CHAPTER-II

RURAL SANITATION PROGRAMMES

IN INDIA
Historically, sanitation was a part of town planning even as far back as 3000 BC. Well laid out drainage and street system were present during Indus Valley Civilization. The earliest evidence of urban sanitation was seen in Harappa, Mohenjo-daro and the recently discovered Rakhigarhi. This urban plan included the world’s first urban sanitation system. Within the city, individual homes or groups of homes obtained water from wells. From a room that appears to have been set aside for bathing, waste water was directed to covered drains, which lined the major streets. Houses opened only to inner courtyards and smaller lanes. In urban areas, sanitation was earlier limited to disposal of human excreta by cesspools, open ditches, pit latrines, bucket system etc., including the dehumanizing practice of removal of ‘night soil’ by humans hands.\(^{73}\)

### 2.1 RURAL SANITATION PROGRAMMES IN INDIA BEFORE INDEPENDENCE

During the British Raj, the frequent outbreaks of fevers and cholera suffered by the British troops led Sir James Ronald Martin to propose a scheme whereby all medical officers would be required to send reports on sanitary statistics of their districts, stations and cantonments. The sanitary perspective and guidelines proposed by Martin was influenced by the growing recognition of clean environment and sanitary practices in England. In 1857, a Royal Commission was appointed to examine the regulations affecting the sanitary conditions of the army along with other medical aspects. The large number of deaths of British soldiers due to cholera, diarrhoea etc., was mainly due to poor sanitary conditions and there was a realization that the main enemy of the British soldier in India was not the Indians but the diseases. To assist all matters relating to improvement of

sanitary conditions in barracks, hospitals and stations, three presidency commissions were set up in 1864. After two years, the sanitary commissions were wound up and sanitary commissioners were appointed in their respective provinces. The British government introduced the first Sanitation Bill in India in 1878, which made the construction of toilets compulsory and also proposed the construction of public toilets. But the efforts on sanitary reforms concerning the general population were not enforced fearing that any element of compulsion might offend the people's customs and religious sensibilities.74

Contrary to this belief, the McKenzie committee found that people were willing to submit to any sanitation measures calculated to promote health at pilgrim centres which were the main centres for the spread of diseases. Lack of governmental intervention resulted in further deterioration in public health and sanitation in India which compelled the international agencies like the League of Nations and the Rockefeller Foundation to initiate steps to address public health challenges.75

The antiquated sanitation systems (bucket latrine) in India used sweepers drawn from the downtrodden communities to empty the buckets which undermined their social position in the society for centuries. As part of the freedom struggle, Mahatma Gandhi established the Harijan Sevak Sangh for the liberation of scavengers and laid the foundation for a rural sanitation movement in India.

2.2 RURAL SANITATION PROGRAMMES IN INDIA AFTER INDEPENDENCE

The Environmental Hygiene Committee (1948-49) appointed by the government of India carried out an overall assessment and planning of environmental sanitation and recommended a 40 years plan to cover 90 per cent of the population. However, the National Water Supply and Sanitation Committee appointed by the Union Ministry of Health as late as 1960, has noted in its report that no concerted efforts were

75 Ibid, p. 44.
taken to implement the recommendations of the Environmental Hygiene Committee.\textsuperscript{76} It was in 1954 that the rural sanitation programme was introduced in the First Five Year Plan (1951-56) as part of the health sector. However, the efforts did not succeed until 1980s due to confusion and inconsistency on the sanitation component. Since the beginning of the Sixth Five Year Plan (1980-85) and the launch of the International Drinking Water Supply and Sanitation Decade in 1980, India has been strengthening its effort to rural water supply and sanitation.\textsuperscript{77}

Though the provision of water supply and sanitation is the responsibility of the state government, the central government funding constitutes nearly 40 per cent of the total investment in this sector. Water supply has received greater attention compared to sanitation. During the International Water Supply and Sanitation decade in 1980s, it was aimed to cover 80 per cent of the urban population through formal sanitation facilities and eradicate manual scavenging. Though some progress was made in this direction, the sanitation target set for 1991 under the programme remained unachieved even now. With the allotment of subsidies and technical assistance for the construction of household toilets during the last decade, there is an overall improvement in the coverage of sanitation amenities. In the Seventh Five Year Plan (1985-90), a new programme of sanitation was introduced at the village level for health centres, schools, anganwadis etc. Individual household latrines' construction was started under a number of government programmes. Tasks like planning, implementing, supervising and coordinating for the Central Rural Sanitation Programme (CRSP) were entrusted to the Ministry of Rural Development in 1986. For the implementation of CRSP, the Central and State governments shared the funds. Following the recommendations from the World Bank/United Nations Development Programme Technology Advisory Board, the twin-pit pour-flush latrine with superstructure became the prescribed toilet technology in India. The governments provided 80 to 100 per

\textsuperscript{76} Gaurishankar Ghosh et. al., Water Supply in Rural India: Policy and Programme, New Delhi: Ashish Publishing House, 1995, p.3.

