction briefly outlines the importance of sanitation, and provides a summary of the sanitation situation in India. The second section traces the evolution of India's sanitation program and policy reforms initiated in the rural sanitation sector. It also outlines some of the steps that have been taken for implementation of the programme and the lessons learnt. This section also outlines what is being done to counter the problems arising from inadequate coverage, both in terms of the processes and strategies by which the Government of India (GoI) plans to address them. The third and final section outlines a future Plan of Action as envisaged by the GoI.

## Why sanitation and hygiene?

A direct relationship exists between water, sanitation, health, nutrition, and human well-being. Consumption of contaminated drinking water, improper disposal of human excreta, lack of personal and food hygiene, and improper disposal of solid and liquid waste have been the major causes of many diseases in developing countries like India. Persisting high infant mortality rate (IMR, national average -- 69) and high levels of malnutrition (national average 41 percent) are also attributed to poor sanitation. Increasingly, sanitation is being seen as a major issue in environmental protection.

Lack of or inadequate sanitation impacts on the local economy, productive and school days lost due to sickness, the overall quality of life for those living in the vicinity including the general aesthetics and tourism. The economic effect on tourism assumes special dimensions in the case of India, with its immense size, pluralistic diversity and almost limitless tourism potential – a vastly improved sanitation scenario implies vastly improved tourist volumes and tourism revenue inflows, robust contribution to increase in employment and opportunities for the private entrepreneurship in the service sector

Historically, sanitation was a part of town planning even as far back as 3000 BC. Well laid out drainage and street system during Indus Valley Civilisation, Harrapa and Mohenjodaro excavation which became diluted over the ages and by the 20<sup>th</sup> century; disposal of human and animal excreta was left to nature in rural areas. In urban areas,

sanitation was earlier limited to disposal of human excreta by cesspools, open ditches, pit latrines, bucket system etc., including the dehumanising practice of removal of 'nightsoil' by humans hands. Today it connotes a comprehensive concept, the lack of which impedes human development. More importantly, young children bear a huge part of

*“Why should our cities and villages be unclean and unhygienic? Can this not be changed visibly by changing the habits and mindset of each one of us? Shouldn't citizens themselves initiate a drive for water conservation, energy conservation, and conservation of our precious cultural heritage?”*

-- Atal Behari Vajpayee

the burden of disease resulting from the lack of hygiene. India, for example, still loses between 0.4 to 0.5 million children below five years of age due to diarrhoea annually – a colossal avoidable loss of young lives.

## Where do we currently stand?

Coverage performance at the rural levels has until recently been slow, growing at approximately one percent annually over the last decade. This has been due to a multiplicity of factors including low awareness of the potential health benefits (and therefore, economic benefits) of better hygiene practices, perception of the costs of having a household toilet as being very high and in most cases unaffordable, the sheer convenience (at least for men) of open defecation (vis-à-vis an enclosed space), and inadequate promotion of awareness.

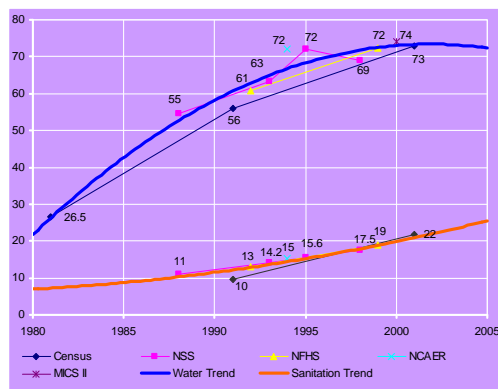
Even where toilets were in use, generally only women used them regularly. Men-folk and children continued with open defecation. The aspect of preventive health and environmental pollution were never perceived as social issues of importance and an agenda to be addressed by the local government. Highlighting the health hazards of open defecation continued to be the main plank of communication and Information, Education and Communication (IEC). As it is difficult to demonstrate health benefits in the short run, it is important that the various other advantages of having a toilet are equally emphasized; safety and dignity of women; safety and security of children; prestige of family; reducing pollution in the community; national pride etc. This has not

been the primary focus of communication. Efforts to reach information to community leaders and families, offering design and price options, ready access to subsidy as support to those below the poverty line, access to institutional finances, loans, and trained masons remained unorganized and intermittent, with no specific strategy or institutional mechanism to provide systematic support services.

The sanitation coverage in terms of individual household latrines during the 9<sup>th</sup> Five Year Plan (1997-2001) was 16-20 percent of total rural households. The National Sample Survey (NSS), 54th Round Report published in July 1999 (Drinking Water, Sanitation and Hygiene in India) indicated that 17.5 percent of the rural population were using toilets. By the end of the 9<sup>th</sup> Plan, household data from the 2001 Census showed that 22 percent of rural household use sanitary facilities.

