

UNPACKING THE PROCESSES OF ACHIEVING OPEN DEFECATION FREE STATUS

A CASE STUDY OF UDAIPUR, RAJASTHAN

AUGUST 2018

RESEARCH REPORT

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About the Centre for Policy Research: CPR is an independent and non-partisan research institute and think tank located in New Delhi. Established in 1973, its main objectives are to provide thought leadership and creative solutions to address pressing intellectual and policy issues. It has been recognized as 38th amongst all leading think tanks in the world by the 'Global Go To Think Tank Index' of the Lauder Institute in 2014. It is also one of the 27 national social science research institutes recognized by the Indian Council of Social Science Research (ICSSR), Government of India. It is set apart by its multi-disciplinary approach and unique blend of scholarship and practical expertise. CPR's faculty have considerable impact on policy and public debates.

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List of Abbreviations

AI – Accountability Initiative	ODF – Open Defecation Free
APL – Above Poverty Line	PDS – Public Distribution System
ASHA – Accredited Social Health Activist	PIP – Project Implementation Plan
AWC – Anganwadi Centre	PPS – Probability Proportionate to Size
AWW – Anganwadi worker	PRI – Panchayati Raj Institutions
BCC – Behaviour Change Communication	PSU – Primary Sampling Unit
BDO – Block Development Officer	SBM – G – Swachh Bharat Mission – Gramin
BPL – Below Poverty Line	SBM – Swachh Bharat Mission
BPMU – Block Programme Management Unit	SC – Scheduled Castes
CAG – Comptroller and Auditor General of India	SHG – Self Help Group
CAS – Community Approaches to Sanitation	SLWM – Solid and Liquid Waste Management
CATS – Community Approaches to Total Sanitation	ST – Scheduled Tribes
CEO – Chief Executive Officer	TSC – Total Sanitation Campaign
CLTS – Community Led Total Sanitation	UNICEF – United Nations Children's Fund
CRSP – Central Rural Sanitation Programme	
CSO – Civil Society Organisations	
CSS – Centrally Sponsored Schemes	
CT – Census Town	
DSBMMC – District Swachh Bharat Mission Management Committee	
FFC – Fourteenth Finance Commission	
FLW – Frontline Worker	
FSM – Faecal Sludge Management	
FY – Fiscal Year	
GOI – Government of India	
GP – Gram Panchayat	
IEC – Information, Education, and Communication	
IHHL – Individual Household Latrine	
IMIS – Integrated Management Information System	
IPC – Inter-Personal Communication	
IT – Information Technology	
MDWS – Ministry of Drinking Water and Sanitation	
MIS – Management Information System	
MPLADS – Member of Parliament Local Area Development Scheme	
NBA – Nirmal Bharat Abhiyan	
NREGA – National Rural Employment Guarantee Act	
OBC – Other Backward Classes	
OD – Open Defecation	

1. BACKGROUND

Open Defecation and its public health outcomes have been a policy challenge in India for several decades. Concerted attempts to address this problem were begun by the Government of India (GoI) in 1986, with the launch of the Central Rural Sanitation Programme (CRSP). The three decades since have seen the efforts expand in scope, first in the form of the Total Sanitation Campaign (TSC), then the Nirmal Bharat Abhiyan (NBA), and since 2014, the Swachh Bharat Mission (SBM).

Each of these iterations have focussed on two aspects. Firstly, each programme has consistently increased the toilet incentive in nominal terms. Introduced at ₹3,200 by the TSC¹ for Below Poverty Line (BPL) beneficiaries, it was increased to ₹5,500 under the NBA, and for the first time included Above Poverty Line (APL) households within its ambit. In 2014, this amount was further enhanced to ₹12,000 under SBM. Secondly, each iteration placed greater emphasis on behaviour change as the primary objective. Recognising the importance of behaviour change activities, the Information, Education, and Communication (IEC) component in the budget was enhanced, and the guidelines stipulated that at least 15% of the NBA budget was to be utilised for these activities.

More importantly, the recommended approach towards implementation also evolved with each programme. The household centric approach of focussing on individual household toilet construction under the TSC was changed to a community centric approach with increased involvement of local governments, first with the introduction of the Nirmal Gram Puraskar, and thereafter with the announcement of the NBA. This shift was necessitated by the realisation that progress in achieving safe sanitation for all, had been slow. In 2011, the Census found that while allocations for the TSC had increased consistently from less than ₹200 crore in 2002-03 to over ₹1,600 crore in 2012-13, toilet access had increased by only 9 percentage points from 22% in 2001 to 31% in 2011.

A report of the Comptroller and Auditor General of India (CAG) released in 2015 estimated that while more than ₹10,000 crore had been spent on toilet construction over the previous decade, close to a third of the toilets constructed were already defunct due to poor construction quality and lack of maintenance. It also found that several states had overestimated the actual toilets constructed during this period, at times by more than 100%. Fund flows too were found to be an impediment, with less than 50% of state demands being released, and despite the underfunding, close to half the released funds remaining unspent year after year (Comptroller and Auditor General of India, 2015). It is against this backdrop that the Swachh Bharat Mission (SBM) was announced on 2 October 2014.

1.1 Swachh Bharat Mission – Gramin

Although the Swachh Bharat Mission (SBM) was an expansion of the NBA, it also marked an important departure from the previous programmes in many ways. For the first time SBM acknowledged the importance of adopting different approaches to address the sanitation needs of urban and rural areas, bifurcating the flagship sanitation programme under separate nodal ministries. The personal involvement and attention by the top most political office of the country also occasioned optimism in a sector which thus far had been criticised for lacking adequate political will. The resource allocations, particularly for the rural component or Swachh Bharat Mission - Gramin (SBM-G), were also increased significantly, and the programme sought to make an important shift in focus from outputs to outcomes. The Mission also set itself a more ambitious goal of ensuring an Open Defecation Free (ODF) India by 2019.

Since the launch of the Mission, GoI has allocated ₹30,973 crores to rural sanitation. In contrast, the three years preceding the SBM had seen largely stagnant GoI allocations totalling ₹7,650 crores. This increase in GoI allocations gains even more significance when understood in the context of the Fourteenth Finance Commission (FFC) recommendations, which changed the fund sharing ratio between GoI and the states for Centrally Sponsored Schemes (CSS). Since FY 2015-16, funds are shared between GoI and states in a 60:40 ratio for most components. For the eight Northeastern states and three Himalayan states, this ratio is 90:10. Resultantly, between FY 2016-17 and FY 2017-18, GoI and states together released ₹25,631 crores under the Mission² and ₹22,496 crores were spent.

¹ It was relabelled as an incentive for the first time under TSC.

² www.sbm.gov.in

SBM OBJECTIVES -

1. To bring about an improvement in the general quality of life in the rural areas, by promoting cleanliness, hygiene and eliminating open defecation.
2. To accelerate sanitation coverage in rural areas to achieve the vision of Swachh Bharat by 2nd October 2019.
3. To motivate Communities and Panchayati Raj Institutions to adopt sustainable sanitation practices and facilities through awareness creation and health education.
4. To encourage cost effective and appropriate technologies for ecologically safe and sustainable sanitation.
5. To develop wherever required, Community managed sanitation systems focusing on scientific Solid & Liquid Waste Management systems for overall cleanliness in the rural areas.
6. To create significant positive impact on gender and promote social inclusion by improving sanitation especially in marginalized communities

(MDWS, 2017)

1.2 Introduction and Need for Research – Udaipur Case Study

As early as July 2014, the Chief Minister of Rajasthan had announced March 2018 as the target for declaring the state ODF. The state went on to hold a Collectors Conferences in 2015 and 2016 which marked sanitation as being the “priority agenda at the district level” and iterated the principles of community-led approaches and the role of Panchayati Raj Institutions (PRIs) in improving the status of sanitation in rural India (UNICEF, 2017). During these conferences, it was decided that the Mission would be implemented at the district level, with districts presenting individual plans and the District Collector and Chief Executive Officer (CEO) leading the planning and monitoring process.

The SBM implementation process was launched by the Udaipur district administration in July 2015. In its first phase, of the 544 Gram Panchayats (GPs) in the district, 105 were targeted for ODF declaration. Progress, however, was slow and only 22 of the targeted 105 GPs could be declared ODF by the end of that fiscal year. Following a review of this progress and its gaps, a more aggressive campaign was launched by the then District Collector, Rohit Gupta. Recognizing that “what works in one district doesn't necessarily work in another”, the district put greater focus on local culture and decided to adopt a ‘block saturation approach’ targeting entire blocks for achieving ODF status (UNICEF, 2017).

To kick off the process, a targeted campaign was launched for ensuring ODF declaration in 30 GPs within the 30 days between 16 July and 15 August 2016. Emphasis was placed on local initiatives focussed on cultural and religious drivers and seeking larger

community participation through behaviour change campaigns and increasing inter-GP competition. The handing over of the “*swachhta kalash*” during the ODF “*Gaurav yatras*”³, organizing “ODF Olympics”,⁴ using local festivals like “*Gavari*”⁵ to disseminate sanitation messaging, offering incentive money in a staggered form to facilitate construction, were some of the innovative efforts undertaken (UNICEF, 2017).

This push was reflected in the substantial increase in utilisation of funds. In Financial Year (FY) 2015-16, only 25% of the ₹21.4 crores released to the district for Mission activities was spent. The pace picked up in the following year, and available funds had been utilised completely by March 2017. In FY 2016-17, by November 2016, concerted efforts had seen 53 Gram Panchayats (GPs) declaring themselves free of open defecation. Within 6 months, by June 2017, when this study was being carried out, this number had increased almost three-fold to 141⁶. Of those GPs declared ODF, Udaipur district had verified 49%.

1.3 Accountability Initiative in Udaipur

In December 2015, the Accountability Initiative (AI) conducted a cross-sectional survey covering 7,500 households spread across 5 states and 10 districts. One of the main objectives of this survey was to understand the process of implementation of the SBM-G up to that point. Udaipur was found to be among the poorer performers of the 10 districts covered in the survey, with less than a quarter of the sampled households having access to a toilet. Even among the households with fully constructed toilets, Udaipur had the highest proportion of households (26%) where

³ Gaurav Yatras were pride parades undertaken in ODF GPs to reinforce the importance of sanitation and instil pride in community efforts. The Swachhta Kalash or sanitation urn was said to be like the baton of cleanliness which was passed from one GP to another.

⁴ With participation restricted to ODF GPs.

⁵ Gavari is forty day long festival celebrated by Bhil tribes in Udaipur district. It takes place in the months of September and October and invites large gatherings, where local art forms are demonstrated and competitions are held.

⁶ Udaipur has met the state government target by declaring all 544 GPs ODF by March 2018.

at least one member defecated in the open. These findings were presented to the district administration which by then had launched the Mission activities, mentioned above. Accordingly, AI was invited to conduct another survey in the district to assess the progress of the renewed Mission activities and to identify the gaps in outcomes in the GPs, which had recently been declared ODF.

It is in this context that this survey was conducted between April and June of 2017, in selected ODF GPs to understand the outcomes, and the processes which led to them.

1.4 Research Objectives

While there have been a number of recent studies including Coffey, et al. (2015), and Duflo, et al. (2015) aimed at understanding the status of sanitation in India, there are relatively fewer studies aimed at understanding the processes involved in declaring villages or GPs as ODF. This study aimed at filling this lacuna by undertaking a detailed process evaluation of the implementation of the recent sanitation efforts in Udaipur.

Specifically, the study aimed to:-

- a) Verify the current status of sanitation in ODF declared GPs;
- b) Understand and evaluate the SBM processes and models of incentive provision and behaviour change adopted by the GPs; and,
- c) Understand the role of different stakeholders – administrative machinery and frontline workers in this process.

Given the need for a comprehensive understanding, the research covered all stakeholders at different levels. Thus, while households in the general population remained the primary target audience, officials associated with the SBM at different levels from the district to the GP/Ward, were also interviewed.

The remainder of this report is organised as follows. Chapter 2 gives an outline of the specific study design. Chapter 3 gives details on the current status of sanitation in the ODF declared GPs. This is followed by Chapter 4 and Chapter 5 which unpack the processes involved in declaring GPs ODF with a special focus on behaviour change and implementation related activities. Chapter 6 highlights threats for the sustainability of sanitation efforts while Chapter 7 assess the role of different stakeholders and their administrative capacities. Finally, Chapter 8 concludes with a summary of recommendations.

2. RESEARCH DESIGN

The study was undertaken using a combination of quantitative and qualitative methods. Data was collected through a survey at the household and village level, and through semi structured interviews with beneficiaries and government functionaries. Government representatives were interviewed at the district, block and panchayat levels along with frontline workers (FLWs) such as Anganwadi workers (AWWs), local community volunteers or *swachhta preraks*⁷, and self-help groups (SHGs). The overall design of the research is illustrated in Figure 1 below.

2.1 Geographical Coverage

The role of the GP is crucial in the recommended SBM implementation process. In Rajasthan, while the overall charge of strategy and implementation lies with the district office, the role of the block office and the Block Development Officer (BDO) was also stressed by the state government. Udaipur district administration too, reinforced the importance of the block office by adopting the block saturation strategy. In Rajasthan, even before the launch of the SBM, sanitation programmes had been transferred to the Panchayati Raj Department (UNICEF, 2017). Thus, both the district and block administration are meant to operate as an upward extension of the Panchayati Raj system rather than a downward extension of the state government.

ODF declarations are initiated by the GP for each individual village and subsequently for the Panchayat itself. Given that the aim of the study was to understand the process of ODF declarations, not only were GPs identified as the sampling unit, but the sample was restricted to those GPs which had already been declared ODF and within that, those GPs which had recently been declared ODF. The final selection was thus made from the 40 recently declared, and declared and verified GPs which were represented in a proportionate manner.

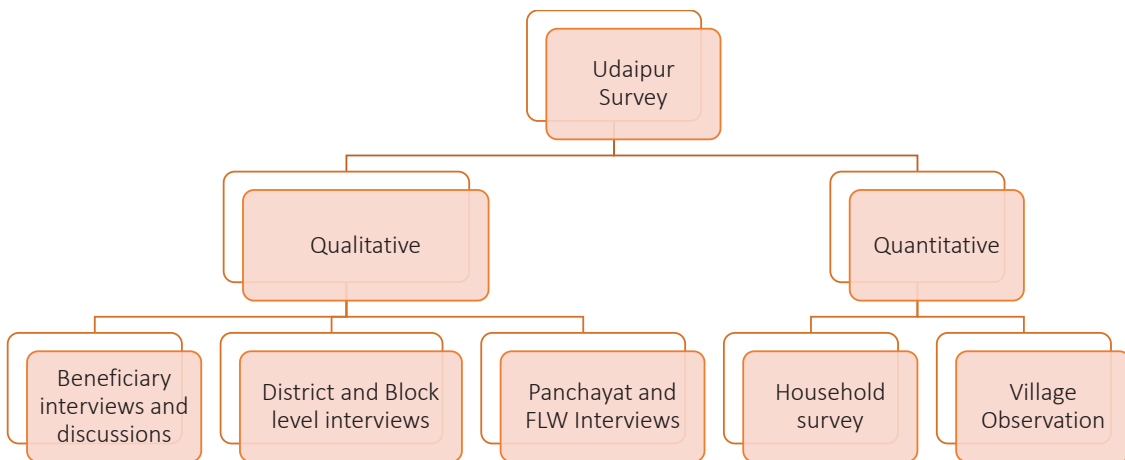
2.2 Sample Size and Distribution

Quantitative –

Given the finite population (202,978) to be studied, the minimum representative sample size required to be covered was 385. A 10% non-response rate was assumed and the final sample was rounded off to 450 for ease of distribution. An additional sample of 60 was covered in Census Towns (CTs).

Of the total 40,9 GPs were randomly sampled and proportionately distributed. Given the criticality of sample distribution and coverage, close to 20% of all villages in the sample GPs were covered. The final sample thus covered a total of 19 villages and 2 CTs.

FIGURE 1 - RESEARCH DESIGN



⁷ Now known as Swachhagrahis

It may be noted that not all GPs had the requisite number of villages. In such cases, the shortfall of villages in any selected GP was covered in the remaining GPs, with an attempt made to maintain a constant average number of villages per GP.

Qualitative –

The sample size for the qualitative exercise was left fluid in the interest of flexibility and adaptability. The final study covered a total of 5 group interviews with beneficiary households, 5 with frontline workers, 2 with masons and contractors, 1 with an SHG, 6 at the panchayat level, 7 at the block level and 2 at the district level. Some of these interviews were conducted one on one, while some were conducted in groups. (See Figure 2).