\textsuperscript{77} Radhika Ramasubban, \textit{op. cit.}, p. 45.
cent subsidy for the construction of latrines. However, it was soon realized that investment and subsidies alone would not ensure improved coverage of sanitation.\textsuperscript{78}

The government's concern since Independence has been raising the quality of life and the health of the people. Several initiatives were taken at policy formulation level leading to various programmes in this direction. Supply of safe drinking water and provision of sanitation are the most important contributing factors for improving the health of the people in any country. As per a World Health Organization (WHO) report 80 per cent of the diseases are due to unhygienic conditions and unsafe drinking water. It is estimated that every year about 1.5 million children under five years die in India of water related diseases. Age old cultural practices coupled with illiteracy of safe drinking water have, therefore, been given very high priority in Indian planning.

Providing drinking water in rural areas is the responsibility of the State governments and the funds were provided for the purpose in their budgets from the First Five Year Plan. During 1954, National Water Supply and Sanitation Programme was introduced in the social welfare sector. The States built up gradually the Public Health Engineering Departments (PHEDs) to attend to the problems of water supply and sanitation. Under the programme 100 per cent grants-in-aid to implement the different water supply schemes for the 'problem villages' were provided by the government of India. In the mid-1960s it was realized that these schemes were implemented only in the easily accessible villages and in the process the hard core 'problem villages' remained unattended. The government of India during the Fourth Five Year Plan took steps to provide assistance to the States to establish special investigation divisions for the 'problem villages'. In order to accelerate the pace of coverage of 'problem villages', the government of India introduced the Accelerated Rural Water Supply Programme (ARWSP) in 1972-73. During 1974-75 the Minimum Needs Programme (MNP) was introduced because of which the ARWSP was withdrawn but it (ARWSP) was reintroduced in 1977-78 when the progress of supply of safe drinking water to identified 'problem villages' was not found to be satisfactory.\textsuperscript{79}

\textsuperscript{78} Ibid, p. 45-47.
\textsuperscript{79} Gaurishankar Ghosh et. al., \textit{op. cit.}, p. 116.
In the year 1977, the United Nations Water Conference separated the issue of drinking water and sanitation from other water issues to stress the seriousness and magnitude of the problem of drinking water. The Conference recommended that each country should develop national plans and programmes for water supply and sanitation giving priority to the schemes of the population which require greatest attention. India was a signatory to the resolution seeking to achieve the target by 1991. The water decade programme was launched in India on 1st April 1981 to achieve definite targets of coverage of entire population by 31st March 1991.

In August 1985, the subject of rural water supply and sanitation was transferred from the Ministry of Urban Development to the Department of Rural Development with the objective of securing implementation of the programme and their integration with other rural development programmes.

The National Drinking Water Mission was launched as one of the five societal missions in the year 1986. The mission has been named as Rajiv Gandhi National Drinking Water Mission (RGNDWM) in 1991. The government of India continues to give highest priority to rural drinking water sector through the activities of the Mission and ARWSP. It also forms the part of the State funded MNP and point no. 7 of the Twenty Point Programme, 1986.

It is claimed that the RGNDWM over the last decade has successfully covered the majority of habitations with hand pumps/stand posts. However, it has now been realized that the objective of supplying safe water would not be achieved to the extent and satisfaction it is expected unless the sanitary aspects of water supply, as well as the issue of sanitation were addressed simultaneously. The focus has now shifted from water to water and sanitation. The mobilization of large funds and efforts through RGNDWM in this direction has not yielded the desired impact on the health of the general population.
2.3 CENTRAL RURAL SANITATION PROGRAMME- 1986

Rural sanitation is a State List subject in Indian Constitution. The State governments implement the rural sanitation programme under State sector Minimum Needs Programme (MNP). The Central government supplements the States efforts providing financial and technical assistance through the Centrally Sponsored Rural Sanitation Programme (CRSP).

The CRSP was launched in 1986 with the objective of improving the quality of life of the rural people and to provide privacy and dignity to women. The concept of sanitation was expanded in 1993 to include personal hygiene, home sanitation, safe water, garbage and excreta disposal and waste water disposal. The components of the programme include construction of individual sanitary latrines for households below the poverty line (BPL) families, conversion of individual sanitary latrines, construction of village sanitary complexes for women, setting up of sanitary marts, intensive campaign for awareness creation, health education etc.

Objectives

- To accelerate coverage of rural population, especially among households below the poverty line (BPL), with sanitation facilities complementing the efforts in rural water supply.
- To generate felt need through awareness creation and health education involving voluntary organizations and panchayati raj institutions.
- To eradicate manual scavenging by converting all existing dry latrines into low cost sanitary latrines.
- To encourage cost effective and appropriate technologies to support other objectives.