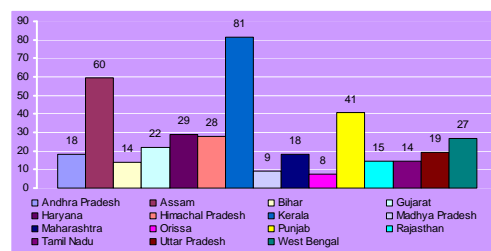
At the same time, growth in rural sanitation coverage has not been keeping pace with that of rural drinking water (see figure 1). This is attributed largely to the fact that until recently in India, as elsewhere, focus had been more on providing infrastructure for drinking water (for which there is a natural demand) rather than on sanitation.

**Figure 1: Trends in rural water supply and sanitation usage**



Disparities across states exist. An analysis of rural home toilet use based on household data from the 2001 Census for major Indian states shows the level of disparity (see figure 2 below). Figures range from as high as 81 percent in Kerala and 60 percent in Assam to as low as nine percent in Madhya Pradesh and eight percent in Orissa.

**Figure 2: Interstate disparities in rural home toilet use**



The question of redressing inequities in sanitation has been at the forefront of policy makers and various mechanisms of targeting subsidies have been devised. It has been observed that the landless and marginal continue to be left without toilets.

Some factors that have stood in the way of effective implementation of a rural sanitation programme include very low priority accorded to sanitation as a social and community issue. Inadequate emphasis on IEC and lack of infrastructure and systems to reach all rural households, inclination to promote a single model i.e., twin-pit pour-flush toilets (which are costly and therefore out of reach of many rural households), heavy reliance on subsidy, lack of motivation among implementers, technology support inconsistent with needs, insufficient involvement of NGOs and CBOs and the private sector, and importantly, scarcity of water.

The Total Sanitation Campaign (TSC) launched in 1999, as a component of the sector reforms process, has helped overcome some of these obstacles. Of the 138.2 million rural households in India, (2001) nearly 3.5 million have constructed household toilets with support from the TSC. Of these, nearly 2 million have been constructed in 2002-2003, reaching five percent of poor rural households. Likewise, over 1,700 women's complexes, 41,000 school toilets have been built, apart from other support facilities such as rural sanitary marts (RSMs), at a total cost of just over Rs. 2.92 billion (approximately US \$ 62 million). The financial break-up below reflects the pattern of sharing resources. Significantly, the community has invested US\$ 11 million so far.

The total financial outlay under the TSC is Rs. 33,780 million (over US \$ 718 million) as follows:

**Table 1: Financial Outlay for TSC**

Share	Rs. Millions	US\$ Millions
Central	20,190.00	429.57
State	7,380.00	157.02
Community	6,210.00	132.13

Total	33,780.00	718.72
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**Table 2: Expenditure on the TSC (up to 30<sup>th</sup> September 2003)**

Share	Rs. Millions	US\$ Millions
Central	1,746.00	37.15
State	651.00	13.85
Community	517.00	10.21
Total	2,915.00	11.00

## Evolution of India's sanitation programme

India's 10<sup>th</sup> Five Year Plan was formally approved and adopted by the National Development Council (NDC) on 21st December 2002. The NDC endorsed the ambitious growth target of eight percent on an average per year, for the economy as a whole. Notably the 10<sup>th</sup> Plan recognizes that economic growth is not the only objective of national planning and therefore over the years development objectives have been defined not just in terms of increases in gross domestic product (GDP) or per capita income but on a broader base including the enhancement of human well-being. Thus among the fourteen objectives of the 10<sup>th</sup> Plan, the role of sanitation and hygiene are intrinsically linked to the objectives of reducing IMR; Maternal Mortality Ratio (MMR); ensuring completion of five years of schooling for all children by 2007; providing potable drinking water in all villages; cleaning of major polluted river stretches and although indirectly yet significantly to providing "shelter for all" by the end of the 10<sup>th</sup> Plan.

Water supply and sanitation were added to the national agenda during the country's first five-year plan (1951-56). In 1954, when the first national water supply programme was launched as part of the government's health plan, sanitation was mentioned as a part of the section on water supply. It was only in the early eighties with the thrust of the International Water and Sanitation Decade that the GoI started fostering alliances with the United Nations (UN) and other external support agencies to focus on improving sanitation in the country. This effort crystallized into India's first nationwide programme for sanitation, the Central Rural Sanitation Programme (CRSP) in 1986 in the Ministry of Rural Development.