FIGURE 2 - QUALITATIVE INTERVIEWS

Beneficiary Interviews	District Interviews –	Block Interviews –	Panchayat Interviews –	Mason/ Contractor Interviews -	FLW Interviews	SHG Interviews
5	2	7	6	2	5	1

2.3 Sampling Methodology

Rural sampling

Post-GP selection, in order to account for the varying number of villages per GP, it was decided that 60% of the villages from each GP would be randomly selected to be included in the sample⁸.

Using the household as the sampling unit, a sample size of 508 households was determined as being sufficiently representative of the GPs under consideration. These were divided into 366 households from the first group (recently declared GPs) and 142 households from the second (verified GPs). The GPs were then listed by household numbers, and using the method of probability proportionate to size (PPS), the number of households to be sampled from each GP was calculated⁹.

This number of households per GP was then proportionally distributed among the villages selected to be in the sample for that GP¹⁰.

Urban sampling

In addition to the rural sample, 60 households from two CTs were also included in the sample. The two CTs were randomly selected from the 3 CTs present in the sampling population and a sample

size of 30 households per CT was determined to be sufficiently representative. The inclusion of CTs was done in order to obtain a comprehensive perspective on the functioning of SBM in the district.

Sample Achievement

The final sample, post-completion of the survey, consisted of 565 households (505 rural households from 19 villages and 60 households from 2 CTs). A few households had to be dropped from the sample due to discrepancies in the data collected (Figure 3).

At the village level, the interviewed households were selected randomly. Care was taken to ensure a dispersed distribution of

selected households. Within the household, an attempt was made to interview the head of the household or the person most involved with managing household expenses. The detailed process is given in Figure 4.

Several challenges were encountered during the operationalisation of the study in the field and these required modifications in the methodology in the interest of representative sampling and optimal coverage. At the outset, ensuring coverage had to take into account the large and unevenly spread terrain of Udaipur district. Further, the initial sample had been drawn from data provided by the district administration of Udaipur. However, households, as defined by the district administration were based on number of ration cards and are different from the census definition. For example, in 3 villages, the actual number of households was far lower than the numbers on which the sample size of the village was drawn. This was addressed in the field through a systematic strategy on a case by case basis to ensure that the requisite sample size was not compromised¹¹.

⁸ If a GP had just one village, as was the case with Nai, the village constituting the GP was included entirely in the sample. In the case of Kathar, which consisted of 7 villages, $4 (7 \times 60\% = 4.2)$, which can be rounded off to 4) were randomly selected.

⁹ For instance, the GP of Toda had 862 households, which made up approximately 15% of the households in group 1. The pre-determined sample size for this group (336) was then multiplied by 15% to determine the number of households to be included in the sample from the GP, which came to 54. Similarly, the GP of Intali Kheda from group 2 was determined to constitute 44% of the households in group 2 and the corresponding number of households to be surveyed was calculated to be 62.

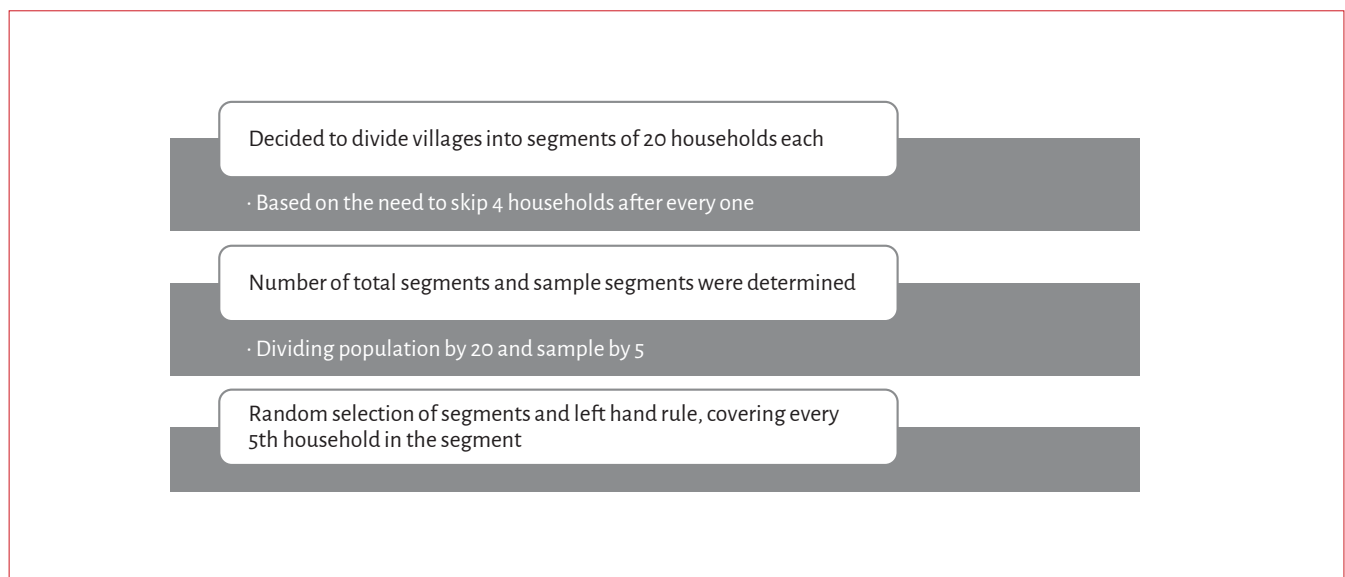
¹⁰ For instance, 3 villages were selected to be part of the sample for Deogaon. The household distribution for the GP between these 3 villages was 52%, 22% and 26%. The number of households calculated for the GP in step 3, which was 52, was then divided between these 3 villages by multiplying the percentages by 52, giving us 27, 12 and 13 households respectively.

¹¹ In villages where fewer households were present, every third household (rather than fifth) was surveyed.

FIGURE 3 - FINAL SAMPLE ACHIEVEMENT

Gram Panchayat	Type of GP	Final Sample Achievement
Bedla	Declared ODF	N=29
Deogaon	Declared ODF	N=53
Gadawat	Declared ODF	N=48
Kolyari	Declared ODF	N=62
Nai	Declared ODF	N=80
Semari	Declared ODF	N=68
Toda	Declared ODF	N=54
Intali Kheda	Verified ODF	N=118
Kathar	Verified ODF	N=53
Aggregate	N=565	

FIGURE 4: INTERVIEW HOUSEHOLDS WERE SAMPLED USING THE FOLLOWING APPROACH



3. FINDINGS: OUTPUTS AND OUTCOMES OF SBM-G IN UDAIPUR

The Ministry of Drinking Water and Sanitation (MDWS) defines ODF as follows—

"ODF is the termination of faecal-oral transmission, defined by

a) No visible faeces found in the environment/village; and

b) Every household as well as public/community institutions using safe technology option for disposal of faeces"

- (MDWS, 2017)

The fulfilment of this definition requires three components to work simultaneously.

First, each household should have access to a **sanitary**¹² latrine. According to the guidelines, a sanitary household latrine must comprise "i) a sanitary substructure (that safely confines human faeces and eliminates the need for human handling before it is fully decomposed), ii) a super structure with water facility, and iii) a hand wash unit for cleaning and handwashing." - (MDWS, 2017)

While the aim is to provide such toilets to each individual household, where provision of toilets to individual households is difficult, row toilets or community blocks are also permitted.

Second, given that ODF declarations are made at the village level, providing access to sanitary toilets in public and community spaces is an integral component of the Mission. The guidelines thus emphasise the need for separate and functioning toilets for boys and girls in schools and anganwadis. The construction of these toilets is to be undertaken under the relevant programmes of the Department of School Education and Literacy, and the Ministry of Women and Child Development. GPs are also urged to use the Fourteenth Finance Commission untied grants for the purposes of construction and maintenance.

Finally, access to toilets is not enough. For true ODF, not only must each member of every household have access to a functional and sanitary toilet in their homes, as well as, in public places, but these toilets must also be used consistently. The SBM guidelines thus expressly state that regular usage is a prerequisite for declaration and verification of the ODF status.

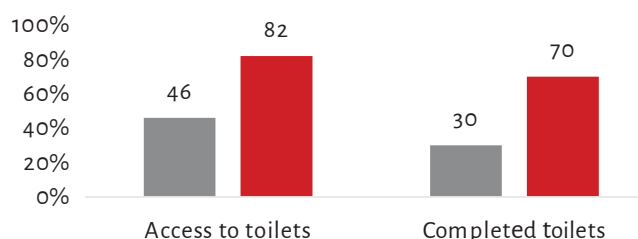
The outcomes of this survey as described in this section must be seen in the context of these three essential characteristics. Assessment of ODF status can therefore be broken down into the following questions. Does every household have access to

a sanitary and functional toilet? Does every member of every household use this toilet consistently? Does every public/community institution in the village have accessible, sanitary, and functional toilets?

Significant increase in construction of new household toilets

Between 2015 and 2017, rapid construction of new toilets was undertaken on a large scale. In order to understand the magnitude, a useful comparator is the district level survey conducted by AI in December 2015¹³. In 2015, out of 145 households sampled in Udaipur from those reported as having constructed toilets in the last 2 fiscal years, only 46% had access to toilets. This increased significantly by April 2017, with 82% households having access to toilets. Moreover, access to fully completed toilets had also more than doubled during the same time period from 30% in December 2015 to 70% in April 2017.

FIGURE 5 - ACCESS TO TOILETS (OVERALL)



Not all households in ODF GPs had access to toilets

Despite this significant increase, it is important to note that there were still gaps in access. This becomes even more important given that unlike the previous survey which was conducted across all blocks in the district, this survey had restricted the sample to just ODF GPs. As a result, it was expected that all households should have access to toilets. However, this was not the case in most of the GPs surveyed.

Overall, 18% of the surveyed households across both the new and verified ODF GPs were found to lack access to a toilet. This proportion was roughly constant across caste and social categories, as well as the rural and urban primary sampling units (PSUs) surveyed. There were also significant differences across GPs indicating that implementation was not uniform.

¹² Emphasis added

¹³ The 2015 survey examined toilet access among two distinct household groups: randomly selected households, and households entered in SBM MIS as having recently constructed a toilet. The comparator used here is from the achievement sample which may be treated as equivalent to households from ODF GPs.

FIGURE 6 - ACCESS TO TOILETS AT GP LEVEL

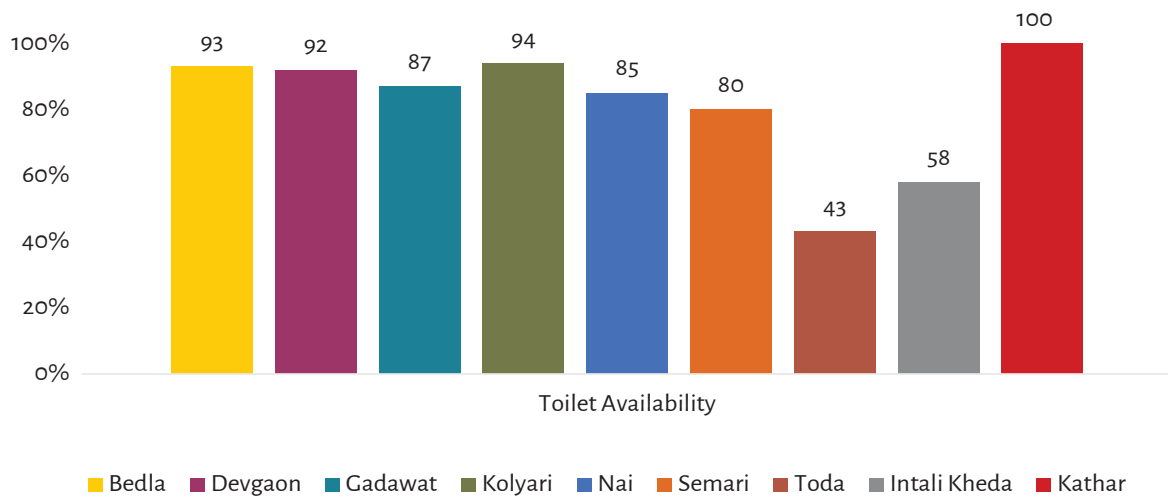
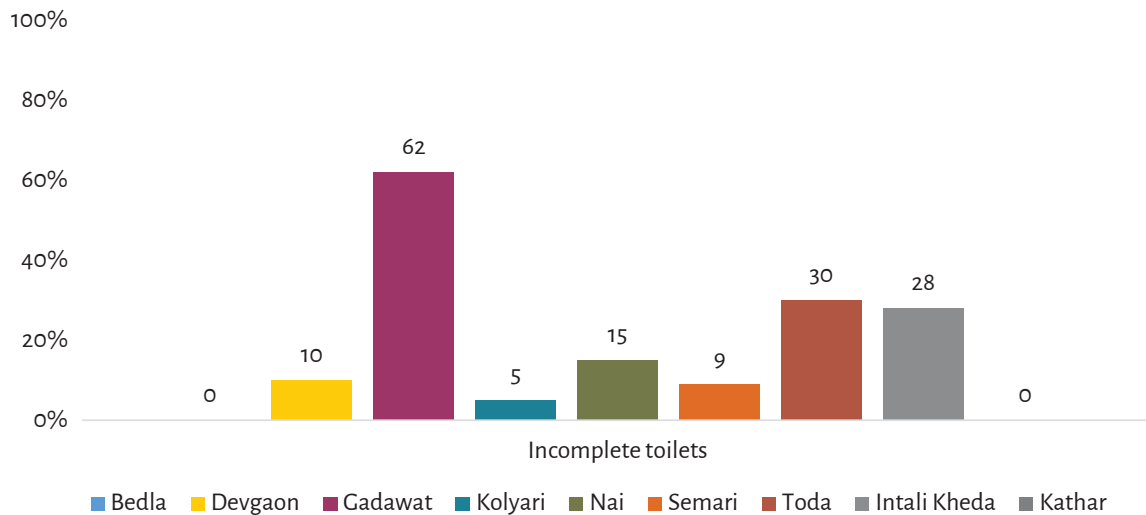


FIGURE 7 - PROPORTION OF INCOMPLETE TOILETS BY GP



Barring one, none of the surveyed GPs were found to have 100% toilet access and less than 60% of surveyed households had access to toilets in two out of the eight GPs surveyed. For instance, only 43% of households in the GP Toda and 58% in GP Intali Kheda had access to a toilet facility. Interestingly, Intali Kheda had been verified ODF at the time of the survey (Figure 6).

Not all toilets available were complete

The survey found that, overall, 14% of individual toilets were incomplete. There were however significant variations across GPs. Thus, in Kathar and Bedla, all toilets were found to be completely constructed. However in other GPs, especially Gadawat, and to a lesser extent Toda and Intali Kheda (a verified GP), a large

number of toilets were left incomplete (Figure 7). If one accounts for the incomplete toilets, actual access to usable toilets drops significantly.

Public places found lacking functional toilets

A village level observation of all prominent public spaces in the village was conducted to determine access to usable toilets in public facilities. These included schools, anganwadi centres, local health centres, panchayat offices wherever present, and IT centres¹⁴. All such facilities and premises in a village were included in the observation exercise.

¹⁴ Seva Kendras established to provide access to online government services in rural areas

Access to toilets in public facilities was found to be low. As can be seen in Figure 8, while all schools and 81% of anganwadi centres had a toilet, availability was low in *samudayik kendra* (community centres) with only 43% of them having a toilet facility and even lower for health centres at 19%. Surprisingly, while a GP is the critical implementing unit, availability of toilets even in panchayat offices and IT centres was not universal. Only one of the surveyed villages was found to have a community toilet, but this did not have access to water and was otherwise found to be unusable.

Attention must also be drawn to the gap between availability and access. Thus in some cases, even where toilets are seen to be available, they lacked adequate water, weren't maintained, or were locked up, rendering their presence ornamental.

Usage not universal or consistent

The survey also tried to capture usage of toilets among households which had them. Before describing the findings, it is important to note that measuring (and monitoring) usage is complicated. In order to ensure reliable estimates, the survey sought to address the issue in some detail. However, even before understanding the usage patterns of toilet owners, it bears reiteration that the significant proportion of households, which did not have access to toilets in these ODF GPs, were by necessity practicing open defecation. These households have not been included in the analysis in this section which is restricted to toilet owners, both with complete and incomplete toilets.