80 http://www.ddws.nic.in
Salient Features

The revised policy for implementation of the rural sanitation programme during the 9th plan period had been approved by the Union Cabinet. The salient features of the policy were as under:

- Raise sanitation coverage to at least 50 percent by 9th plan.
- Total sanitation campaign (TSC) in select districts with 50 percent allocation during the first year.
- Balance 50 percent for existing allocation-based programme.
- Switch over from allocation based programme to a demand driven one.
- Shift from high subsidy to low subsidy regime.
- Greater beneficiary participation and private sector involvement.
- Active participation of the non-governmental organizations (NGOs)/cooperative institutions etc.
- Emphasize school sanitation.
- Increased technological options and adoption of vertical upgradation concept.

Achievements

- The total latrines constructed under the programme (CRSP+MNP) upto the end of the Eighth Plan period (1996-97) were 4,337,609 with a total expenditure of Rs. 757.62 crore.
- The Central allocation for the year 1997-98 was Rs. 100.00 crore; the state MNP provision was Rs. 209.83 crore. The total latrines constructed in 1997-98 were 1,387,080.
- During 1998-99 the Central allocation was Rs. 67.00 crore as against the state MNP provision of Rs.213.34 crore and 824,520 household latrines have been constructed up to January 1999.
Funding Pattern

Under the revised programme the States were required to formulate total sanitation campaigns (TSCs) in select districts. To allow time for the proper grounding of the new approach, the existing allocation-based programme will also be continued and would be phased out at the end of the 9th Plan period. While the first year will have 50 percent of funds earmarked for the existing programme, only 30 percent will be allotted in the next year followed by 10 percent during the third year.

The State governments should provide matching contribution under the Minimum Needs Programme (MNP) equivalent to the allocation under CRSP.

The extent of subsidy from Centre, States and beneficiaries/panchayats for a few components of the programmes was in the following ratio:

- Construction of household sanitary latrines and women's complexes 60:20:20
- School sanitation 60:30:10
- Alternate delivery mechanism 80:20 up to 5 percent.

Implementing Agency

The programme was being implemented through the State governments' departments/boards.

Evaluation

A very comprehensive baseline survey on knowledge, attitudes and practices in rural water supply and sanitation was conducted during 1996-97 covering 39000 respondents in 74 districts throughout the country. The study showed that 55 percent of those with private latrines were self-motivated. Only 2 percent of the respondents
claimed the existence of subsidy as the major motivation factor, while 54 percent claimed to have gone in for sanitary latrines due to convenience and privacy. The study also showed that 51 percent of the beneficiaries were willing to spend up to Rs. 100/- to acquire sanitary toilets.

**Corrective Action Taken**

Taking into account the deficiencies of the programme which were mainly heavy reliance on subsidy, inadequate participation of beneficiaries, limited choice of models and inadequate involvement of NGOs, a comprehensive review of the rural sanitation programme has been done. The changes effected in the programme involve a major shift from a high-subsidy to a low-subsidy regime, adoption of “total sanitation campaign” approach, choice of technology according to customers’ preferences and greater community participation. School sanitation is an important component of this programme.

**2.3 REVISION OF CRSP -1993**

Based on the feedback received on implementation of the programme from the States, UNICEF and voluntary organizations, the programme was revised by the Government of India in March 1991. For the construction of individual sanitary latrines, liberal subsidy at the rate of 95% for Scheduled Castes/Scheduled Tribes and people below the poverty line and 80-90% for general public were provided. The programme also provided for construction of village complex with bathing facilities. Hand pumps, latrines, drainage facilities, washing platforms, etc. Up to 5% of the outlay could be utilized towards administrative cost and another 10% for training of masons, awareness, and health education. The contribution by the States from their own funds was limited to one-third of the assistance received from the Central Government.

The programme has since been further revised based on the recommendations of the National Seminar on Rural Sanitation in September 1992, and the strategy outlined in the Eighth Five Year Plan. The revised programme aims at generation of felt need and peoples’
participation. The subsidy pattern has been changed limiting to 80% for persons below the poverty line for individual household latrines. For exclusive sanitary complex for women, the subsidy will be limited to 70% the balance 30% being the contribution by the Panchayats/beneficiaries. For other sanitation facilities in the village the subsidy will be 50% balance cost being met by the Panchayats 3% of the funds can be utilized towards administrative cost and 10% for health education, awareness campaigns, training of masons, demand generation based on felt needs, etc. The revised programme aims at an integrated approach of rural sanitation. The concept of sanitary marts for supply of materials required for construction of sanitary latrines and involvement of voluntary organizations in publicity campaign and execution of the programme are also the new elements. At least 10% of the total funds are to be channeled through voluntary organizations, apart from the funds earmarked for activities under CAPART. The subsidy will be shared equally by the Central and the State Government. Another salient feature of the revised programme is to develop at least one model village covering facilities like sanitary latrines, conversion of dry latrine, garbage pits, soakage pits, drainage, pavement of lanes, sanitary latrines in village institutions, cleanliness in ponds, tanks, clean surrounding around hand pumps and other drinking water sources.