## Low priority

Sanitation was never perceived as a priority especially in rural areas where open space is readily available until today albeit the growth of population and urbanization. Nor was it seen as a development programme – more often relegated to lower levels in the priority ladder and left unmonitored. The CRSP, which hinged on substantial subsidy as a means for "creating demand" for household toilets was soon found to be strategically weak; constructing toilets was a dynamics of need, an understanding of its importance, financial capability and availability of hardware and skilled masons. Of the sanitary pour-flush toilets constructed in the decade of the eighties and nineties, less than fifty percent were found to be used. Studies further showed that factors other than subsidy had far greater appeal; this was later borne out in United Nations Children's Fund (UNICEF) assisted integrated water and sanitation projects.

## The Water and Sanitation Decade – a good beginning

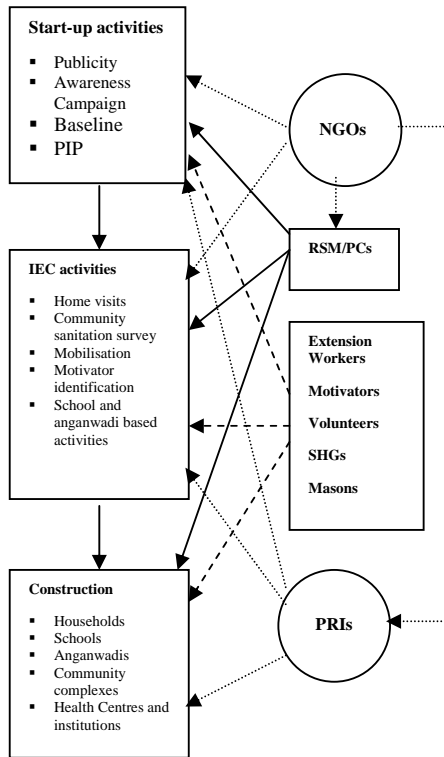
At the launch of the International Drinking Water and Sanitation Decade in 1981, an attempt to estimate the coverage of sanitation, pegged the coverage (by individual sanitary household latrines) at an astoundingly low of 1 and 27 percent for rural and urban India respectively. Since then a variety of surveys (census, NSS, and demographic surveys) have tried to capture the coverage situation leading to some apprehensions with regard to consistency in progression. The most recently available data from the 2001 census suggest 22 percent of rural households in India have toilets (see figure 1 above). The figures continue to be alarming in that it underscores the fact that 78 percent of rural households continue to contribute to the hazards of open defecation and transmission of disease. The more alarming realization is that approximately 24 percent urban households living in big cities and small towns either have no access or choose to pollute the environment and make it more conducive for the spread of communicable diseases including polio that has been long targeted for eradication.

## Policy reforms

With the emergence of the above findings and the realisation that high subsidies were not promoting uptake of sanitation facilities, the TSC was launched in April 1999, with advocating shift from a high subsidy to a low subsidy regime, advocating a greater

household involvement and demand responsiveness, and providing for the promotion of a range of toilet options to promote increased affordability.

**Figure 3: TSC delivery structure**



It also included strong emphasis on IEC and social marketing, providing for stronger back up systems such as trained masons and building materials through rural sanitary marts and production centres and including a thrust on school sanitation as an entry point for encouraging wider acceptance of sanitation by rural masses as key strategies.

GoI's reforms in sanitation along with water supply thus started to gain in strength from middle of 1999 onwards. While the low subsidy policy met with initial resistance, gradually, there is growing acceptance among implementers and local communities.

The main objectives of the TSC are:

- Bring about an improvement in the general quality of life in rural areas
- Accelerate sanitation coverage
- Generate demand through awareness and health education
- Cover all schools and Anganwadis in rural areas with sanitation facilities and

promote hygiene behaviour among students and teachers

- Encourage cost effective and appropriate technology development and application
- Endeavour to reduce water and sanitation related diseases.

### Communication for behaviour change

Another aspect of both management and structural reforms has been reorganization of support structures at the state level to provide support and integrate field experiences into strategy reforms. While separate human resource development (HRD) and IEC cells had been set-up in the mid-nineties in various states, these were not very effective, and there was a felt need for an integrated agency at state level that could combine these functions and had the ability to source sector expertise from the market. As a result, Communication and Capacity Development Units (CCDUs) are being set up in state nodal departments to provide specialist inputs into HRD, communication planning and monitoring of progress.