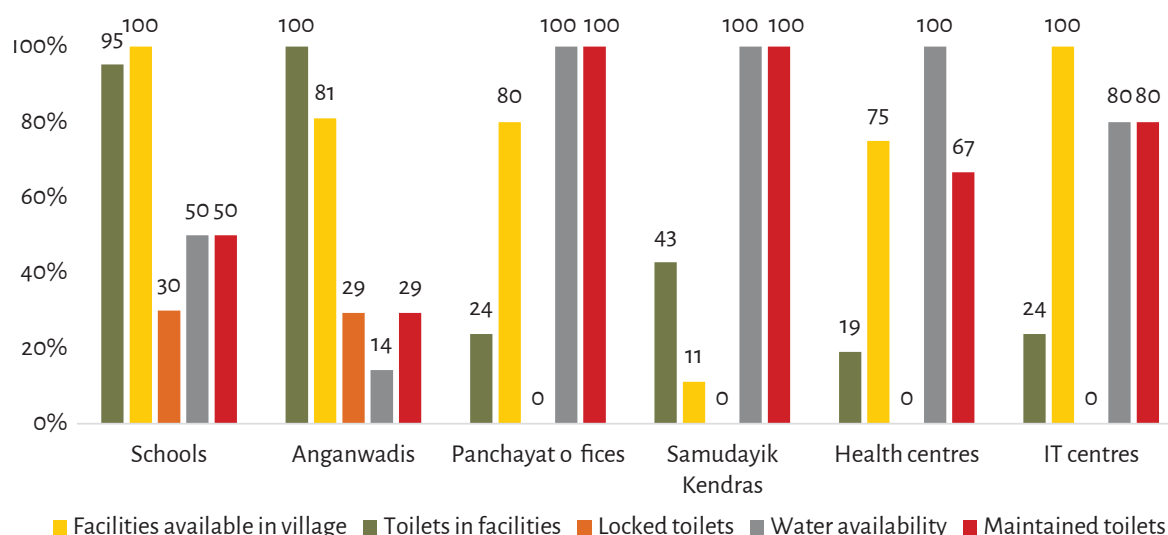
Seeking as holistic a picture as possible, this study sought to assess usage in several different ways and for every member in the household. An attempt was made to verify this information with each member individually, and to understand usage not only as a current phenomenon but in terms of regularity and seasonal variations. As a first step in estimating regular usage, the respondent was asked whether he/she defecated in the open or used the toilet for defecation on the day of the survey¹⁵. The question was repeated for each individual season and for each household member and responses were recorded on a scale representing regularity.

Overall, more than a third of the toilet owners (38%) reported defecating in the open on the day of the survey. In fact, barring one, 100% usage even on the day of the survey was reported in none of the GPs. Interestingly, Bedla, where 100% usage was reported on the day of the survey, is peri urban¹⁶, and thus has limited access to open spaces in the vicinity. Moreover, as previously noted, all toilets were also found to be complete in this GP.

Usage proportions were significantly lower in Gadawat, which also reported the highest proportion of incomplete toilets. Consequently, usage on the day of the survey was reported by less than 25% of all toilet owners.

The survey also tried to distinguish between use on the day of the survey, and those that regularly a toilet across seasons. The study

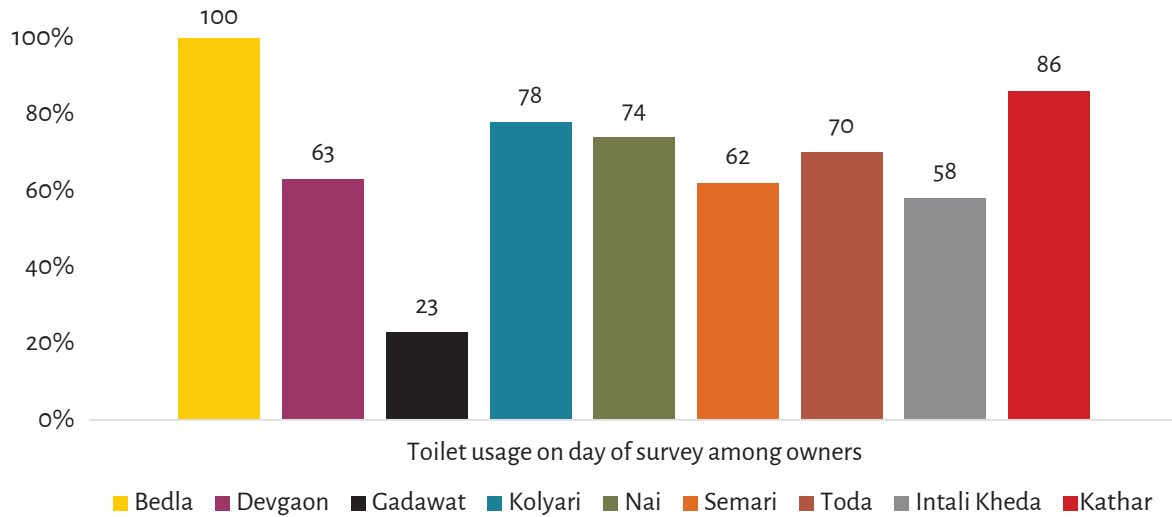
FIGURE 8:- TOILET ACCESS IN PUBLIC SPACES



¹⁵ The wording of the question is important and was so structured to minimise the social desirability bias. See Coffey, et al. (2014) for more details.

¹⁶ Bedla is located on the outskirts of Udaipur city, within 10 kms of the city centre.

FIGURE 9 - USAGE ON DAY OF SURVEY BY GP



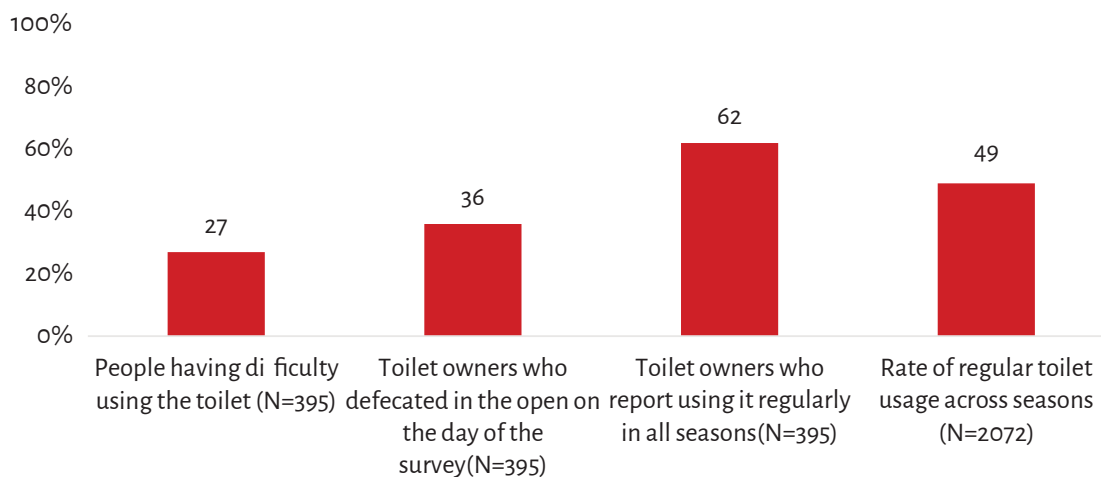
found that a little more than 60% of the respondents reported using it regularly across all seasons. Among a larger sample of all household members in the sampled households, this proportion dropped below 50%. Thus, less than half of the individuals who had access to households toilets in the ODF GPs reported using them regularly across all seasons. Interestingly, no significant difference was observed between usage by male and female members.

A comparison with the 2015 AI survey, suggests that the usage amongst those that had fully constructed toilets seems to have decreased, or that constructions outpace uptake. In 2015, 26% of households with fully constructed toilets in Udaipur were found

to have at least one member who defecated in the open. In 2017, this number was 36%.

To summarise, 100% access was not found in any of the ODF declared GPs barring Kathar, and even among these toilets, close to 15% were found to be incomplete. Usage on the day of the survey was reported to be as low as 23% in Gadawat, and was less than 100% in all GPs except Bedla. It is clear from these findings that there are significant access and usage gaps in the ODF declared GPs. These gaps contradict their ODF status and are significant enough to be representative of a pattern among a subset of SBM beneficiaries. They also raise questions on the process followed towards ODF declaration. The next chapter explores these issues in detail to understand the barriers to access and usage.

FIGURE 10 - REGULAR TOILET USAGE



4. FROM ACCESS TO USAGE: IMPORTANCE OF BEHAVIOUR CHANGE

The SBM guidelines explicitly state that the programme is a departure from previous government efforts in the sanitation sector. SBM contends that while the previous programmes were output driven and indulged in ‘toilet counting’, SBM focuses on outcomes. The inclusion of ODF as the measure of success was intended as a means of rectifying a bureaucratic target-driven approach, and departing from technical solutions by focusing on collective behaviour change.

The SBM thus envisages a “massive mass movement” towards complete sanitation led by the states, which are offered significant flexibility in choosing their approach within the broad guidelines (MDWS, 2017).

The strategy statement and the mission implementation framework highlight some critical activities that the administration must undertake in order to facilitate and sustain the desired mass movement. These involve communicating and convincing people of the need for a toilet, advocating the right approach to constructing and using it, and ensuring sustainability. The need for robust monitoring and verification to ensure progress, allow for course correction, and prevent lapses, is integral to this approach. The Mission also recognises that the existing administrative machinery requires capacity augmentation to enable it to achieve these complex objectives.

This chapter looks at the process as it unfolded in Udaipur, in some detail.

4.1 Process of ODF Declaration

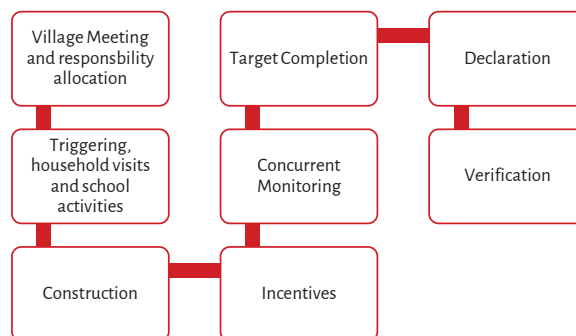
The implementation of SBM-G is proposed with the district as the base unit and the goal of creating ODF GPs. The District Collectors/CEO's of Zilla Parishads are expected to lead the mission and facilitate district level planning. The guidelines require that “[a] District Swachh Bharat Mission Management Committee (DSBMMC) chaired by the District Collector/Magistrate and comprising of all district level officers of relevant departments and all BDOs/ Block level officer in charge of sanitation, shall be formed and shall meet once a month to plan and monitor the implementation of the Mission”. (MDWS, 2017).

The process of achieving ODF status thus begins with meeting at the district and block offices where toilet construction targets are delegated to relevant authorities. At the block level in Udaipur, this typically means the BDO and the Sanitation Coordinator.

At the village level, the Panchayat Secretary and the Sarpanch have been assigned responsibility. This top down communication

follows well defined bureaucratic channels with the district communicating to the blocks, which would remain responsible for downward relay to all panchayats within their jurisdiction.

FIGURE 11: TYPICAL PROCESS OF ODF DECLARATION FOR A VILLAGE



Target Setting

ODF declarations are tied to the baseline survey data of 2012–2013. In 2012, following the Census 2011 findings of low toilet access and significant number of defunct toilets, a country-wide survey was undertaken wherein GPs identified the number of households lacking toilets. The findings were then entered in the Integrated Management Information System (IMIS) by January 2015, and formed the basis of the mission's toilet target. It is only on completion of this target that a GP is allowed to declare itself ODF.

Inclusion in this baseline list is a prerequisite to getting the incentive. The GP is only allowed the flexibility to make revisions by replacement, as “total incentive shall be restricted as per the PIP” (MDWS, 2017). The guidelines does permit updating this list to reflect changes in the village demography. These are to be made by states at the beginning of every financial year on an incremental basis. A grievance redress mechanism at the GP is also proposed to address issues pertaining to exclusion. However, there are restrictions that bind the possibility of revision. For instance, the guidelines ensure an end point for the programme by mandating that “Once a village obtains ODF status, the maintenance of the ODF status will be the responsibility of the community. Any new household added to the village must have access to toilets.” The State is given an option to make more substantive corrections to the baseline only with “reasonable explanations” to MDWS (MDWS, 2017).

IEC Process Prescribed

The criticality of behaviour change efforts cannot be emphasised more forcefully than in this statement in the SBM guidelines, which insist that “[t]he Swachh Bharat Mission (Gramin) is not

about constructing toilets but aims at behavior change of the masses to adopt better sanitation practices. Therefore, information, education and communication (IEC) strategies, planning and their effective implementation is the key to the success of Swachh Bharat". (MDWS, 2017)

It is important to distinguish between IEC activities and Behaviour Change Communication (BCC). While the IEC approach usually manifests in a top down dissemination of information on a mass scale, BCC places greater reliance on interpersonal communication (IPC) and dialogue.

Towards this need of community led and community saturation approaches, the guidelines advocate interpersonal communication, door to door contact, and "triggering" or "nudging" as significant tools for achieving collective behaviour change. Further, it is recognised that demand generation activities require to be continuous, and should also be 'area specific', 'community specific' and involve all sections of the rural population. (MDWS, 2017)

Given its pre-eminence, a separate set of guidelines have also been issued specifically for IEC under SBM which go into some detail to prescribe best practices and proscribe known pitfalls. For instance while the scheme provides for financial incentives, in practice, the idea is to avoid government support as a motivator. Instead, construction of toilets is to be ensured by convincing people of their importance for health and safety.

The guidelines further suggest that the use of shame, coercion and regressive messaging is to be avoided. As the IEC guidelines state, "[S]ince sanitation is a collective endeavour, one may be wary of using any IEC / BCC tools that divides / shames people on the basis of toilets (e.g. pasting of red/green stickers on houses)." They go on to say, "coercive tools have to be avoided lest it should further alienate the community. At the most, the community may devise do's and don'ts for themselves and enforce internally. As long as such social pressure is exerted in a legal manner, the administration should not interfere with the initiatives taken by the community itself, nor be seen publicly advocating them." (MDWS, 2017)

Institutional and financial support is also provided to facilitate this process. Recognising the tendency to resort to events and programmes to disseminate the message, the SBM-IEC norms recommend that 60% of the total IEC budget be ringfenced for IPC activities. The guidelines have also recommended the creation of separate posts for IEC and behaviour change. At the district level, this constitutes an IEC consultant. Further, in order to facilitate IPC, the guidelines stress the need for mobilising an army of "foot soldiers" or "Swachhta Doots"¹⁷ as village motivators.

It is recommended that existing frontline machinery such as PRIs, Cooperatives, AWWs, ASHAs, Community Based Organisation, SHGs etc may also be mobilised. As the guidelines state, "[t] here should however be at least one person in each GP who is made responsible for the sanitation communication and should preferably work on this on a full time basis". Further, this person should be supported by "a community-based vigilance committee in every village who shall be responsible for motivating, assisting construction and ensuring sustained latrine use by every person in each household in the village". (MDWS, 2017).

4.2 IEC process in Udaipur

Central to the government's role in the community movement that SBM desires is its responsibility to educate and convince the people. In form, the process of declaring the village or GP ODF had all the right components. At the village level the process began typically with a Gram Sabha or village meeting, organised by the Panchayat to inform and educate the local residents about the need for toilets.

Simultaneously, SBM Nigaran Samitis/Village Water Sanitation Committee and *prerak* or 'motivation' teams were also mobilised at the GP level to "trigger" and "nudge" the behaviour of households to construct toilets. These usually comprised Anganwadi workers (AWW) and helpers, ASHAs, panchayat workers such as the Secretary and the Ward Panch. These teams reportedly went for household visits and reinforced the message that was disseminated during the village meeting.

A number of innovations were attempted by the Udaipur administration. A key component of Udaipur's renewed focus on SBM was the 30 Days-30 GPs ODF campaign with a focus on local innovation aimed at igniting inter-GP competition. As part of this strategy a number of activities were conducted. These innovations included: the use of local festivals to time communication, use of students as motivators, an ODF Olympics involving an inter-GP volleyball competition, and focused messages on "pride and valour" that is characteristic of the Mewar region (in which Udaipur falls), as well as, messaging on safety and privacy of women.

Once a household had constructed a toilet, concurrent monitoring of usage and prevention of open defecation through daily spot checks was also initiated. Almost every functionary reported early morning visits by the teams to well-known OD spots in the vicinity of the village as a key activity during the process.