OBJECTIVES

The objectives of Central Rural Sanitation Programme are:

- To accelerate coverage of rural population especially among the households below poverty line with sanitation facilities complementing the efforts in Rural Water Supply and slowly breaking the vicious circle of disease, morbidity and poor health resulting from unsanitary condition and water borne diseases.
- To generate felt need through awareness creation and health education involving voluntary organizations and Panchayati Raj Institutions helping thereby to establish sanitary latrines with lesser dependence on Govt. subsidy.
- To eradicate manual scavenging by converting all existing dry latrines in rural areas into low cost sanitary latrines.
• To encourage suitable cost effective and appropriate technologies to support the other objectives.

STRATEGIES
The strategies would be:
• To provide subsidy to the poorer among the households below poverty line.
• To encourage other households to buy the facilities through markets, including sanitary marts.
• To launch intensive campaign in selected areas and to support such campaigns with infrastructural facilities to establish individual sanitary latrines wherever possible.
• To establish sanitary complexes exclusively for women wherever necessary.
• To encourage locally suitable and acceptable models of latrines.

PROGRAMME COMPONENTS
The components of the programme are as under:
• Construction of individual sanitary latrines for households below poverty line with subsidy (80 percent) where demand exists.
• Conversion of dry latrines into low cost sanitary latrines.
• Construction of exclusive village sanitary complexes for women by providing complete facilities for hand pump, bathing, sanitation & washing on a selective basis where adequate land/space within the premises of the houses do not exist and where village Panchayats are willing to maintain.
• Setting up of sanitary marts.
• Total sanitation of village through the construction of drains, soakage pits, solid and liquid waste disposal.
• Intensive campaign for awareness generation and health education for creating felt need for personal, household, and environmental sanitation facilities.

EXTENT OF SUBSIDY
• The extent of subsidy from Central/ State government and contribution from persons below poverty line/ panchayat for various components of the programme are as follows:
<table>
<thead>
<tr>
<th>Item</th>
<th>Subsidy by Centre</th>
<th>Subsidy by State</th>
<th>Contribution by user/Panchayat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction of Sanitary latrines and conversions of dry latrines</td>
<td>40 %</td>
<td>40 %</td>
<td>20 %</td>
</tr>
<tr>
<td>for individual households below poverty line</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Village complex for women</td>
<td>35 %</td>
<td>35 %</td>
<td>30 %</td>
</tr>
<tr>
<td>Drains and other sanitation facilities (as far as possible, to be</td>
<td>25 %</td>
<td>25 %</td>
<td>50 %</td>
</tr>
<tr>
<td>met out of JRY and other funds)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness campaigns, Health education, demand creation etc.</td>
<td>Upto 10 % of annual Allocation</td>
<td></td>
<td>Nil</td>
</tr>
<tr>
<td>Administrative cost</td>
<td>Upto 3 % of annual Allocation</td>
<td></td>
<td>Nil</td>
</tr>
</tbody>
</table>


- For sanitary marts, the assistance will be limited to an interest free-loan as revolving fund of Rs. 50,000/- per mart for the purpose, which would be repayable at the end of three years. Adequate funds for this purpose can be provided from the funds released to the States/UTs depending upon the actual need.
CRITERIA FOR ALLOCATION OF CENTRAL ASSISTANCE TO STATES/UTs FOR IMPLEMENTATION OF CRSP AND ITS UTILISATION BY SYATES

• Funds available under Annual Plan will be allocated to the States/UTs in accordance with the following formula:
  ➢ 50% weightage being given to incidence of poverty in States/UTs
  ➢ 40% weightage being given to rural population
  ➢ 10% weightage being given to the recognized hill states and hilly areas on the basis of their population.

• Of these funds,
  ➢ Upto 72% can be utilized for giving Central share of the subsidy to construct individual sanitary latrines to households below poverty line.
  ➢ Upto 10% can be used for subsidizing construction of sanitary complexes exclusively for women.
  ➢ Upto 10% for health education/motivation, creation of felt need etc.
  ➢ Upto 5% for construction of other components such as bathing platform, garbage pit etc.
  ➢ Upto 3% for expenditure towards staff, administration etc.
  ➢ At least 10% of the funds may be utilized for construction of latrines through NGOs.
  ➢ Adequate funds from the Central and State share can be used to set up sanitary marts.