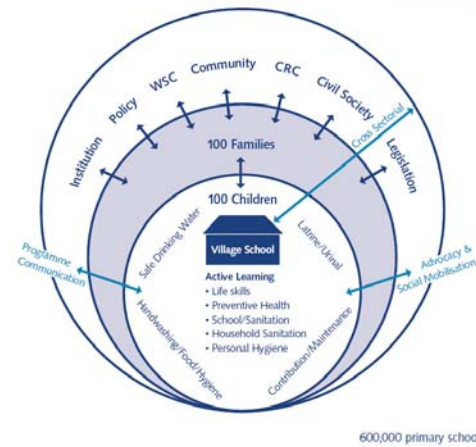
It is envisaged that under TSC, state units with professional and technical expertise will become functional by middle of 2004. Successful development communication or IEC for sanitation and hygiene requires a tested and proven delivery mechanism, which can ensure contacts with households on a regular basis. Behaviours often have to be negotiated with families and individuals agreeing to comply with those they choose to be 'doable'. This requires the presence of motivators, mobilizers, or hygiene educators who reside in those communities. Respected individuals with credibility setting examples have proven to be good motivators; young women and men with ability to establish good rapport have been successful communicators in India's Guinea worm Eradication effort. A vast network of such communicators, with tools for interpersonal and group communication and creative methods need to be supported by block, district and state units that respond with matching supply inputs i.e. household toilet hardware, waste disposal designs and hardware, trained masons, school and anganwadi toilet arrangements, baseline and repeat surveys, microplanning and monitoring, holding of workshops and public meetings. The TSC has outlay provisions of Rs. 12.5 million (approximately US\$ 266,000) for each district towards IEC.

## Low to no subsidy

One of the key aspects of the reform agenda was reduction of central and state subsidy levels from as high as Rs. 2000 (around US\$ 42) to household toilets to Rs. 500 (around US\$ 10.5) for rural households below the poverty line and zero subsidies for those above the poverty line. Even among the poor the subsidy was reduced for people opting for high cost technology options. This met with initial scepticism and resistance from many but over a period of time the rationale has been realised by majority of states and country is fast moving in this direction.

## School Sanitation and Hygiene Education (SSHE)

The TSC has progressed further with the realization that to sustain change, young minds need to be influenced in the formative years. Further, if the national goals have to be realized then there is a need for meaningful intersectoral coordination; therefore addressing the young and most vulnerable has become significantly a key objective of the national sanitation strategy. The GoI through its



the Rural Development and Education Departments of GoI.

**Figure 4: The SSHE Framework**

The TSC (currently covering 350 of India's 594 districts) aims to cover all primary and upper primary schools with safe water, child-friendly toilets, and hygiene education that empower children to lead healthy lives and has a potential for a deeper generational change. Additionally, TSC will attempt to cover village based early childhood development centres for under five children known as anganwadi centres also with safe water and baby-friendly toilets.

## Rural Sanitary Marts/Production

### School Sanitation – The Mysore Experience

The novel idea of a special sanitation programme for schools, under the support of UNICEF, began in Mysore district in 1992, with 20 schools. The SSHE Project continued to grow and today covers 1474 schools in Mysore, Tumkur, Chitradurga, Mandya, Raichur, Bangalore (U), and Bangalore (R) districts.

The strategic focus of the project was to combine technology with human resource development and develop a sustainable approach that had children's participation at the core. Emphasis was placed on transformation that brought a visible change, thereby enthusing and galvanizing children, teachers, parents, communities, and local authorities into further action. Also central to the project was the development of quality standards that would enable sustained replication and the build-up of enduring infrastructure.

## Centres

The recognition of the need to not just generate demand for sanitation, but to also have in place supply chain mechanisms that could cater to the increased demand by providing the necessary hardware and ancillary services was

### School Sanitation -- Estimate of nationwide backlog:

- 345,000 primary & upper primary schools without drinking water facilities
- 573,000 primary & upper primary schools without toilet facilities

### Plans for covering by end of 10<sup>th</sup> Plan:

#### Coverage through Department of Elementary Education resources:

- Drinking Water: 120,000 schools
- Toilets: 220,000 schools

#### Coverage through Department of Drinking Water Supply resources:

- Drinking Water: 225,000 schools
- Toilets: 353,000 schools

Source: RGNDWM notifications and circulars

Ministry of Human Resource Development is implementing the DPEP and Sarva Siksha Abhiyan (SSA) aiming at universalization of primary education. The government has been striving to achieve the objective of providing safe drinking water, sanitation and hygiene facilities in schools but until today, huge gaps and disparities exist (see box above). Safe water and sanitation for India's 638,738 primary schools is now a priority within both



essential. Thus, TSC funding also provides for setting up and operation of RSMs and PCs at sub-district level for fabricating sanitary hardware components to feed the growing demand for construction. NGOs with suitable experience or panchayats are eligible for funding.