The process ended with disbursing the incentive amount of ₹12,000, which is to be given post construction of the toilet. While all these measures were formally implemented,

¹⁷ Interchangeably called preraks and swachhagrahis as well

KEY IEC ACTIVITIES CONDUCTED IN UDAIPUR

- 8 groups were mobilised in Girwa GP during the Gavari festival celebrated by the Bhil community in Rajasthan
- More than 88000 letters were written by students to their parents to encourage construction and usage of toilets.
- A Gaurav yatra (or a walk of pride) was conducted in which a swachhta kalash was passed. Since participation was linked to ODF declarations, community members pressured “left out” households to construct and use toilets.
- An ODF Olympics was organised in September 2016, where only ODF GPs were allowed to participate in a volleyball tournament organised by the district administration. The winning GP received a trophy and cash awards and each of the participating GPs received 2,00,000 from the MPLADS Funds for village development activities; Forty five ODF GPs who had attained ODF status by the enrolment deadline participated.
- Holy trees were planted in known open defecation sites to discourage people to defecate.
- A card known as ‘Carvilo Parivar’ was issued to ODF households. Their ration cards were also stamped as such.
- In addition to positive reinforcements, notice boards listing penalties for open defecators was also placed in ODF GPs

in practice, the time bound nature of the process of ODF declaration had unintended consequences. Even outside of campaign mode, GPs were given as little as 30 days to achieve ODF status. These timelines were imposed from the block or district and added significant pressure on the administration. Consequently, the process diverged from the ideal at different points impacting outcomes. These are described in detail below:-

4.3 Limited focus on inter-personal communication

During the survey, 42% of the sampled households reported having been visited at home by anyone in the context of the SBM. This proportion was found to vary between a maximum of 77% and a minimum of 14% across GPs.

Even among households that were visited, the ensuing discussions do not seem to have played a pivotal role in the decision making process. The survey found that 86% of those who had been visited at least once had constructed toilets, as against 77% among those who had never been visited. Moreover, home visits were said to have persisted only until the construction process was commenced.

The limited attention to IPC is also evident from the budget allocations. 60% of the IEC budget is to be ringfenced for IPC related activities. In FY 2017-18, 71% of the Udaipur IEC budget was earmarked for IPC. However, on removing trainings and other related activities, direct expenditure was found to be 51% of the IEC budget. 18% remained allocated for events and output driven activities such as printing and distribution of posters etc.

4.4 Gaps in Messaging

The importance of messaging in getting communities to change behaviour is evidenced in the reasons stated by households for constructing toilets. The most common reason reported was convenience. This was followed by pressure from administration and women's safety (Figure 13).

The overemphasis on messaging about women's safety and honour, and pressure from administration have important consequences on the access usage gap.

FIGURE 12: PROPORTION OF HOUSEHOLDS VISITED AT HOME IN THE CONTEXT OF SBM

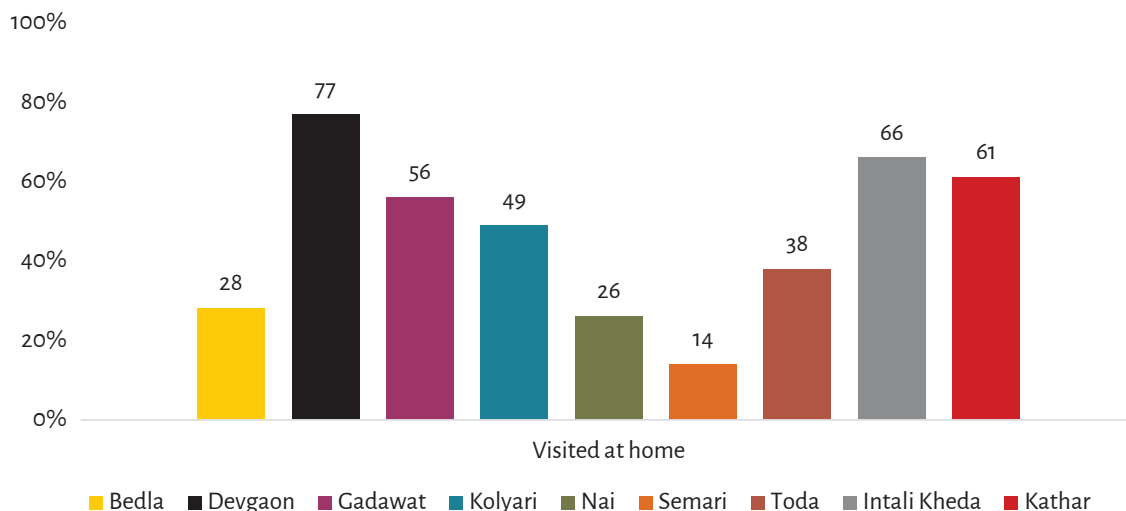
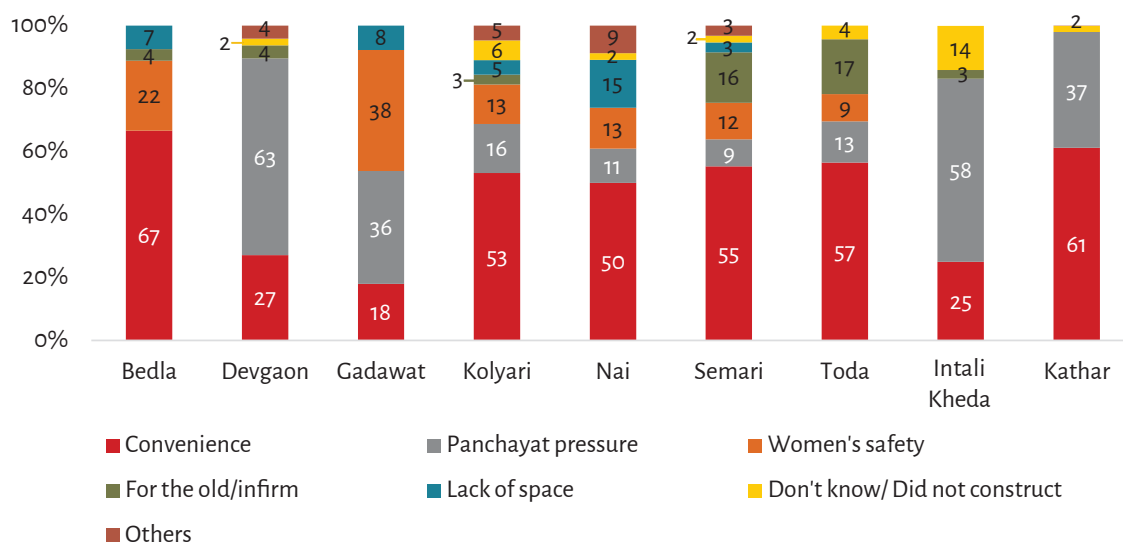


FIGURE 13: STATED REASONS FOR TOILET CONSTRUCTION AMONG TOILET OWNERS



Overemphasis on Women's Safety and Honour

In order to ensure gender sensitive messaging, a separate set of guidelines has been issued by SBM. As these guidelines state, “[It] is noted that behaviour-change messaging in SBM(G) often includes subjects like ‘shame and dignity of women’. While these may be useful for entry-point messaging, they carry risks of lack of ownership by men and reinforcing gender stereotypes (eg: women should not step out of the house, men as custodians of women’s dignity, etc.) The IEC/BCC messaging should, therefore, be gender sensitive and target both men and women, particularly focusing on men who are often the primary decision makers in rural households where household expenditure is involved.” (MDWS, 2017)

Interviews with beneficiaries, as well as functionaries, however suggested that the eventuality which the guidelines warn against came to pass in Udaipur. Several male beneficiaries when asked about usage during the qualitative interviews, reported that since toilets were made for women, the women in the households were using them while they continued to defecate in the open. In addition to affecting the ODF status, in the social context of conservative states, this “toilets for women” narrative can reinforce the desirability of limiting the freedom of movement of women. The implicit lack of agency of women in decision-making for the household is also of concern in this narrative. The skewed need perception also squarely places the additional labour of cleaning and maintenance of toilets in the woman’s share.

“Behaviour change is difficult. We first explained to men, then women. Ladies are more inconvenienced by absence of toilets. ‘Beizzati’ hoti hai women ki.” – BDO

“Reputation of women was a critical factor” - Sarpanch

Focus on incentives

Another widely used tactic to ensure toilet construction was the indiscriminate promise of incentives. Descriptions of the Gram Sabha meetings by a number of functionaries indicated that in some instances at least, the meetings were centred on a general announcement and promise of the government incentive¹⁸.

As the incentive allocation is capped at the static toilet target, this approach of driving behaviour change through monetary incentives could have been counterproductive in cases where it was unavailable. For instance, financial constraint was reported as the most common cause of non-construction. In fact, 95% of beneficiaries without toilets reported it as the primary reason.

Whether people are unable to construct a toilet due to lack of resources or they choose not to do so because no need is perceived is an important question for the Mission. Findings from the survey, however, indicate that lack of resources do not adequately explain non-construction, especially given that other households of similar socio-economic backgrounds had managed to get toilets constructed.

¹⁸ In one instance, the Community Led Total Sanitation (CLTS) triggering exercise was reported by a Block Coordinator.

“Tell people not to OD because it causes harm (nuksaan). Also went to people’s houses. Told people about the 12k scheme.”- Sarpanch

“At the village level meeting people were convinced that they would receive money for constructing the toilets” - Sarpanch

Firstly, among those that built toilets, most households opted for more expensive models. While the government incentive is only ₹12,000, the average cost of a toilet in their estimation ranged between ₹34,631 to ₹42,657. To facilitate construction, 19% of toilet owners reported having taken loans. About 40% of them had to approach the local moneylender for this loan, paying anywhere between 24%-36% as annual interest. The mean loan amount was found to be close to ₹59,000, which is much higher than the average cost of construction. This would suggest that loans were generally taken for constructing more expensive toilets which are considered to be better. For instance, as many as 93% of those who took a loan were found to have constructed septic tanks¹⁹.

There were also differences in the reasons stated by households which took loans to build toilets. More than 70% of them reported that they were constructing toilets for the safety of the women in their household, for convenience, or for privacy. In contrast, less than 10% of the households who took a loan, reported panchayat pressure as the primary cause of construction. This would indicate that households which are adequately convinced of the need for a toilet are likely to not only get the toilet constructed but also to bear considerable expenditure to do so.

Secondly, while affordability can be a barrier, perceived need and prioritisation are also important factors. The survey tried to investigate the priority accorded by households to different financial needs. The findings suggest that 40% of non-owners did not accord the highest priority to constructing a toilet. Instead, 29% of the non owners felt that social obligations such as marriages were a bigger priority for them. Considered in isolation, 82% non owners report thinking about getting a toilet constructed. But when offered as one among a basket of goods, not everyone would choose a toilet.

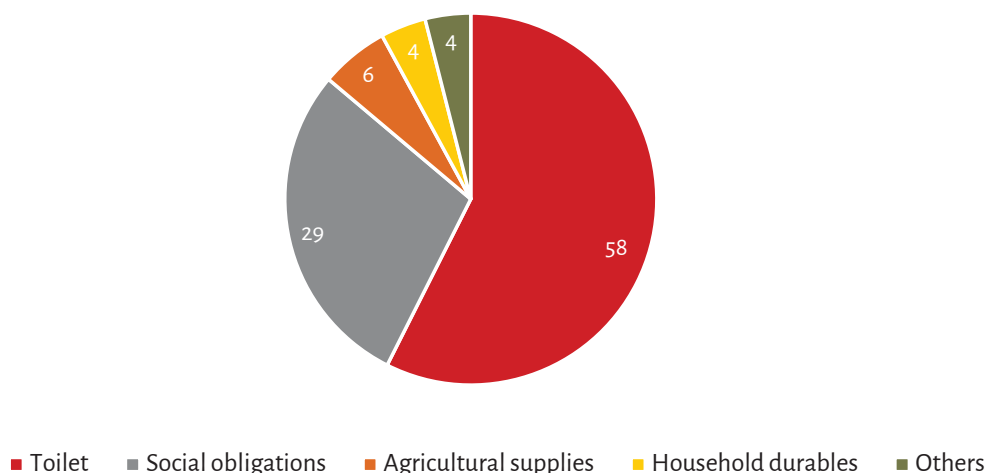
In order to motivate construction, many beneficiaries were reported to have been assured the ₹12,000 incentive if they built a toilet. However, given that the allocations are tied to baseline targets, exhaustion of funds often resulted in non-payment or exclusion of beneficiaries and more commonly, delayed or partial payments. Thus further acted as a disincentive in some cases leading to abandonment of partially constructed toilets.

“People don’t use even if they have a toilet. People get annoyed when they don’t get made beneficiary. They don’t use toilet even if they have it out of anger. Try to convince them to keep it separate.” - BDO

Use of threats and coercion

It was also found that while the district office explicitly disavowed the use of coercive tactics and stated that they did not have government sanction, a number of block and GP level functionaries routinely violated the SBM guidelines which discourage the use of shame and coercion in ensuring toilet construction.

FIGURE 14: STATED SPENDING PRIORITIES AMONG NON OWNERS



¹⁹ Of all the septic tank owners, more than a quarter were found to have taken a loan.

The need and importance of “correct” messaging to trigger behaviour change can be best understood by cross-tabulating the primary motivation for constructing a toilet with usage on the day of the survey. The survey found that in cases where toilets were constructed due to considerations such as lack of open spaces for OD, for ensuring privacy or better health outcomes, the likelihood of them being used on the day of the survey was higher. On the other hand, for toilets which were reportedly constructed under panchayat pressure or without adequate buy in on the part of the beneficiary, usage was found to be lowest.

“Threatened to remove people from NREGA, BPL etc. Used ‘administrative terror’ – refused to get their work done. You can always find pressure points even for the richer communities. If you demoralize the leader of the community then people follow the example.” - BDO

“Threatened with ration cuts and throwing kids out of school. Mortgaged jewellery to make toilet. Cost over a lakh. Had to build, no choice. Even if it means taking loans” - Beneficiary

The survey however found that 25% of all those who constructed toilets reported GP pressure as the primary cause of construction. During the qualitative interviews as well, many respondents mentioned threats and compulsion as the main cause for construction.

“Once you convince a person that they need a toilet, the battle is won. The government is not an issue. Use shame to trigger person to construct a toilet/use a toilet. Show him defecation around temple. Follow up within 48 hours and then leave follow up to village people. Also make it an issue of self-esteem because amount is not a lot.” – Block Development Officer

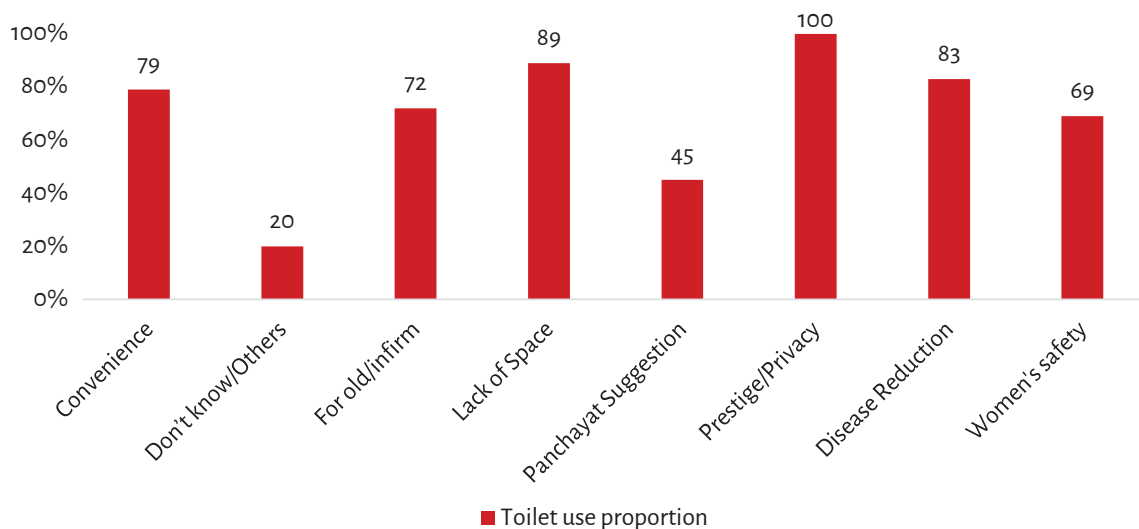
“Only those who construct the toilet themselves actually use them.” – AWW

The impact of adopting coercive tactics on toilet usage is evident from the survey data. While these tactics may induce people to construct toilets, they can also have a counterproductive impact on usage. Thus, Intali Kheda (58%), Gadawat (36%), and Devgaon (63%), where the most number of people report construction under pressure, also had the lowest reported usage of toilets on the day of the survey (Figure 15).

Weak outreach towards marginalised communities

A number of frontline functionaries noted that the commonly used tactics of incentives or disincentives in the form of coercion did not work amongst the remote tribal population. Functionaries also suggested that the terrain made it difficult for them to conduct IEC or monitoring visits. In such a scenario, top down supply driven models for construction were initiated. (Discussed in detail in the next section).