RELEASE OF FUNDS

The central assistance shall be released to the States/UTs in two equal installments. The first installment will normally be released in April every year. Provided that the release of first installment in April will be withheld till the prescribed reports and returns and certificates from Accountant General for all the previous years except for the year immediately preceding are submitted. The release of second installment will be subject to the following conditions:
• A matching contribution to the first installment released from the centre is provided by the States/UTs to the implementing departments/agencies.
• Utilization of at least 50% of resources available (the releases made by the Centre and state plus carryover un-utilized funds from the previous years) by September.
• Utilization of at least 35% of annual allocation by September.
• Receipt of prescribed reports and returns; A.G. Certificate of actual expenditure.
• Utilization of at least 85% of the releases in the earlier years under CRSP and MNP. In other words, carryover of funds from earlier years in excess of 15% of the Annual allocation will be deducted at time of release of 2nd installment.

INSTITUTIONAL ARRANGEMENTS
The agency implementing the Rural Development Programme shall normally be the nodal department to implement the Projects under this programme in order to ensure homogeneity in approach. Where CRSP is implemented through other departments like PHED, PWD, State Governments are requested to consider involving the Rural Development Department also for purposes of coordination, monitoring etc. The monitoring of the entire programme should be with one identified nodal officer and Department in the State Govt. a Monitoring Cell may be set up under this nodal officer.

SELECTION OF DISTRICTS, BLOCKS AND VILLAGES
The selection of the Districts, Blocks and Villages to be taken up for intensive coverage should be on the basis of the following criteria:
• Districts, Blocks and Villages where coverage under Rural Water Supply has been adequate particularly for weaker sections of the people, including scheduled castes and scheduled tribes and where there is a demand for sanitary latrines.
• Mini-Mission districts where integration of water supply and sanitation programme is being attempted should be given preference in preparing projects for intensive coverage.
• Districts where reputed voluntary agencies are working.
• Villages which have endemic health problems, resulting from water and excreta borne diseases, villages with no sanitary facility for women or where demand from women-folk exists.
• Villages where felt need has already been generated and there are other ongoing programme, in order to ensure maximum (possibly 100%) coverage.

SANCTION OF SCHEMES

State Government would have full powers to approve the projects under this programme within the approved unit cost which on an average is not more than Rs. 2500 with superstructure, roof and door at 1993 prices. Any cost beyond this limit should be met by the user in addition to his share. Schemes with unit cost of more than Rs. 2500 with Govt. assistance would require prior approval of the Central Govt. Once the basic norms have been approved by the States, the implementing agency may take up implementation of replicative projects based on these norms, subject to the funds availability. Normally in a year the schemes to be approved should not exceed 1.25 times of the annual allocation.

MAINTENANCE

It is essential to train the community, particularly all the members of the family in the proper upkeep and maintenance of the sanitation facilities. The maintenance expenses of individual household sanitary latrines should be met by the beneficiaries where as that of sanitary complexes for women may be at the cost of the Panchayats/voluntary organization/charitable trusts.

SCHEDULE OF INSPECTIONS

Monitoring through regular field inspections by officers from State level and district level is essential for the effective implementation of the programme. The inspection should be to check and to ensure that construction work has been done in accordance with the norms, that the community has been involved in construction, that the latrines are not polluting the water sources and also to check whether there has been correct selection of beneficiaries and proper use of latrines after construction. Such inspection should ensure
that the sanitary latrines are not used for any other purpose, as has happened some times in the past.

**EVALUATION OF THE PROGRAMME**

The implementation of the programme, results achieved and its impact will be evaluated at the end of two years. Any further modifications in the programme could be formulated based on the results of such evaluation.

**2.4 TOTAL SANITATION CAMPAIGN- 1999**

Sanitation was never perceived as a priority especially in rural areas where open space was readily available until today albeit the growth of population and urbanization. The Government of India (GOI) launched the first Central Rural Sanitation Programme (CRSP) in 1986. It hinged on substantial subsidy as a means for creating demand for household toilets, which was soon found to be strategically weak. Constructing toilets was a dynamics of need, an understanding of its importance, financial capability and availability of hardware and skilled masons. Of the sanitary pour-flush toilets constructed in the decade of the 80s and 90s, less than 50 percent were found in use due to many reasons i.e. lack of awareness, poor construction standards, emphasis on high cost designs, absence of participation on the part of beneficiaries, etc. The CRSP had also neglected school sanitation, which is considered as one of the vital components of sanitation. Also, CRSP failed to have a linkage with various local institutions like Integrated Child Development Scheme, Mahila Samakhya, PRIs, NGOs, research institutions, self help groups, etc.