The RSM is typically a retail outlet that produces and/or sells hardware for sanitation and drinking water and related components for maintenance. Pans and traps, pit lining rings, etc are locally manufactured in PCs. Long handled ladles for drinking water pots, brooms, and brushes and other items related to sanitation and personal hygiene are also sold.

In areas with arsenic or fluoride problems, the more enterprising RSMs also sell drinking water purification filters for domestic use in varying price ranges. One RSM typically covers about 25,000 families. The annual sales of successful RSMs is around 1500 pans annually as for instance in West Bengal. Monitoring sales of RSMs is a good proxy indicator of the level of real demand.

### Incentives and awards – *Nirmal Gram Puraskar*

To add vigour to the TSC, in June 2003, GoI initiated an incentive scheme for fully sanitised and open defecation free Gram Panchayats, Blocks, and Districts called the 'Nirmal Gram Puraskar'. Eligible Gram Panchayats, Blocks, and Districts will be those that achieve (a) 100% sanitation coverage of individual households, (b) 100% school sanitation coverage, (c) free from open defecation and (d) clean environment maintenance.

Also eligible for the award will be individuals and organisations, which have been the driving force for effecting full sanitation coverage in their respective geographical areas. The incentive pattern will be based on population criteria and will be as follows:

**Table 3: Incentive pattern under Nirmal Gram Puraskar (in Rs. lakh)**

Particulars	Gram Panchayat		Block		District	
	Up to 5000	5001 and above	Up to 50000	50001 and above	Up to 10 lakh	Above 10 lakh
Cash Incentive Recommended Rs. In Lakhs	2.0	4.0	10.0	20.0	30.0	50.0
Incentive to Individuals	0.10		0.20		0.30	
Incentive to	0.20		0.35		0.50	

Organisation/s other than PRIs			
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### Partnerships

The TSC aims to make sanitation and hygiene a people's agenda through a management structure that makes the gram panchayat the prime mover, motivator and monitor of the programme. The challenge before the nation is to facilitate a process of providing resources for decentralized capacity, institutional support systems, hardware, and software outreach and technical inputs for technology and design choices for nurturing the movement for sanitation and hygiene in every community. NGO and private sector participation with entrepreneurships in marketing household, school, and anganwadi toilets will be an integral part of the national strategy. The RGNDWM will also continue to foster partnerships with key external support agencies.

### Some key achievements

Experience showed that districts which had faith and confidence in the TSC principles made significant progress, and many panchayats and blocks have been able to eliminate the practice of open defecation. There are several such success stories from across India. Some of these, such as East Medinipur in West Bengal, Khammam in Andhra Pradesh, Ramanathapuram in Tamil Nadu, and South Tripura in Tripura uniformly reflect strong commitment to achieve results with a range of innovations that have brought the leaders and managers closer to the people. The techniques have been inherently participatory and inclusive. Some of these are outlined in the boxes below.

#### Total Sanitation Campaign - Ramanathapuram

The TSC project in Ramanathapuram District, Tamil Nadu, Southern India was sanctioned in June 2002. Within one year's time, it has managed to construct 15123 individual household toilets, 247 school toilets with functional water supply, and 391 Balwadi toilets. Ramanathapuram District has 7 talukas divided into two sub divisions and total population as per 2001 census is 0.1 million. The credit for this remarkable success goes to the community whose synergistic efforts made the achievements possible', says one of the Field Monitors of Ramanathapuram. The prompt funding support from GoI and State to the district project and subsequent recruitment of committed and hardworking team with quality training and proper

orientation inputs were the first step that laid the foundation of such achievements. The extensive and creative use of IEC components, Incorporation of PLA methods, various technological options in hardware components to end-users and strategic planning made the entire project efforts acceptable to community involved in the project. Convergence of efforts of different agencies working at district level such as District Administration, District Coordinating Agency, UNICEF, SHG Animators, Panchayats, NGOs, AWW, etc also paved way for faster implementation of projects within the context of TSC guidelines. A leader in sanitation drive, Ramanathapuram District, is in the making.

water supply and sanitation coverage in Sathupalli (57 schools) and Dammapeta (102 schools). Khammam TSC project district has also covered 708 schools against the target of 1034. Mayamma, a woman from Dammapeta says "Earlier it was difficult for us to go for nature's call but now we feel comfortable." A special focus on rural schools has been created with the help of School Education Committees, which not only made schools centres of 'cleanliness' but also ensured the full community contribution for the installation of water and sanitation system and subsequent maintenance. Interestingly, this entire sanitation drive has been carried out without any involvement of NGOs.