FIGURE 15: LINKAGE BETWEEN PRIMARY CAUSE FOR CONSTRUCTION AND USAGE



“Naya Gaon – tribal village – uneducated, ‘waise se hai’. Even if they have money, they don’t want a toilet.” – Sarpanch

This difference in approach for marginalised communities gains some significance in Udaipur. 60% of the rural population in Udaipur belongs to the Scheduled tribes (STs). While ST hamlets can be found in many villages, there were also ST dominated villages.

These are usually situated in hilly terrain and the households are spread out widely instead of clustered together. The terrain makes it difficult to transport materials and undertake pit digging and construction without heavy machinery (involving higher cost of construction). The empty spaces also make open defecation convenient.

The study found non-ownership to be comparable across caste groups. Thus, the proportion of non-ownership (~18%) among ST households was not found to be greater than any other community or caste group. However, the inability of the local administration in reaching the marginalised was evident in the usage behaviour. On average, 55% of ST respondents reported having defecated in the open on the day of the survey, as opposed to, 11% of the respondents from other communities.

Lack of sustained communications

Finally, the survey also found that consistent communication efforts after the declaration of ODF as advocated by the guidelines were lacking. All activities were found to persist only till the respective construction target was met, and the GP declared itself ODF. In every instance, it was reported that efforts ended as soon as the self-declaration was made.

Several of the gaps identified in the programme implementation in Udaipur are understood to be systemic, and therefore potentially relevant even beyond the district.

Top down pressure and capacity gaps were identified as the two main ingredients of this problem by frontline functionaries. Although the responsibility given to the functionaries is that of generating demand, stringent timelines and inadequate manpower or training impeded this task. Given that demand cannot be generated within the time allowed, supply driven models of toilet construction were put into place, with the understanding that more complex activities like behaviour change be undertaken later.

Outcomes, however, suggest that these supply driven models are not entirely successful. How do supply driven models come to be adopted in achieving demand related outcomes, and why are they unsuccessful? These questions are of some importance and are explored in the next chapter.

5. IMPLEMENTATION PROCESS: CONSTRUCTION AND INCENTIVES

5.1 Process of Construction

In Udaipur, the construction process primarily took three forms.

- **Self-construction** – Households that construct toilets from their own finances or through loans. This is the ideal model as envisaged by the SBM wherein households understand the need for safe sanitation and construct toilets on their own.
- **Split Incentive: 8000-4000 model** – For households which were not able to afford the initial expenditure on the toilet, the district allowed some of the blocks to use what they called the 8000-4000 model wherein, materials worth ₹8,000 rupees would be bought by the GP on behalf of the beneficiary and the remaining ₹4,000 was to be given to the beneficiary for the actual construction work.
- **Contractor model** – There were reports of a third model of construction employed in Udaipur. In some cases, the local administration hired contractors to build basic, uniform toilets in multiple households, sometimes across entire villages. These toilets were supposed to be constructed mostly for those who are either unwilling or unable to construct on their own. A fixed number was thus communicated to the contractor who would undertake the construction. The contractors informed us that they only took the incentive amounts for these constructed toilets as recompense and did not charge anything from the beneficiaries.

5.2 The Incentive Process

As initially conceived, the incentive provided under the Mission for the construction of Individual Household Latrines (IHHL) was to be available to all Below Poverty Line (BPL) Households and certain Above Poverty Line (APL) households restricted to SCs/STs, small and marginal farmers, landless labourers with homestead, physically handicapped and women headed households. Subsequently this eligibility criterion was loosened and the incentive was asked to be given to any household in need, after due revisions in the target list. Despite the relaxation of the eligibility criteria, the guidelines still maintain that priority be given to households belonging to certain categories, including SC and ST households.

While the SBM guidelines allow complete flexibility to the states in terms of incentive provision²⁰, including the options of - not paying the incentive at all, paying it in two or more stages, in cash or kind, to the individual or the community - Direct Benefit Transfer (DBT) is nevertheless advocated. States are advised to include a series of steps in the DBT process for efficient

disbursement. This process includes online demand generation on the part of eligible beneficiaries, onsite verification of toilets including upload of geotagged photographs by the assigned supervisor, and finally detail verification and payment approval on the part of the competent authority.

In Udaipur too, except in instances where initial assistance is given, the incentive amount was to be given subsequent to construction and verification of the toilet as functional. This physical verification had to be substantiated with a picture of the toilet along with the beneficiary and the toilet was to have the SBM logo and date of construction painted on it for purposes of verification and to prevent double counting.

5.3 Gaps in Implementation

The survey found a number of gaps in this process which had consequences on both toilet access as well as usage. These are described below: -

Inaccuracies in Baseline

Across several interviews, GP and block level officers reported that the baseline numbers were not reliable. They were reportedly compiled *“in a hurried manner without entirely realising their relevance”*. By implication, they were not accurate even at the time of submission, notwithstanding the increase in household numbers in the interim.

The inaccuracies in the baseline target have two important consequences. Firstly, given that the target forms the basis of both toilet constructions and subsequent ODF declarations, inaccuracies bring into question the validity of the ODF status. The presumptions that the estimation of toilet needs during the baseline was accurate and that the toilet needs for a village remain static, stand in stark contrast with the finding that 18% households in ODF declared GPs did not have access to a toilet. Secondly, given that the total allocation for toilet incentives remained capped at the total number of households identified during the baseline, it has consequences on the receipt of incentives and coverage of beneficiaries (described below).

Baseline of 2011 is not authentic. There was not enough time, names were repeated, people got left out, it was just done by collating APL BPL information. But baseline has to be used because the payment cannot be made without the beneficiary but only gave a random estimate number which is now necessary to be followed - BDO

²⁰ The states are permitted to increase the amount if considered necessary

Gaps in the construction processes

As mentioned, in addition to cash, many GPs in Udaipur chose to provide materials for construction. Of all toilet owners, 23% were found to have received only construction materials and 4% had received both materials and cash. It is worth noting that the complete incentive amount of ₹12,000 was received by only 26% of toilet owners.

Moreover, the manner in which the district had envisaged the material-cash model was very different from its actual implementation on the ground. As per the government orders, instead of the GP buying materials on behalf of the beneficiary, they were only meant to issue ₹8,000 directly to the beneficiary once the household had dug a twin pit, as advance to procure the materials and start the work.

The remaining ₹4,000 was then to reach them once construction was complete. This flexibility was to be offered only for households belonging to the ST community.

In practice, the process was not demand driven, and in order to approach the issue at scale, bulk procurement was adopted

in some villages. The household was required to transport the material from the GP office. This model was subsequently discontinued by the district administration due to complaints of corruption and leakages.

Incentives and Disincentives

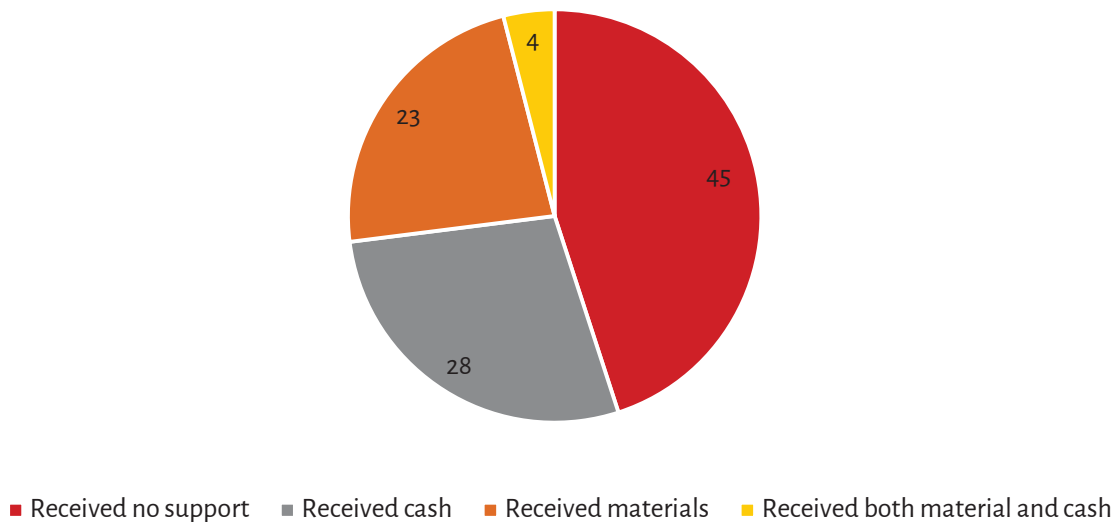
Not all toilet owners had raised a demand for the incentive. The survey found that only 65% of all toilet owners had applied for any incentive under SBM.

There were also gaps in receipt of incentives. Of total toilet owners, assistance was received by 55% of all toilet owners. Interestingly, only 65% of those who had applied for the incentive received it, and by implication, several beneficiaries (34%) who received the incentive in either cash or kind reported not having applied for it.

The receipt of government support, and consequently, the complaints of non-receipts were not uniform across different GPs. In 5 of the 8 GPs, less than half the toilet owners had received **any** government support. This proportion was less than 1 in 5 toilet owners in Devgaon.

"Stopped the 4000-8000 model because of complaints. The tendering process for the procurement of materials takes place at the panchayat level." - BDO

FIGURE 16: TYPE OF GOVERNMENT SUPPORT RECEIVED BY TOILET OWNERS



While in most cases, the number of applicants exceeded the number of receiving beneficiaries, the case of Gadawat is peculiar where only 17% report demanding any support but 82% report receiving it. Interviews with GP functionalities revealed that the GP had suo moto procured materials for toilet construction and distributed it to all households in the GP.

It is worth noting that, while the guidelines recommend that the administration “ensure payment of incentive only after verification of completed toilet thus preventing fraud” (MDWS, 2017), the survey found 4 cases where households with incomplete toilets had received incentive payments.

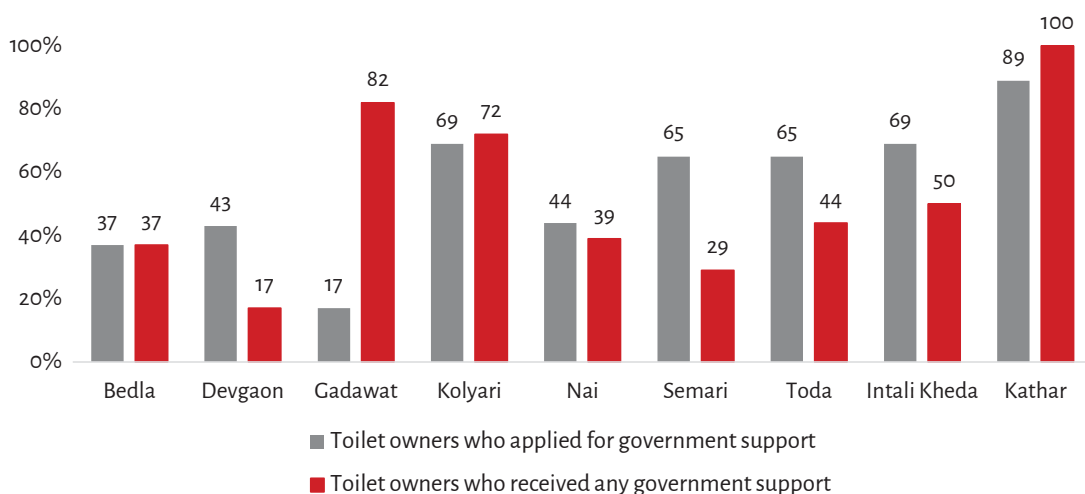
The gaps in receipt of government support has some consequence on completion of toilets. 92% of the 66 households with incomplete toilets reported lack of money or materials as the reason for non-completion²¹. Even with materials being provided, a labour cost of approximately ₹400 per day was to be incurred to employ the masons. In over 90% of the cases of incomplete toilets, beneficiaries were found to have received no government support, or support only in the form of materials. Those households which had received government support in terms of materials found it insufficient.

The guidelines also recommend that all transfers be made directly to bank accounts, but till shortly before this survey, this process was not in place in Udaipur.

Given the difference between applications and receipts of incentive, the questions of “eligibility” and priority becomes pertinent. While the survey was unable to accurately capture “eligibility”, a good proxy for it can be the proportion of households that belong to SC/ST categories. The sample covered during the survey comprised 52% (294) households belonging to SC/ST categories.

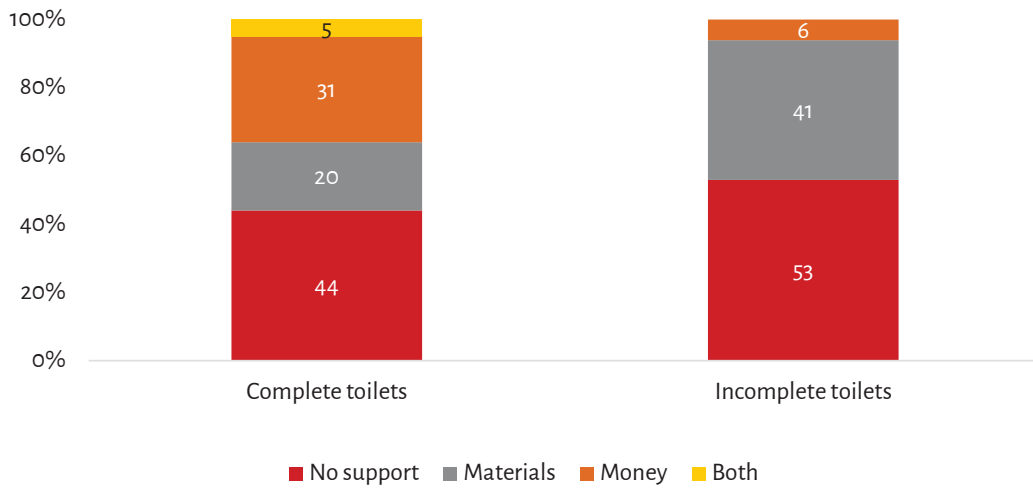
It was seen that 82% of these SC/ST households owned toilets, and this proportion is largely constant across social categories. However, this proportion drops significantly to 63% when one removes incomplete toilets from consideration. The proportion of SC/ST households who received any government support was lower still at 43%. The proportion which received money (as opposed to materials procured by the GP on their behalf) was only 21%. Thus, only one in five SC/ST households covered during the survey received any part of the incentive in monetary form.

FIGURE 17: APPLICATIONS FOR AND RECEIPT OF GOVERNMENT SUPPORT BY GP



²¹ The incomplete toilets were invariably found to be missing some part of the super structure. As the pits had to be dug by the beneficiaries themselves this was almost always found to have been done.

FIGURE 18: CORRELATION BETWEEN TYPE OF RECEIPT AND COMPLETION OF TOILET

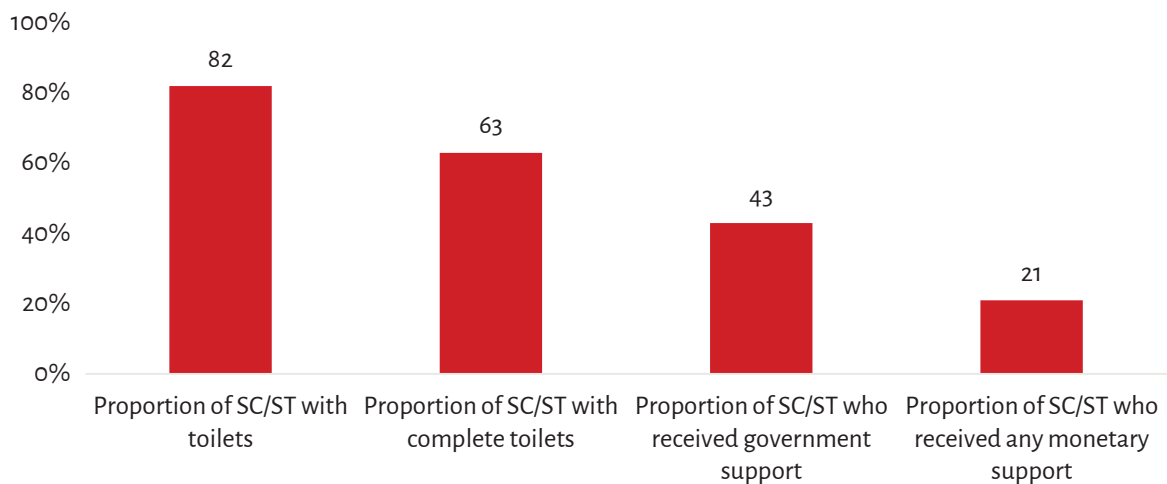


5.4 Impact of Supply Driven Models

As mentioned, there were reports of a contractor based model being resorted to in some GPs. While most government functionaries denied that this model existed, one BDO informed us that this was indeed happening in other blocks, although he made it clear that because this model offers “scope for corruption”, it was not allowed to GPs within his jurisdiction.