Realizing weaknesses in CRSP, various experiments were carried out in the country. With the assistance of the Rama Krishna Mission Lok Shiksha Parishad (RKMLSP), Narenderpur, West Bengal and the UNICEF, one such experiment was made in Midnapur district of West Bengal where approximately 800,000 toilets were constructed by the rural people without any subsidy from Central or State government. This successful model later on became the basis for revamping the Central Rural Sanitation Programme.
In addition, a baseline survey on knowledge, attitudes and practices in rural water supply and sanitation was conducted during 1996-97 by the Indian Institute of Mass Communication, which showed that 55 percent of those with private latrines were self-motivated. Only 2 percent of the respondents claimed the existence of subsidy as a motivating factor.

GOI launched reform initiatives in the rural sanitation sector in 1999 by introducing a demand driven, participatory, people-centered programme called Total Sanitation Campaign (TSC) which is being implemented in a campaign mode, taking district as a unit. TSC follows a paradigm shift in approach from an allocation-based and supply-driven programme to a demand-driven programme, from a top down to a participatory approach, from a high to low subsidy regime; and more importantly, it tries to generate a campaign in the entire district to highlight issues related to sanitation by involving all stakeholders. The key features of the shift in GOI policy has been listed in the table below:
### Table 2.2

**Shift in GOI Policy towards Rural Sanitation**

<table>
<thead>
<tr>
<th>S.No</th>
<th>CRSP-1986</th>
<th>TSC-1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Centralized planning at state /block level for selection of villages and fixing targets for each village</td>
<td>Decentralized planning and implementation. Selection of villages and beneficiaries are based on the demand from them</td>
</tr>
<tr>
<td>2.</td>
<td>Centralized implementation</td>
<td>Decentralized implementation through village panchayats</td>
</tr>
<tr>
<td>3.</td>
<td>Hardly any focus on building awareness building and change in behaviour for relevant hygiene practices</td>
<td>Reliance on IEC, social mobilization for demand generation and focus on hygiene education</td>
</tr>
<tr>
<td>4.</td>
<td>Target based approach</td>
<td>Demand based approach with users participation, including women</td>
</tr>
<tr>
<td>5.</td>
<td>High subsidy based, lack of community participation and no cost sharing by beneficiary</td>
<td>Reduced subsidy to poorest of poor for low cost options only cost sharing by beneficiaries to ensure better usage of toilets.</td>
</tr>
<tr>
<td>6.</td>
<td>Limited choice of design</td>
<td>A range of technological options to beneficiaries</td>
</tr>
<tr>
<td>7.</td>
<td>Rural welfare officers/NGOs construct latrines by engaging local contractors</td>
<td>Beneficiaries themselves construct latrines using local trained masons</td>
</tr>
</tbody>
</table>

Source: Frequently asked Questions, [http://www.ddws.nic.in](http://www.ddws.nic.in)
Total Sanitation Campaign –A Brief

Total Sanitation Campaign (TSC) was launched in 1999 advocating a shift from high subsidy to a low subsidy regime, greater household involvement, demand-responsiveness, and providing for the promotion of a range of toilet options to promote increased affordability. It also gives strong emphasis on information, education and communication (IEC) and social marketing for demand generation for sanitation facilities, to set up a delivery system through rural sanitary marts (RSMs) and production centers (PCs) and a thrust on school sanitation. TSC is implemented in a campaign mode-taking district as a unit so that 100 percent saturation in terms of households, anganwadi and school toilets can be attained which would result in significant health benefits.

2.4.1 Objectives of the Programme

The main objectives of the TSC are as under:

- Bring about an improvement in the general quality of life in the rural areas.
- Accelerate sanitation coverage in rural areas.
- Generate felt demand for sanitation facilities through awareness creation and health education.
- Cover schools/ anganwadis in rural areas with sanitation facilities and promote hygiene education and sanitary habits among students.
- Encourage cost effective and appropriate technologies in sanitation.
- Eliminate open defecation to minimize risk of contamination of drinking water sources and food.
- Convert dry latrines to pour-flush latrines, and eliminate manual scavenging practice, wherever in existence in rural areas.81

These objectives confirm that the programme aims at the total facelift of rural India in the field of sanitation and that also not in the form of imposing a government scheme but in a felt need mode.

2.4.2 Strategy

The strategy is to make the programme 'community-led' and 'people-centered'. A demand-driven approach is to be adopted with increased emphasis on awareness creation and demand generation for sanitary facilities in houses, schools and for cleaner environment. Alternate delivery mechanisms would be adopted to meet the community needs. Subsidy for individual household latrine units has been replaced by incentive to the poorest of the poor households. Rural school sanitation is a major component and an entry point for wider acceptance of sanitation by the rural people. Technology improvisations to meet the customer preferences and location specific intensive IEC campaign involving panchayati raj institutions, co-operatives, women groups, self help groups, NGOs etc. are also important components of the strategy. The strategy addresses all sections of rural population to bring about the relevant behavioural changes for improved sanitation and hygiene practices and meet their sanitary hardware requirements in an affordable and accessible manner by offering a wide range of technological choices.