### **Saturation in Nandigram II**

The last sixteen years of the national programme has shown uneven progress. The most remarkable is the fact that in the state of West Bengal Nandigram II block (Medinipur District) has achieved the distinction of being the first block in the country to have saturated all rural households with sanitary toilets. The key to success has been the close coordination of Panchayati Raj institutions, UNICEF, and facilitation by NGOs at the district and village levels, combined with State level policy formulation, funds allocation, and close monitoring, coordinated by the State Sanitation Cell. The Ram Krishna Mission Lok Siksha Parishad supports RSMs at the block level with the help of youth clubs who promote the concept of hygienic sanitation in their areas. At the district level, this role is entrusted to the Janaswasthya Sthayee Samiti or the standing committee for public health and education. RSMs produce and supply the necessary materials, and motivators from the RSM work at village level to encourage adoption and use of home toilets. With Nandigram II showing the way there are now about nine blocks in the district, which claim one hundred percent achievement. It is estimated that West Bengal has achieved coverage of an estimated 40 percent against the national average of 22 percent although there are disparities across the districts.

### **Total Sanitation Campaign - South Tripura**

TSC was launched in South Tripura District, Tripura, Northeastern India in December 2001 to ensure reduction in mortality and other diseases. TSC started functioning with a goal of achieving 100 percent sanitation coverage all over the District by the end of September 2003 for improving the quality of life of the tribal people and to provide privacy and dignity to women.

Out of total targeted 1,03,273 BPL families, 83,541 families have been covered with sanitary toilets and out of total targeted 44,116 APL families, 21,087 number of families have been covered with sanitary toilets. Out of total targeted 597 schools, 236 schools have been covered with sanitary toilets. Different models have been designed for different locations, cost, availability of water, flood prone areas using local materials. Rajibnagar and Ratanmani are the two Gram Panchayates Satchand Block and West Jalefa and Bankul Mahamani GPs jointly under Rupaicharri block to achieve full coverage of sanitation. The first three GPs in the District making 100% coverage of targeted families were also given awards (by the Chief Minister) consisting of additional allocation of development fund to the block as well as the Gram Panchayats. This really acted on the morale and boosted the enthusiasm of the implementing agencies of RD programmes in the district.

### **Total sanitation Campaign - Khammam**

Khammam district, in Andhra Pradesh, Southern India, comprises of 46 mandals grouped into four Revenue Divisions-Khammam, Kothagudem, Paloncha and Bhadrachalam. Khammam is important centre for tourism, agriculture, and industries. Two Mandals of Khammam district viz., Sathupalli and Dammapeta have attained the status of 100 percent open defecation free mandals, the ultimate aim for the Total Sanitation Campaign. In Sathupalli and Dammapeta, 100 percent coverage has been achieved in Individual Household Toilets (IHHL) the target of 13320 and 11066 respectively. Similar trend is shown in school sanitation coverage with 100 percent achievement in functional

## **Key issues and lessons Learned**

The policy reform experience in India showed that several key issues -- lessons that must be considered while scaling up the implementation throughout the country and also contemplating a future National Sanitation Policy. Some of these are briefly discussed below.

### **Technology choices**

Scant attention has been hitherto paid to availability of water for flushing and washing. Lack of water has been a natural deterrent in acceptance and therefore dry improved pit

toilets and ecological sanitation needs far more attention than has been given. Related designs of good quality and skills for construction are essential at all outreach locations (RSMs and PCs) and needs to be integrated in the communication/IEC plans. Increased emphasis on technologies that consume less water and building awareness to appropriate designs for superstructures for toilets, etc are also important.

### **Supply chains**

No amount of communications and demand generation will be successful unless easy access to sanitation supplies and ancillary services such as trained masons, etc are available. As such, the importance of supply chain mechanisms such as RSMs and PCs (ideally, one per block) are vital to the success of any sanitation programme. This becomes even more important considering that the TSC is scaling up to cover the whole country.

### **SHGs as partners**

Insufficient attention has been paid to women's and youth groups, in building their capacity to be agents of change. Emerging experiences show that Self-Help-Groups (SHGs) can be a powerful local institution to manage sanitation and hygiene delivery. This has been amply borne out by experiences from Ramanathapuram and Trichy in Tamil Nadu, South Tripura in Tripura and elsewhere.

### **Gender in communication**

Communication targets have largely tended to focus on women as homemakers and caregivers of children, the sick and elderly, and this has yielded considerable success. In general, women in India are more acutely aware of the need for improved sanitation and hygiene behaviour, and use existing facilities. However, this gender specific focus results in the communication not targeting males as responsible members of families and communities. This assumes significance as open defecation is more popular among male members owning household toilets.