“Some GPs have contractors but not in our block. Uniform construction is a giveaway. Contractors need sarpanch support and this leads to corruption and kickbacks which impacts quality of construction”. - BDO

FIGURE 19: CONSTRUCTION AND RECEIPT OF GOVERNMENT SUPPORT AMONG SC/ST HOUSEHOLDS



In the contractor model too, the Sarpanch had control over the hiring of the contractor and the procurement of materials. However, there was no documentation available for tracking the cost of the materials, the cost of construction, and the amount paid to the contractor in the instances where he was hired by the Sarpanch. No formal tendering process was found to have been adopted at the GP level as in the case of procurement of materials. Complaints about the poor quality of material used in the construction, with cases of toilets falling apart were also noted.

The supply driven model had consequences on toilet access and usage. For instance, 14% of the toilets in Intali Kheda were reported to have been contracted to an NGO. Intali Kheda, a verified ODF GP, was found to have toilet access among 58% of the sample, of which 28% were incomplete. During an interview with one of the contractors, he mentioned operating a non-profit which took contracts for *“everything from triggering to monitoring”*, although construction remains a mainstay of the terms of reference. Moreover, during the qualitative interviews it was found that several of these toilets were unused by the owners. Some of them in fact, were used for storage or other purposes.

“There was no tendering process for this appointment. The tendering process was avoided as it was seen as long drawn and there was timeline pressure” - Sarpanch

Quite apart from the impact on access and functionality of toilets, the linkages between the reason why a household constructs a toilet and the likelihood of its being used have been outlined previously. The SBM is aware of this linkage and repeatedly stresses the need for the beneficiary to be involved and invested in the construction process. While coercive tactics or monetary incentives can motivate the construction of toilets, its usage is dependent on the perceived need and advantages. In order for these to be understood and accepted by households, a sustained engagement and dialogue is essential. It is this dialogue in the form of IEC and behaviour change communications which is an important factor in the success or failure of the SBM.

6. MOVING TOWARDS SUSTAINABLE SANITATION

Two types of threats imperil the gains made under the SBM. While important, the possibility of relapse into open defecation is only one of the threats to sustainability. Other threats are in fact occasioned by the changes achieved by the Mission. As the access and usage of toilets increase, second order issues such as mechanisms and infrastructure for Faecal Sludge Management (FSM) emerge.

The Mission recognises that ensuring sustainability of gains implies three essential elements. These are: a) adoption of sanitary and suitable toilet technology; b) continued engagement with beneficiaries and awareness generation efforts, and c) robust verification and evaluation processes post ODF declaration. The survey found gaps in each of these three aspects.

As a part of the continuing engagement mandate, the guidelines recommend several sanitation related activities which are clubbed into a set called ODF Plus. These include – “*Water, cleanliness of water sources and public water bodies, decentralized solid and liquid waste management, 3Rs (Reduce, Recycle and Reuse), drains, maintenance of school and Anganwadi toilets, hand-washing and personal hygiene, hand-washing in school before Mid-Day-Meal, awareness and training on pit emptying and faecal sludge management etc*” (MDWS, 2017).

Two issues emerge as a result. One, many of these activities, such as, hygiene promotion and Faecal Sludge Management (FSM) are closely intertwined with the core objectives of SBM. By placing them outside the scope of the core requirements, and deferring them to after ODF declaration, the Mission tacitly pronounces them to be of secondary importance. As a result, little attention is

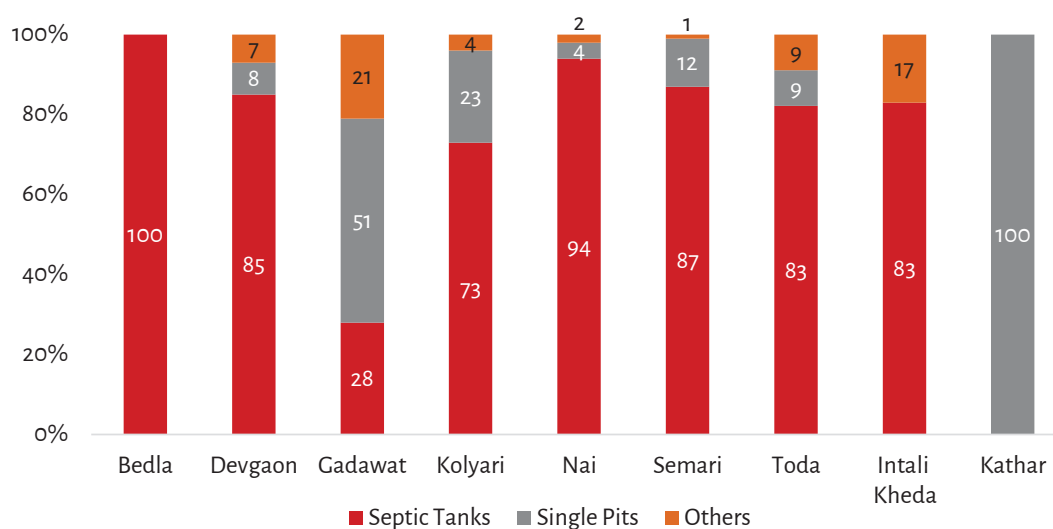
paid to issues like FSM during the IEC process. Further, by placing them outside the scope of ODF (by naming them ODF plus), there is limited pressure to pursue them once ODF is declared. The consequences of this approach on sustainability are adverse and potentially severe and will be discussed in this section.

6.1 Understanding Toilet Technology – Choices and Implications

Failure to adopt appropriate toilet technology can have serious repercussions on sustainability of gains. The guidelines list several safe toilet technologies. These include: twin pit, septic tanks, and bio toilets among others. While the guidelines offer flexibility in toilet choices, and encourage innovation to suit local topographical and climatic conditions, there are certain cautionary recommendations. First, the guidelines expressly mandate that insanitary latrines as defined by the ‘The Prohibition of Employment as Manual Scavenger and Rehabilitation Act, 2013’ may not be constructed. This would by definition exclude the construction of single pit toilets, which are designed to require manual clearance and handling of faecal matter before complete decomposition in order to continue usage. Second, septic tanks while requiring no disposal, do need intermittent cleaning, which is not a straightforward task and can be dangerous for untrained or underequipped workers. Further, septic tanks are expensive and require an ecosystem of services, making them more suited to urban locations. Keeping these criteria in mind, the SBM-G guidelines recommend the construction of a twin leach pit toilet in most rural areas.

Other than the sanitary requirements of the substructure, the guidelines recommend that the superstructures should be

FIGURE 20: TYPE OF TOILETS BY GPS



comfortable and as per the requirements of the households. Further, that “overconstruction” should be avoided to ensure that the costs remain low and affordable.

The study attempted to capture the types of toilets that were being constructed by the beneficiaries. Since it was not possible to observe and verify the substructure, toilet types were recorded according to stated responses. Our findings are given below: -

A large proportion of households are choosing not to construct twin pit toilets. In our overall sample, we only encountered 3 households which reported having twin pit toilets. A majority of the toilets were reported to be septic tanks while the remainder were primarily single leach pits.

The proportion of septic tanks²² was highest in Bedla, which as previously noted, has the greatest proximity to the urban centre, granting it more access to urban technology and masons. On the other hand, in Kathar,²³ the first GP to be declared ODF in a time period of 42 days, all the toilets that were encountered were found to be single leach pits. In Gadawat too, more than half the toilets were reported to be single pits.

Limited awareness on Toilet Technology

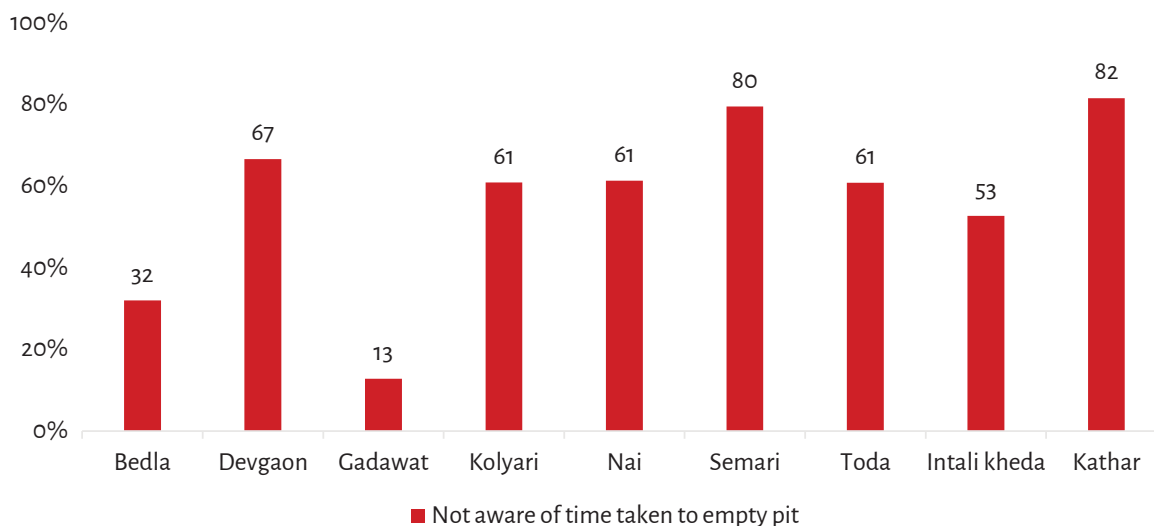
One of the main drivers behind wanting a ‘better’ or bigger toilet, usually in the form of septic tanks, was the lack of awareness on issues related to substructures and safe confinement. On average, 61% of the toilet owners did not know the time it would take before their pit would fill up if every member in the family used the toilet.

Lack of Formal Faecal Sludge Management

The limited understanding of toilet technology is exacerbated by the lack of any formal FSM options, such as, mechanised pit emptying services in most of these villages. When asked about whether people would clean their own pits, 73% of all respondents were clear that no one in their communities would empty their own pits, while another 24% did not comment on the question.

In such a scenario, the traditional systems of employing manual scavengers are seen as the only resort. As can be seen in Figure 22, 86% of the toilet owners clearly stated that they would call manual scavengers to empty their pits when required, while another 13% either did not respond to the question or said that they would revert to open defecation when such a time came.

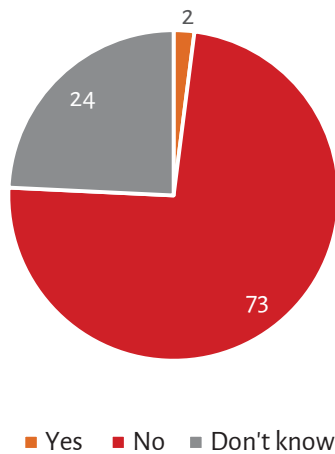
FIGURE 21: PROPORTION OF TOILET OWNERS UNAWARE OF TIME TAKEN FOR EMPTYING PIT



²² Based on the descriptions given by respondents, it is possible that some of the toilets which are called septic tanks are in reality larger single pits, walled and cemented on all sides to prevent leaching. If so, then they cannot be considered sanitary toilets.

²³ Kathar was the first GP to be declared ODF in Udaipur in a duration of less than 45 days

FIGURE 22: PROBABILITY OF PEOPLE EMPTYING THEIR OWN PITS



The lack of awareness on the part of the beneficiaries suggests that the behaviour change and IEC efforts in explaining toilet technology and its implications have not succeeded. On the contrary, the appeal to family pride and honour in the communication activities might nudge relatively well-off households to opt for the more expensive (and by implication better) toilets. While this survey did not capture data on income indicators, some tentative conclusions may be drawn from the fact that 48% of Scheduled Tribes (ST) respondents reported owning a septic tank as compared to 73% of the general category respondents and 97% of the OBC respondents.

“Why are people still making single pit? Depends on the person's economic condition. We wanted to at least start toilet usage. Once it starts, they get into the habit of usage. There's no set design for toilets. Designs are different everywhere” - BDO

Moreover, in the absence of information, households are dependent on toilet technologies promoted by masons. A group interview conducted with masons found that a number of them also reported that larger toilets and septic tanks are 'better,' and encouraged households to construct them.

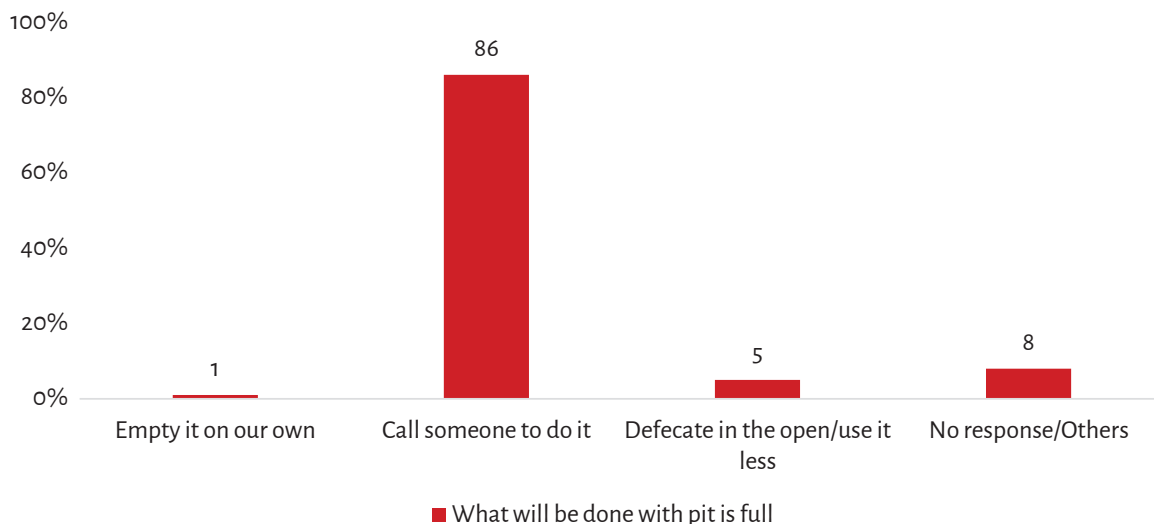
These questions, however, were seen as distant and secondary by some of the frontline functionaries, one of whom suggested that it is enough that, *“at least they have something in the form of a functional toilet.”* They focus on the immediate priority of getting the toilet constructed. This short-sighted approach could have an impact on the sustainability of the programme even in the medium term. As the pits fill, toilet owners would be either forced to resort to manual scavenging, an unlawful activity, or potentially relapse into open defecation.

Sustainability of ODF status will face significant challenges over the next few years as the question of FSM becomes urgent given the massive increase in toilet access. A more preventive approach to this problem requires two simultaneous activities. First, sustained engagement and IEC after ODF declaration, and robust post declaration verification mechanisms to identify gaps and prevent lapses.

The guidelines state that *“IEC/BCC activities should be carried out in the post-ODF phase as well, to continue focus on issues such as cleaning and maintenance of toilets, emptying of toilet pits by the household, continuation of usage, developing Gram Panchayat mechanisms to ensure sustainability, ensuring water for sanitation, SLWM activities etc.”* (MDWS, 2017)

In the GPs visited during the study, however, no such ODF Plus activities were encountered. This was further verified by every frontline functionary interviewed

FIGURE 23: WHAT TOILET OWNERS WOULD DO WHEN PITS ARE FULL



6.2 Lack of Concurrent Monitoring

In response to the possible fallout of the supply driven model without adequate demand generation activities, the usual retort is that of gradual change. It is contended that behaviour will change over a period, once access is provided. This argument is tenuous, especially in the absence of strong monitoring feedback into the implementation process. The SBM guidelines give a detailed protocol for monitoring activities before and after ODF declaration. In fact, a portion of the budget is to be ringfenced for these activities and mechanisms to be put in place. The guidelines state - “[t]o ensure that monitoring and evaluation activities are carried out in the States, 5% of all the funds available at the State level for administrative expenditure shall be utilised for relevant monitoring and evaluation studies of the programme. State will make arrangements for **concurrent monitoring and social audits**²⁴. Third party/independent evaluations and impact studies may also be conducted by reputed national level agencies empanelled for the purpose” (MDWS, 2017).

While much of this is to be the responsibility of the state governments, actual concurrent monitoring is to be a concerted effort between the frontline functionaries and the community. Social audits are specifically mentioned and the role of the block office is given prominence. Further, at least three verifications of each toilet’s functionality are to be conducted, by the AWW, ward panch, and panchayat secretary. In addition, geotagged pictures of the toilets are to be clicked and paperwork completed before the incentive can be released. The survey found that on average only 43% of households had been visited by any official with respect to the SBM, toilets and their usage, with this proportion being as low as 14% in some GPs. Overall across Udaipur district, only 20% of toilet pictures had been uploaded at the time of the survey.