2.4.3 Implementation

Implementation of TSC is proposed on a project mode. A project proposal emanates from a district, is scrutinized by the State government and transmitted to the government of India (Department of Drinking Water Supply, Ministry of Rural Development). TSC is implemented in phases with start-up activities. Funds are made available for preliminary IEC work. The physical implementation gets oriented towards satisfying the felt-needs, wherein individual households choose from a menu of options for their household latrines. The built-in flexibility in the menu of options gives the poor and the disadvantaged families opportunity for subsequent upgradation depending upon their requirements and financial position. In the campaign approach, while a synergistic interaction between the government agencies and other stakeholders, intensive IEC and advocacy, with participation of NGOs/panchayati raj institutions/resource organizations, take place to bring about the desired behavioural changes for relevant sanitation practices, provision of alternate delivery system, proper technical specifications, designs and quality
of installations are also provided to effectively fulfill the generated demand for sanitary hardware.

The TSC is being implemented with a district as unit. The States/UTs are expected to draw up a TSC project for the selected districts to claim GOI assistance with commitment of their support. The number of TSC projects in a State is allocated based on the demand raised by the States as well as their performance in implementation of the existing projects. Selection of the districts is done by the respective State/UT governments. The number of project districts will be progressively increased to cover the entire rural area of the country. The TSC project cycle in the project districts is expected to take about 4 years or less for implementation.

Implementation of the Total Sanitation Campaign requires large scale social mobilization so its implementation at the district level should be done by the zilla panchayat. However, in case zilla panchayat is not in existence, District Water and Sanitation Mission should implement the project. However, both the TSC and the Swajaldrha should be implemented by the same agency. The line departments will play the catalytic role in implementation.

At the state level, State government should set up an appropriate institutional arrangement to monitor the projects and facilitate the districts in implementing TSC. However, in States where water supply & sanitation are handled by two different departments, separate institutional set up may also be made subject to the condition that officials handling water supply should be actively associated with this institutional set up. Specialist consultants from the fields of communication, human resource development, monitoring and school sanitation and hygiene education can be engaged at the State level. The expenses towards engaging these consultants will be borne by the GOI and the States under the human resource development (HRD) fund available on 75:25 basis. Similarly common IEC and HRD activities for the whole State can be taken up at the State level for which limited fund may be provided to the States on a 75:25 sharing pattern. Separate bank account in any public sector bank would have to be opened exclusively for this programme.
2.4.4 Components of the Programme

The programme components and activities for TSC implementation are as follows:

(a) Start-up and IEC Activities:

The start-up activities include conducting of preliminary survey to assess the status of sanitation and hygiene practices, people’s attitude and demand for improved sanitation, etc. with the aim to prepare the district TSC project proposals for seeking government of India assistance. The start-up activities will also include conducting a baseline survey (BLS), preparation of project implementation plan (PIP), initial orientation and training of key programme managers at the district level. The cost of – start-up activities will be met fully by the government of India assistance, and should not exceed 5 percent of the total project.

Information, education and communication (IEC) are important components of the programme. These intend to create demand for sanitary facilities in the rural areas for households, schools, anganwadis, balwadis and community sanitary complexes. The activities carried out under this component should be area specific and should also involve all sections of the rural population, in a manner, where willingness of the people to construct latrines is generated. The motivator can be given suitable incentive from the funds earmarked for IEC. The incentive will be performance based i.e. in terms of motivating the number of households and schools/ anganwadis to construct latrines and soakage pits and also use the same subsequently. The IEC should also focus on health and hygiene practices and environmental sanitation aspects. Under IEC, wall painting on a community building or hoardings should display the details of activities undertaken in that panchayat. Further, audio/ video clippings in All India Radio, Doordarshan and cable TVs may be screened for demand generation. IEC funding will be in the ratio of 80:20 between GOI and the State governments and the total IEC cost should not be less than 15 per cent of the project. Each project district should prepare a detailed IEC action plan with defined strategies to reach all sections of the community. The aim of such a communication plan is to motivate rural people to adopt hygiene behaviour as a way of life and thereby develop and maintain all facilities created under the programme.
Funds available under IEC may be used for imparting hygiene education to the people as well as children in schools.