### **Facilities in work places**

Another key learning has been that even where 100 percent saturation of home toilets has been achieved, many still are forced to resort to open defecation, as it is impractical for them to return to their homes from work places such as agricultural fields to use toilets. This then also means that saturation with home toilets is not enough to eliminate open defecation –

mechanisms for suitable institutional public toilets in carefully chosen locations will also be necessary.

### **Public education on environmental pollution**

The damage that is caused to fresh water bodies through indiscriminate open defecation and disposal of waste including bio-medical is still not widely disseminated to the general public and elected representatives. Concerted efforts to elevate this critical issue on the local development agenda and regular monitoring are imperative to protect the earth and children who will inherit it from the present generation.

### **Stakeholder participation**

Any future sanitation policies must be developed and formulated with the involvement and participation of the stakeholders including political leaders, government officials, donor representatives, the private sector, and the public in general to facilitate informed decision-making. The health impacts of sanitation and the associated economic implications for national and household economies are a primary reason for developing sanitation policies.

### **Coordinated and holistic approach**

Although decisions may be made based on service levels, convenience, costs or regulatory factors, the health (and therefore, economic) consequences of sanitation provision should be the key rationale for formulation of policies. Taking into account sanitation-related health concerns, such as prevalence of diarrhoea, outbreak of gastroenteritis and other sanitation and hygiene related morbidity for instance worm loads among school children, other skin and helminth infections, and finally infant mortality, will necessitate proactive collaboration between the water and sanitation, health, education and local government authorities.

Each of these elements, if well addressed in policies, will help define an enabling policy environment for sanitation improvements.

## **The way forward -- towards total sanitation and hygiene**

### **Continual assessment of existing policies and their impact/effectiveness**

One of the key steps towards total sanitation and hygiene will be ongoing assessments of the situation, documentation of key lessons and determination of what needs to be addressed. Such assessments will include analyses of statistics, periodic updating the India Assessment 2002 report, financial data relating to program and project costs, sources of investment funds their performance aspects and impacts.

### **Building political will**

Central to the plans will be sustained advocacy to encourage state governments to adopt low to no subsidy regimes. In addition, policies related to sanitation need to reside in multiple sectors, for example, apart from the nodal Ministries of Rural and Urban Development, the Ministry of Health and Family Welfare and the Ministry of Education, are key stakeholders. Although awareness and expressions of interest in sanitation by influential individuals are necessary components of political will, they are not sufficient. To be effective, political will for sanitation must embrace understanding of people's needs and priorities for sanitation especially those of women and young girls, the sick, elderly and people with special needs. There must be will to allocate government resources and private sector investments. The best and creative minds need to be attracted to accelerate implementation and improve services, with a commitment to reach the underserved.

A beginning has already been made in this direction with the development of understanding between the Departments of Drinking Water Supply and Education on the need to collaborate for effective implementation of school sanitation in India and to eliminate overlaps.

Similar collaborative arrangements will be developed, with the Department of Health and Family Welfare, for the development and implementation of sanitation and hygiene promotion programmes in India. These efforts will be complemented by local governments,

public utilities, donor agencies, private sector, NGOs, and the public in general.

### **Thrust to the CRSP**

Extra efforts to reach the poor and marginalised, and women and children will be made. Strategies are required for various groups, and diverse terrain. Women have a particularly important role to play in sanitation decisions since they are often the primary collectors, transporters, of domestic water and promoters of domestic sanitary activities. Strategies envisaged include:

- Building political will;
- Developing social marketing strategies and promote alternate delivery systems in order to accelerate sanitation coverage;
- Developing schools and anganwadis as vehicles for expanding the outreach of the programme;
- Empowering women with knowledge and management skills;
- Expanding the scope of the programme to include both rural and urban areas (with emphasis on peri-urban);
- Undertaking research and development on technology, design, and maintenance;
- Building and institutionalising human resource capital;
- Developing total sanitation approaches to achieve visible results; and
- Coordinating monitoring and evaluation with health, education and other sectors to measure benefits and impact on quality of life.

Plans also include extension of the TSC to cover all districts in India, develop water and sanitation facilities (incorporating child and baby friendly designs and technologies) in all rural primary schools and anganwadi centres, building adequate capacities by developing a network of resource centres at national, regional, state, and district level, developing and putting in place efficient monitoring mechanisms at all levels.