On the question of monitoring, the “morning follow ups”, where a team visits known OD spots and catches people in the act, were commonly reported. Most officials mentioned the Nigarani Samiti which was invariably the same group of functionaries otherwise involved in scheme implementation. Children were reported to have been involved in monitoring in some places. However, only 10% of the respondents had heard of the Nigarani Samiti and its activities. Further, all officials agreed that this monitoring had stopped entirely after the declaration of ODF. This could certainly be a contributing factor behind the high rates of open defecation on the day of the survey.

6.3 Verification and the Challenge of Sustainability

Detailed processes have also been laid down in the guidelines for the verification of the ODF status which is otherwise self-proclaimed. The guidelines recommend that, “[s]ince ODF is

not a one-time process, at least two verifications may be carried out. The first verification must be carried out within three months of the declaration to verify the ODF status. In order to ensure sustainability of ODF, a second verification may be carried out around six months after the first verification.” They further state that, “[t]he State will ensure **at least one level of verification of all households**²⁶ in every village that declares itself ODF. If some States may have more than one level of verification, the subsequent verifications can be on a sample basis.” (MDWS, 2017)

A model checklist of verification parameters is provided and the states are allowed the flexibility of including other indicators as locally relevant. The verifications may also be carried out through internal teams or independent external evaluators.

The state of Rajasthan has put in place its own detailed verification guidelines involving four administrative levels. This verification is to happen at the GP, Block, District, and State level and is to be repeated regularly. In addition, external agencies are to play a role in independent verification.

Collecting evidence on the implementation of the verification process remained beyond the scope of this study. However, the fact that Intali Kheda, an ODF verified GP lacked access to toilets in 42% of its surveyed households, raises questions about the robustness of this process. Moreover, interviews with frontline functionaries revealed that there was limited understanding on the verification process. This is despite the fact that BDOs and Block coordinators have a key role to play in inter-block verifications.

The SBM guidelines also adopt a curiously liberal approach towards cases such as Intali Kheda. This could further compound the consequences of limited verification. A notification dated August 22, 2017 by the Ministry of Drinking Water and Sanitation illustrates the potential loophole that is provided for retaining ODF status despite lapses.

“Clarification on ODF declaration, verification and sustainability of ODF Status - It is observed that despite declaration and verification, there are instances of ‘slip-back’ by some households or ‘outsiders’. It may be noted that an ODF declared and verified village, district or State does not necessarily lose its ODF status on account of the temporary ‘slip-back’. If an ODF declared village is found to have gaps in its status during the verification, the district administration needs to ensure that such gaps are plugged. The ODF declared and verified villages and districts must continue to focus on intensified IEC and behavior change campaigns to ensure that their ODF status is restored and sustained until the practice of defecating in the open by the entire community is eliminated. Any institutional issues that may be found, such as inactive Nigarani Samitis at the village level must be addressed till instances of open defecation are stopped.” (MDWS, 2017)

²⁴ Emphasis added

In effect this order states that even if the ODF self-declaration is observed to be unfounded during the verification, it need not be rescinded. This can potentially relegate the verification exercise into another round of monitoring with little or no corrective potential.

The process failures in IEC and verification contribute significantly to the deficient outcomes of the programme owing to their centrality in the SBM implementation strategy. Admittedly, these tasks are non-routine and complicated, require multiple interactions with beneficiaries across touchpoints, and also demand discretion on the part of the frontline functionaries. The question of structural capacity needs examination in order to understand these outcomes. The next chapter examines the capacity of the system to bear the load of the Mission.

7. CHALLENGE OF ADMINISTRATIVE CAPACITY

The execution of a complex scheme such as SBM with its focus on effecting behaviour change through dialogue and communication in a time bound manner requires the presence of a strong bureaucratic machinery with the capacity and motivation to deliver. The efforts involved in mobilising and sustaining a mass movement seeking to overturn established social customs are tremendous. They demand a sound understanding of the issue and the patience and skills to communicate its importance to people who are often unwilling to listen. The sheer scale of the exercise is unparalleled anywhere in the world. Understandably, administrative capacity needs to be fortified substantially in order to execute these responsibilities effectively. Thus as the guidelines note, a key strategy of the mission is:

- “Augmenting the institutional capacity of districts for undertaking intensive behaviour change activities at the grassroots level”, and,
- “Strengthening the capacities of implementing agencies to roll out the programme in a time-bound manner and to measure collective outcomes”

The augmentation of institutional capacity and skill building of individual agents are both prerequisites and ongoing requirements. In many ways, human resource is the most important input for the Mission. Having examined the outputs and outcomes, and traced them back to process failures, the logical next question is whether the inputs in the form of human resources towards Mission implementation have been adequate. This question is sought to be explored in this chapter.

ROLE OF SELF HELP GROUPS AS MOTIVATORS

In one Panchayat, self help groups were said to have played an important part in the process of becoming ODF. This panchayat and its involvement of SHGs has received some attention and was otherwise lauded. It was reported that the women of the SHG were involved in household visits and IEC activities. Importantly, the SHGs had also arranged for micro loans for toilet construction at 24% annual interest. In some instances they even reported contributing labour to a household's construction efforts. These SHG members were subsequently given formal inclusion in the resource groups by the district.

The research however found that the impact of SHG involvement was mixed. Panchayats where SHGs were active also had a high proportion of incomplete toilets. Some of the “toilets” were found to be abandoned pits with no adjacent superstructure.

As previously mentioned, the district is the focal point of SBM implementation. In order to facilitate implementation, the SBM-G guidelines envisage a number of different posts including: a District Coordinator, 1 Assistant Coordinator, 1 IEC Consultant, 1 Capacity Building Consultant, 1 Monitoring and Evaluation Consultant, 1 Sanitation and Hygiene expert, and 1 Solid and Liquid Waste management expert, other than an Accountant and a Data Entry Officer.

At the block, the Block Programme Management Unit (BPMU) is to play a key role. The guidelines advise state governments, “to post a government officer as a full-time Block Sanitation Officer. Until that is made operational, the State governments may officially assign SBM(G) activities to a senior official posted at the Block level. He/She may be assisted by a Block Coordinator and a Data Entry Operator engaged on contract who shall be provided emoluments to be decided by State. This Block level arrangement shall be asked with handholding, supervising and monitoring every GP in the implementation of the scheme.” (MDWS, 2017)

At the village or community level, GPs play a pivotal role in implementation. Their responsibilities include IEC, construction, monitoring and verification. In Udaipur, they were also initially charged with distribution of incentives along with the block office²⁵. Given this crucial role in the implementation of the programme, GPs are meant to work in collaboration with other frontline functionaries at the village level, namely the AWWs and ASHA workers, for on ground activation. The guidelines further recommend building a volunteer cadre called *preraks* (now *swachhagrahis*) to assist in dissemination of information.

The study however found a number of challenges in administrative capacity ranging from vacancies, limited training and lack of clarity on roles and responsibilities. These are described below:-

Gaps in staffing and high vacancies

In Udaipur, at the district level the CEO of the Zilla Panchayat with the support of a District Coordinator, was found to be implementing the programme in coordination with the Block Development Officers (BDOs).

“Motivators – swachhta prerak – only working well in 2-3 blocks. It needs team to function in coordination. Needs leadership. Udaipur is very low on staff in most blocks.” - BDO

²⁵ Towards the end of the survey the role of the blocks and the panchayats in disbursement of incentives was reported to have been withdrawn, with funds being directly transferred from the district office to the account of the beneficiary.

Full time positions of consultants and experts recommended by the guidelines, however, were not found to exist and no full time block sanitation officers had been appointed in any of the blocks visited. This role was found to be played by a contractual Block Coordinator who worked with the GPs through the relevant panchayat secretaries. Moreover, at the time of the survey, the Block Coordinator post was found to be vacant in 4 blocks of the district.

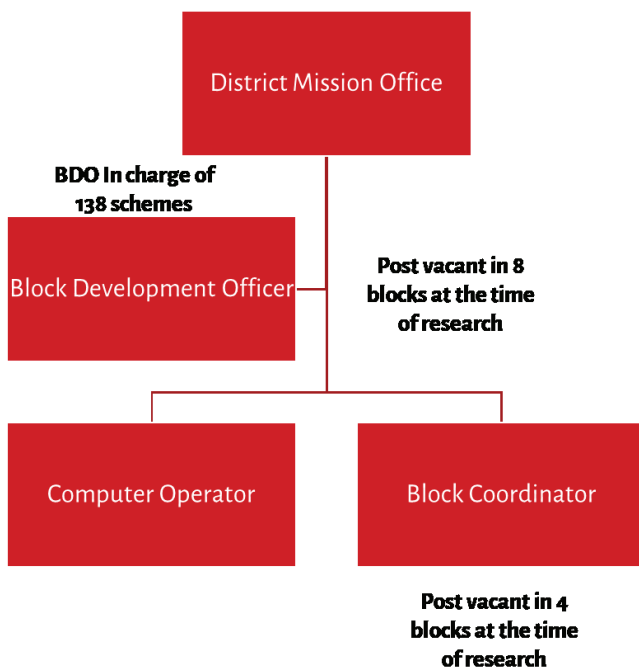
The presence of *swachhta preraks* in the district was also found to be sparse and their involvement limited. Many AWWs could not identify *preraks* in their catchments and reported that they themselves were charged with target completions. Where they were present, these *preraks* were said to be people associated with the GP. In some cases, previous ward panches and masons were acting as *preraks*.

Lack of clarity on roles and responsibilities

The study also identified several gaps with respect to clarity of roles and responsibilities resulting in overburdening human resources and low motivation.

Firstly, there was lack of clarity on the role of the Block Programme Management Unit (BPMU) within the administrative machinery. While at the time of the survey, fund disbursement to GPs was the responsibility of the BPMU, some block officers denied having much of a role to play in the implementation of the programme, and specifically in fund disbursement.

Figure 24 - SBM Implementation structure - Udaipur



However, interviews with various authorities including the district office suggested that the actual implementation is led by the BDO. According to the district office, the significant disparities in implementation across blocks is due to differences in block leadership.

BDOs in Udaipur are in charge of simultaneously handling 138 programmes other than the SBM, which affects their ability to deliver on SBM. Additionally, at the time of the survey, the post was vacant in 8 blocks and many BDOs were handling dual charges. Considering that the guidelines require that “[c]apacity building and generating awareness including triggering demand among the community on various aspects of sanitation will be taken up by BPMUs though the designated CSO/Swachhagrahis/Sena etc.” (MDWS, 2017), the gaps in capacity at the BPMU level can have a significant impact on programme outcomes.

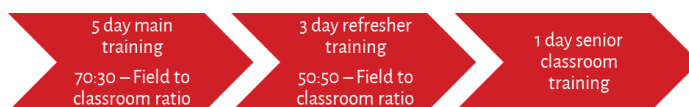
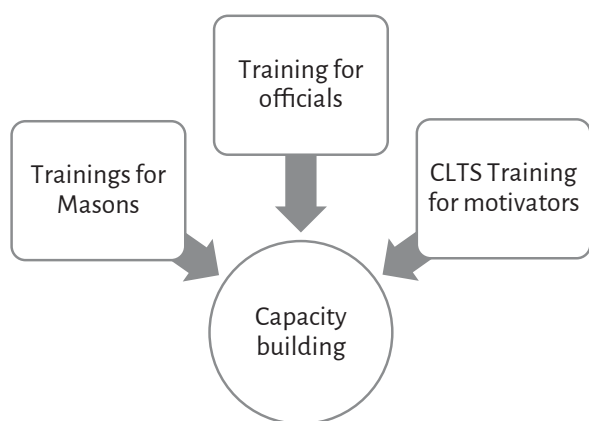
Secondly, involvement of the community could not be identified at all except in so far as the GP and its functionaries can be said to represent the community. Moreover, given that accountability of the GPs flows upwards towards the district rather than downwards, for all practical purposes they operate as a downward extension of the bureaucracy.

High Pressures and Low Motivation

Several GP and block officers complained about the strict timelines and severe pressure on target completion. They reported that they had no option but to transfer this pressure downwards and hastily meet the targets. During the time when the scheme was active in their respective jurisdictions, all other work was reported to have been stalled. Subsequent to target completion, the pressure reduced and post completion activities required by the guidelines, such as, monitoring and persistent communications were absent.

“If we had waited for people to demand, wouldn't have done it in 42 days. Stopped all our other work.” - Sarpanch

FIGURE 25: TYPES OF TRAININGS UNDER SBM



In order to overcome human resource gaps in the short term, contractual positions such as for Block Coordinators, and volunteers such as the *preraks*, are two commonly adopted measures. These, however, led to their own problems. Low wages as compared to permanent employees, delays in payments, and demands of being given permanent positions tend to be demotivating factors for contractual employees, and can, occasionally disrupt work.

For instance, in Udaipur, while *preraks* were supposed to be paid a “*protsahan rashi*” of ₹75 per toilet, subsequently increased to ₹150 per toilet (MDWS, 2017), many *preraks* had not received this incentive, contributing to their low motivation.

Protests by *preraks* against non payment of dues have taken place across many states including Haryana and Bihar, and litigation has been commenced in some cases. Udaipur administration too was facing litigation from contractual Block Coordinators which had led to the courts declaring a stay on further appointments at the time of the survey.

Gaps in Capacity – Insufficient Training

Capacity building is an essential component under SBM which emphatically states, “[a]dministrative and technical experts (e.g. in IEC and BCC, capacity building, technical supervision, SLWM and Monitoring and Evaluation) are to be engaged at the State, District and Block levels. Ministry has empaneled 36 Key Resource Centres (KRCs) and these can be engaged by States and Districts for local level capacity building” (MDWS, 2018b). The presence of these experts was not discovered in any of the blocks during the research.

The guidelines also recommend training support at three different levels: Officials, masons, and CLTS training for motivators (see Figure 25). Of these, only the training of trainers, for the GP and Block functionaries, facilitated by UNICEF was found to have taken place everywhere. Trainings for motivators which largely included the frontline functionaries, were reported irregularly and did not follow a fixed template. Trainings for

masons, while reported by one GP member, were found to not have taken place in most cases.

Further, there are three forms of training programmes that have been created. These are: (a) main training for all motivators, (b) refresher training, and (c) a one day training for senior officials. The main training is intended for all implementers and lasts 5 days, extensively covering all relevant issues including triggering and communication techniques. Roughly 70% of this training takes the form of classroom sessions. Refresher trainings last three days, half of which time is to be spent on the field (UNICEF, 2017).

Trainings however do not follow a regular schedule. Instead, trainings are arranged based on a needs assessment undertaken by the district. However, the assessment and followups of those trained were not systematised. The process was dependent on external agencies including UNICEF, and capacity to conduct these trainings in a self-sufficient manner did not exist. Other than regularity, quality control and standardisation of trainings were perceived to be insufficient. Issues like IPC did not get enough attention and the ability to contextualise and adapt existing tools for specific local contexts was not found to be inculcated. The downward transfer of these learnings was also of concern in the process.

Overburdening weak systems

The capacity of these limited resources cannot be considered sufficient for the implementation of a multifaceted programme like SBM, in accordance with the norms laid out in the guidelines. The manifestation of poor institutional capacity is particularly stark on complex processes involving individual discretion and multiple intertwined activities, such as in attempting social and behavioural changes. In the absence of requisite capabilities, frontline functionaries are often left dependent on specific instructions to follow, unable to react to local complexities and challenges. Outcomes which are predicated on the success of complex processes are left wanting as a result.

The case of Udaipur provides some evidence of the impact of inadequate capabilities on outcomes. The response of the administration in such situations is usually to reinforce specific instructions, issue fresh directives, and add layers of supervision. Invariably however, these new activities are to proceed through the very same channels and only serve to add to the burden on already weak systems. These measures are thus liable to weigh down the administrative mechanisms and drive the implementation further away from its desired objectives.

8. CONCLUSIONS – THEORY AND PRACTICE OF SUSTAINABLE SANITATION

The failure of India's sanitation policy prior to the launch of the SBM has been studied and commented upon widely. Huesco & Bell (2013) examined the implementation of the TSC and concluded that implementation was unaligned with policy guidelines. Specifically, they criticised the programme for being “government-led, infrastructure-centred, subsidy-based and supply-led” leading to poor outcomes. The reasons for this policy – implementation gap according to them, included, “low political priority; flawed monitoring; distorting accountability and career incentives; technocratic and paternalistic inertia; and corruption” (Ibid).