### **Determining appropriate levels of service**

The delivery of rural sanitation services may range from pour-flush toilets to simple pit latrines located some distance from the house. In most cases, the level of service is determined by service costs, the economic

status of communities and households, and the willingness of users to pay or otherwise contribute to the installation of a sanitation system. In many areas, such as remote tribal areas of India, household toilets may not necessarily be the most appropriate option. The availability of water -- as a transporting agent, a cleaning agent, or a personal hygiene agent—also affects the level of service that can be provided. Efforts will be made to develop and target appropriate levels of service leading to protection of health and contributing to the welfare of the community, taking into account issues of affordability, willingness to pay, etc., and to provide adequate information to enable consumers to make informed decisions.

## **Developing intersectoral linkages**

### **Developing the health interface**

The health impacts of sanitation will be one of the primary reasons to develop a National sanitation Policy. The policy process will address identified sanitation-related health concerns, such as diarrhoeal rates, infant mortality, helminth infections, and cholera epidemics, to ensure that the general public become aware of the problems that arise from poor sanitation and understand the role that proper sanitation services can play to address these problems, and the economic benefits that accrue out of reduced disability adjusted life-years (DALYs). In this regard, the Ministry of Health and Family Welfare will be crucial in the establishment and implementation of effective sanitation policies. Efforts will be made to ensure that a balance is established by the Ministry of Health and Family Welfare between providing preventative and primary health care services versus curatives services.

### **Building on the education interface**

As mentioned earlier, the RGNDWM has taken steps to co-ordinate school sanitation related activities with the Education Department to ensure synergy and eliminate duplication of efforts. This initiative will be taken further to develop and issue guidelines for quality assurance of both hardware and software interventions in school sanitation, develop a programme of documentation of best practice and to ensure adequate capacity building to sustain the program.

### **Incorporating environmental considerations**

Increasingly, sanitation is being seen as a major issue in environmental protection. Improper disposal of human wastes can pollute water bodies, groundwater, and land surfaces, causing great risks to health and impacting the local, regional and national economy, and such practices can adversely affect general aesthetics and the overall quality of life for those living in the vicinity and exacerbate health risks in situations such as natural disasters, especially floods. As such, efforts will be made to make environment concerns explicit in the policy process and to develop a clear understanding of the magnitude of the sanitation-related environmental problems.

### **Formulating financial mechanisms**

The financial issues related to the CRSP and related policies include the capital costs required for sanitation infrastructure and facilities, and recurrent costs required to operate and maintain the facilities. Additional program costs include training, institutional development, community organization, and hygiene education.

Since the level of service, capital costs, and recurrent costs are inextricably linked, efforts will be made to ensure that levels of service take into account not only the availability of funds (from household, government, and other sources) for capital costs, but also the ability to recover recurrent costs over the long term and household willingness-to-pay for improved sanitation.

Assessing the magnitude of the overall national need for sanitation will be an essential first step in formulating relevant policies to ensure that meeting these needs is expressed in monetary terms, such as total capital investments plus annual recurrent costs, or in resource terms, such as required increases in annual budgets or personnel requirements. Efforts will also be made to increase availability of capital funds for sanitation, especially household access to capital for improved sanitation, for example, through micro credit programs. The current policy of reduced subsidies will continue to be advocated for acceptance by all State Governments. GOI will be giving full priority to sanitation programme and required funds will be made available to the programme. If need arises, additional allocation will be made or external funding may also be sought for.

Efforts will also be made to develop mechanisms by which stakeholders, especially households are fully aware of the recurrent costs associated with sanitation systems

including the maintenance, repair, and general upkeep of their facilities to be able to fully realise the benefits of improved sanitation. This is based on global experience that shows that the more clearly the recurrent costs of sanitation services are recognized, accepted, and supported by the users, the greater are the prospects for sustainability. These will be on-going processes.

### **A shared vision for change**

Recognising the need for cross-sectoral approaches to sanitation and hygiene, the policy process will support an accelerated programme and involve clear delineation of roles and responsibilities of all involved institutions at various levels towards a common goal.

### **A National Sanitation Policy**

Sanitation policies are critical to creating an enabling environment to encourage increased access to sanitation services. National policies can serve as a key stimulus for local action. Such policies serve to set priorities and provide the basis for translating needs into action,

creating conditions in which sanitation can be improved, to galvanize support for sanitation among state governments, local governments, and other agencies. More importantly, a national sanitation policy can provide the trigger for increased private sector involvement and for fostering public-private partnerships. While India has made a radical policy shift from a target driven approach to a more demand driven approach to water supply and sanitation with the introduction of Sector Reforms for the drinking water sector and the TSC for the Sanitation Sector in 1999, it does not yet have a codified National Sanitation Policy. The need for this is becoming increasingly apparent, and India will take the necessary steps towards formulation of a new National Sanitation Policy.