In many ways the SBM was to mark a departure from these methods. The guidelines repeatedly stress the need for better monitoring, community involvement and leadership, and behaviour change through inter-personal behaviour change communications. It must, however, be noted that the guidelines offer complete flexibility to states along with the several approach options to every aspect. This led one senior bureaucrat who was closely associated with the programme to comment that “guidelines which say everything say nothing at all”.

The findings of the survey are representative only of the ODF GPs in Udaipur. The various disparities found even within this limited sample further inhibit generalisation. However, identifiable gaps in outcomes can be traced back to structural or procedural flaws in implementation. In Udaipur, the process of implementation was found to at least loosely adhere to the guidelines. The deviations were often contextual peculiarities.

There is no evidence to suggest that the implementation processes adopted in other districts and even states are fundamentally and significantly different. At the same time, the systemic shortcomings which handicap Udaipur administration also affect other jurisdictions to differing degrees. Even if local and context specific factors outweigh all others in driving outcomes, the average district would confront similar challenges during and subsequent to ODF declaration.

The question of whether the SBM has succeeded in shaking off the legacy of its flawed predecessors gains in importance as its time bound mandate comes to a close. Timely identification and recognition of gaps is essential to formulating a response within the limited period left to the mission. One important way in which the SBM significantly differs from previous sanitation programmes is in terms of public and political interest. The announcement of its launch by the Prime Minister and his subsequent attention to the programme have clearly translated into administrative pressure down to the last village. Its role in ensuring timely ODF declarations has been significant and this has managed to, at least temporarily, shake the frontline bureaucracy out of its inertia. However, neither the political

interest nor the resultant pressures can be permanent. Even declaration of ODF is sufficient to abate it.

The Mission is even now faced with three essential questions. What can be said about the role of the community in this mass movement? Has the frontline functionary sufficiently understood and engaged with the change that she seeks? And, will the average beneficiary really use the toilet she/he is building? One more question underpins all of these. Have the largely unchanged structures of implementation been able to absorb the added pressure? Or has the impact of this significantly increased political pressure on these beleaguered systems led to what Andrews, et al. (2017) would call “premature loadbearing” whereby excessive responsibility is placed on systems too soon? Andrews, et al. (2017) posit that, in the absence of adequate support and seeing little possibility of success, these systems resort to pro forma activities, mimicking the form of their activity without concern for substance. It is with the limited objective of exploring these questions that the survey findings are conceptually presented as potential challenges for the Mission as a whole, in this section.

Role of the community – The SBM repeatedly stresses the need for community involvement and leadership to make the Mission a success. The success of the effort is thus tied to the endorsement and adoption by the community. To what extent is the implementation of the programme aligned to this policy vision is an important question. The experience in Udaipur can offer some initial insights.

Community approaches to sanitation are varied and constantly evolving. A useful framework to understand the alignment of the SBM implementation with community approaches to sanitation can be found in UNICEF (2009) on the 9 “non negotiable” elements of Community Approaches to Total Sanitation (CATS). Given that these were adopted in the training and orientation modules for senior managing officers of the government by MDWS, they provide a useful base against which to measure implementation realities. These 9 essential elements are listed in the MDWS training module (MDWS, 2018). Relevant findings from Udaipur are briefly discussed here –

■ **Focus on sustainable use of facilities and appropriate technology:** “CATS aim to achieve 100 per cent ODF communities through affordable, appropriate technology and behavioral change. The emphasis of CATS is the sustainable use of sanitation facilities rather than the construction of infrastructure.”

The very first non-negotiable element is of utmost importance and stresses three points which subsume the criticism of Huesco & Bell, (2013). It is also seen that the implementation in Udaipur sharply diverges from this ideal. The focus in Udaipur has remained on the short term objective of getting toilets

constructed, as reported by the functionaries. This led to neglect of both the technology issue, and the sustainable use issue. As a result, a majority of the toilets constructed were found to be septic tanks which were unsuitable to rural conditions, or insanitary single pit toilets. It also led to a significant access-usage gap. The result was that none of the GPs studied were found to be 100% ODF.

■ **Broad engagement of diverse members of the community:** *“CATS depend on broad engagement with diverse members of the community, including households, schools, health centres and traditional leadership structures.”*

While such an engagement was attempted in Udaipur, its depth and success are questionable. Two issues identified during the study serve to highlight this. Firstly, the lack of adequate inclusion of the SC/ST sub-groups. The ST sub-group especially is of importance given their socio-demographic prominence in the district. Yet, this sub-group was the most excluded in incentive receipts. Lack of adequate IEC activities and IPC acknowledged by the functionaries also led to deficient usage practices. To a limited extent, the lack of functional toilets in public facilities also indicates that the primary focus of the Mission implementation remained on household toilet targets.

■ **Community role central to planning and implementation:** *“Communities lead the change process and use their own capacities to attain their objectives. Their role is central in planning and implementing CATS, taking into account the needs of diverse community members, including vulnerable groups, people with disabilities, and women and girls.”*

Divergence from this ideal was the most evident. The role of the community in either planning or implementing the Mission was negligible, except in so far as the GP may be considered to represent them. However, as previously mentioned, the GP functions as a downward extension of the centralised bureaucracy in this case. Further, the role of the GP was restricted to implementation with the centralised planning for the blocks and district.

■ **Subsidies, incentives, and rewards should not be the focus:** *“Subsidies, whether funds, hardware or other forms, should not be given directly to households. Community rewards, subsidies and incentives are acceptable only where they encourage collective action in support of total sanitation and where they facilitate the sustainable use of sanitation facilities.”*

While the guidelines allow flexibility to states to either deny incentives, or offer them at a community level, neither of these options were exercised in case of Udaipur, which is not exceptional in this regard. The SBM also presents the subsidy as an “incentive”. However, for most purposes, this is a distinction

without a difference. While the inclusion of this incentive may be argued to be necessary and pragmatic given the socio-economic conditions of rural India, the findings suggest that exclusion from the subsidy net is more likely to act as a barrier. The inverse however, is not necessarily true, and receipt of incentive, on the other hand, was not found to be an equally powerful driver for toilet construction.

■ **Local materials, designs, and technology decisions should be preferred:** *“CATS support communities to determine for themselves what design and materials work best for sanitation infrastructure rather than imposing standards. External agencies provide guidance rather than regulation. Thus, households build toilets based on locally available materials using the skills of local technicians and artisans.”*

The Mission partially adheres to this ideal. This partial adherence however is seen more in letter than in spirit. Thus, while the administration in Udaipur did not regulate the types of toilets being constructed, nor was there evidence of adequate guidance being provided, either to the community or the technicians, in terms of technology options. Low awareness about technology issues and FSM were seen as a direct result, which contribute to the construction of unsuitable toilets. In other less important ways, such as with the superstructure, the design is determined not based on local conditions and availability but on generally accepted standards.

■ **Building local capacity is essential to ensure sustainability:** *“CATS focus on building local capacities to enable sustainability. This includes the training of community facilitators and local artisans, and the encouragement of local champions for community-led programmes.”*

The weakness, if not complete absence, of the *prerak* network in Udaipur suggests that neither local champions, nor local capacities were adequately developed. The stoppage of activities subsequent to declaration, and extent of open defecation a few months thereafter result from this shortcoming.

■ **Government participation while required should not be the focus:** *“Government participation from the outset at the local and national levels ensures the effectiveness of CATS and the potential for scaling up.”*

The essence of this ideal is understanding the extent of government participation. Continuing facilitation on the part of the government is certainly important, but CAS requires that this participation must neither be in a leadership capacity nor be overbearing. In Udaipur, it was found that government efforts were paramount, and the relative success or failure of implementation was directly attributed to the capacity and involvement of the BPMU.

■ **Hygiene promotion should be integrated:** *“CATS has the greatest impact when it integrates hygiene promotion into programme design. The definition, scope and sequencing of hygiene components should always be based on the local context.”*

While assessing the inclusion of hygiene promotion was outside the scope of this research, it is noteworthy that almost none of the households mentioned hygiene as a reason for toilet construction or usage. Few functionaries stressed its importance either. The main drivers for motivating construction remain either functional or socio-cultural. Convenience, privacy, pride, honour were the mainstay of the communication efforts.

■ **Focus should be on natural leaders and the human element:** *“CATS is an entry point for social change and a potential catalyst for wider community mobilisation (which can include other health and education based interventions).”*

Far from mobilising the community to initiate local reforms, in Udaipur it was seen that the Mission was being used as a vehicle to offer preferential benefits under varied government programmes. Used as positive reinforcement, ODF declaration was made a prerequisite for administrative favours and scheme benefits, such as new water connections or other local demands. It is usually the local politicians who benefit from this situation in the form of political outreach .

8.1 System failure or Systemic failure?

The multifarious criticism by Huesco & Bell (2013) can therefore be collapsed into a singular divergence from the ideal of community led sanitation. A programme in which the community does not participate (such as in Udaipur) will, by necessity, have to be led by the government. Changes which are not adopted will have to be enforced. Thus, lacking adequate demand as a result of community disinterest, the programme will be driven by supply. On failing to incentivise, the government will subsidise. Focus will shift from issues which are seen as being beyond control, such as the behaviour of people, and towards that which can be controlled, namely the creation of infrastructure.

SBM as it has been found to be implemented in Udaipur, focuses primarily on infrastructure and the material and technical elements of sanitation. Construction of a predetermined, fixed number of toilets persists as the main activity. This is because success is measured by counting toilets as the purported outcome of freedom from open defecation is de facto measured in terms of toilet access. While the increased amount is called an incentive by the government, for all practical purposes it remains a subsidy and has been a sufficiently important factor to frustrate if not facilitate construction.

Fixed targets, whether in terms of toilets or time, are inimical

to sustained engagement, awareness generation, community leadership, and local innovations. Ambitious targets even more so. Pressed for time and resources, it is rational for the administration to approach the implementation in the manner evidenced in the district. Udaipur presents a typical case of an underequipped administration battling exceedingly complex socio-cultural and topographical challenges.

It may be argued that these are peculiarities of Udaipur and therefore not applicable to the Mission as a whole. This is a tenuous argument. The trends in mission expenditure at the national level indicate that the Udaipur approach is widely subscribed. Nationally, expenditure on construction of Individual Household Latrines (IHHLs) accounts for the largest share of all spending. In FY 2016-17, 98% of all Mission expenditure was for IHHL construction (Accountability Initiative, 2018).

It is only subsequent to the declaration of ODF that expenditure on other components is seen to rise in proportion. Expenditure on SLWM and IEC may be analysed to substantiate this point. IEC expenditure as a proportion of total expenditure was in fact seen to decline between FY 2014-15 (4%) and FY 2016-17 (1%) (Ibid). This is slowly picking up in FY 2017-18 subsequent to ODF declarations in multiple states . The 8% benchmark set by the guidelines is yet to be met in any of the Mission years.

Expenditure on SLWM has in some ways fared even worse. Focused on toilet construction, the other essential elements of sustainable sanitation became relegated to the “ODF Plus” category. Thus, only ₹39 crore was spent on SLWM across the country in FY 2015-16. This subsequently increased to ₹73 crore in FY 2016-17 and till January 2018, ₹79 crore had been spent on SLWM for FY 2017-18. Only two states, namely Himachal Pradesh and Mizoram, had touched more than a tenth of their villages for SLWM activities, and Himachal Pradesh alone accounted for 39 per cent of all SLWM activities across rural India till 15 January 2018. (Ibid)

The outcomes found in Udaipur are perhaps neither unique nor a deviation from the norm. Such outcomes are inevitable given the manner of programme implementation.

8.2 Recommendations and Way Forward

Offering recommendations to a programme like SBM is a difficult task. Recommending reforms would require greater government involvement and top down directives, and a vicious cycle is thereby created. What is needed instead is a reorientation of the mission implementation towards the ideals of CAS. How this can be done within the politically imperative target driven paradigm is a critical question to which this report does not offer solutions. But a useful first step would be greater alignment with the Mission guidelines.

For instance, implementation is seen to fail in the absence of rationalisation of work across administrative levels. There is urgent need for greater focus on BCC. The *prerak* system needs to be strengthened, and monitoring, including social audits, needs to be made more robust. Water provision and thorough verifications are warranted. All of these points are made and highlighted in the guidelines. In order to achieve the Mission's ambitious call to use sanitation for social inclusion and positive gender impact, a forceful reorientation towards this displaced ideal is a must. The question however remains whether this is possible within the current governance framework? The preceding discussion would indicate that a cultural shift within the administration remains the biggest barrier to sustainable sanitation.

Nevertheless, certain immediate and short-term measures are also possible, specifically for Udaipur but with wider applicability. These are briefly listed below.

Low Hanging Fruit: Fixing Access in Public Facilities

Less than half the schools and anganwadis in Udaipur were found to have usable toilets. This proportion was lower in some other public facilities, such as, health centres. Ensuring well maintained and functioning toilets in all public facilities can be done immediately, and unilaterally by the administration and is a relatively easier step. Given the focus on behavior change among children, this is even more crucial. The habit of using a toilet may be inculcated early in this manner.

Beyond IEC

The current IEC approach was noted as having several gaps. There was limited focus on IPC and event based and output driven activities remain dominant. The use of CLTS tools was muddled, and important issues such as health aspects, were neglected. Problems such as FSM and toilet designs were found to have been largely ignored. The outcomes of these gaps were adverse. Greater emphasis on IPC and adherence to the 60% budget ring-fencing norms for IPC is essential. But more importantly, the use of incentive as a driver must be avoided, certainly during community meetings. Focus on health issues and usage instead of construction (which should be restricted to explaining the implications of technology options) is needed. Gender sensitivity demands a move away from the conflation between safety and honour of women.

Stronger Systems

During the survey, the *prerak* system was found to be weak and inconsistently implemented. A dedicated cadre of *preraks* was found to be lacking and their incentive payment mechanisms were found to be unclear. Nigarani Committees are found to be disbanded post declaration. Trainings and capacity building remain significant challenges in the process. Trainings are found to be need-based rather and irregular. Dependence on external agencies for conducting trainings persists, given limited local capacity. Follow-up and assessment of training outcomes

remains inconsistent. Trainings are largely restricted to the top of pyramid with greater focus on government officers. Trainings on technology and sustainability are currently lacking.

Establishing a dedicated frontline sanitation cadre at the GP level might address this problem partially. A dedicated and adequate ground force of functionaries needs to be built up. Their payment systems need to be clearly established in order to avoid conflict and demotivation. It is further proposed that the already overburdened frontline health worker cadre not be handed dual responsibility but that a dedicated frontline sanitation worker cadre be built. A similar approach has also been adopted by the district of Dungarpur in Rajasthan. The training process needs significant strengthening in the following respects -

- Consistency of trainings, and downward transfer of learnings from officials and engineers;
- Hiring, retention, and use of local training facilitation resources and master trainers;
- Ensuring ability to adapt modules to local needs and assess applicability of modules to contexts;
- Focus on building capacity for IPC;
- Innovations beyond standard CLTS and ability to choose from a basket of tools;
- Trainings on technology and sustainability;
- Regularly scheduled instead of need based trainings;
- Follow-up and assessment of training outcomes;
- Reduction of dependence on external agencies over a period.

Addressing disincentives

Several gaps were noted in the incentive delivery process including low awareness of eligibility as per guidelines, dependence on incentive for construction leading to abandoning of toilets in case of inevitable delay. Static target based allocations and inflexibility of beneficiary lists combined with lack of clarity on grievance redress mechanisms can lead to demotivation. A radical proposal must be considered towards resolving these issues. If possible, the incentive system should be avoided as in the case of Haryana. While it is understood that such an overhaul of the mechanism might not be possible, some course correction measures can be taken. These are proposed as follows –

- Conducting fresh and regular surveys at the GP level to identify beneficiaries;
- Ensuring that Direct Benefit Transfer is adopted across all GPs for incentive delivery;
- Reduction of burden on block in the process, removing a bottleneck and reducing delays;
- Ensuring clear communication of eligibility criteria to beneficiaries;
- Setting up a clear redress mechanism at the district level.

Sustaining Sanitation

In most of the study villages, it was found that all work related to SBM ends on self-declaration of ODF. This raises questions

on the sustainability of the status, as well as, the means of tackling future challenges. It also reinforces the need to have a dedicated frontline sanitation cadre at the GP level. Regular monitoring and verification exercises can ensure more credible self-declarations. While this is a layered problem with multiple facets, one contributing factor could be the lack of monitoring post declaration of ODF. Consistent and sustained monitoring is necessary from the perspective of sustainability of ODF status. The role of regular, independent assessments including social audits will also be essential to ensure community ownership.

None of these measures will however suffice by themselves. The administration must accept a supporting role to the community, which must take the mantle of the protagonist.

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