(b) Rural Sanitary Marts (RSMs) and Production Centres (PCs):

The RSM is an outlet dealing with the materials required for the construction of not only sanitary latrines but also other sanitary facilities required for individuals, families and the environment in the rural areas. The RSMs should necessarily have those items, which are required as a part of the sanitation package. It is a commercial venture with a social objective. The main aim of having a RSM is to provide materials, services and guidance needed for constructing different types of latrines and other sanitary facilities, which are technologically and financially suitable to the area. The PCs are the means to improve production of cost effective affordable sanitary materials. The PCs/ RSMs could be opened and operated by NGOs/ self help groups/ women organizations/ panchayats. For this purpose, less than 5 percent (subject to a maximum of Rs. 35.00 lakh) of the total government outlay has been earmarked. Funding for this component will be in the ratio of 80:20 between the government of India and the State government. Further, under the TSC project, maximum amount of Rs.3.5 lakh per RSM/ PC can be provided. The fund may be provided to the NGOs/ panchayats/ other agencies for setting up of RSMs/PCs. The fund can be provided for construction of shed, training of masons and also as a revolving fund. After RSM/ PC attains a level of sustainability, the revolving fund should be refunded to the district implementing agency. The district implementing agency should identify key training institutions/ resource persons to train the RSM/ PC managers. They should also have a memorandum of understanding with the RSMs/ PCs and, a system of joint monitoring evolved to ensure that the RSMs and PCs are successful as an enterprise, and function in accordance with the objectives of the programme.

(c) Construction of Individual Household Latrines (IHHLs):

A duly completed household sanitary latrine shall comprise of a basic low cost unit (without the superstructure). All existing dry latrines in rural areas should be converted to pour-flush latrines. The programme is aimed to cover all the rural families. Incentive as provided under the scheme may be extended to below poverty line (BPL)
families, if the same is considered necessary for full involvement of the community. The construction of household toilets should be undertaken by the BPL household itself and on completion and use of the toilet by the BPL household, the cash incentive can be given to the BPL household in recognition of its achievement. The financing pattern including the incentive for BPL household for construction of individual household latrines (IHHLs) is as follows:

Table 2.3
Financing Pattern for Construction of IHHL

<table>
<thead>
<tr>
<th>Basic Low Cost Unit Cost (Rs.)</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>GOI</td>
</tr>
<tr>
<td></td>
<td>BPL</td>
</tr>
<tr>
<td>Up to Rs. 2500/-</td>
<td>1500</td>
</tr>
</tbody>
</table>


The incentive given by the Central government will continue to be admissible with reference to the cost of the basic low cost unit as given in the above Table and in no case will the overall quantum of Central incentive exceed the admissible amount. It is assumed that APL families, through motivation, will take up construction of the household latrines on their own. The IEC activities, will, however, cover all the families in the district, without exception. Construction of dry latrines is not permitted in the rural areas. The existing dry latrines, if any, should be converted to pour-flush latrines and the unit cost and sharing pattern shall be identical to that of construction of individual household latrines.
(d) Community Sanitary Complex:

Community sanitary complex is an important component of the TSC. These complexes can be set up in a place in the village acceptable to women/men/landless families and accessible to them. The maintenance of such complexes is very essential for which gram panchayat should own the ultimate responsibility or make alternative arrangements at the village level. Maximum unit cost prescribed for a community complex is up to Rs 2 lakhs. However, it will be approved by the National Scheme Sanctioning Committee based on the detailed design and estimates. Sharing pattern amongst Central government, State government and the community is in the ratio of 60:20:20. The community contribution, however, can be made by the panchayat. There will not be any upper ceiling for expenditure on this item. However, total expenditure proposed on community sanitary complex and individual household toilets should be within the ceiling of 60 percent of the total government outlay. Ordinarily, such complexes should be constructed only when there is lack of space in the village for construction of household toilets and the community owns up the responsibility of their operation and maintenance. The ultimate aim is to ensure construction of maximum IHHLs and construction of community complexes will be restricted to only when IHHLs cannot be constructed, for whatever reason, and also teach the community of hygiene practices. Such complexes can also be made at public places, markets, etc. where large scale congregation of people takes place.

(e) School Sanitation and Hygiene Education (SSHE):

Children are more receptive to new ideas and schools/anganwadis are appropriate institutions for changing the behaviour, mindset and habits of children from open defecation to the use of lavatory through motivation and education. The experience gained by children through use of toilets in school and sanitation education imparted by teachers would reach home and would also influence parents to adopt good sanitary habits. School sanitation, therefore, forms an integral part of every TSC project. Toilets in all types of government schools i.e. primary, upper primary, secondary and higher secondary and anganwadis should be constructed. Emphasis should be given on toilets for girls in schools. The Central assistance per unit will be restricted to Rs.12,000/- for a unit cost of Rs.20,000/-. Separate toilets for girls and boys should be provided which are treated as two
separate units and each unit is entitled to Central assistance upto Rs.12,000/-. Funding for school sanitation in a TSC project is provided by the Central government, State government and parent teachers in the ratio of 60:30:10. Gram panchayat can also contribute the 10 percent share of parent-teachers. State/UT governments, parent-teachers association and panchayats are free to contribute from their own resources over and above the prescribed amount.

In addition to creation of hardware in the schools, it is essential that hygiene education is imparted to the children on all aspects of hygiene. For this purpose, at least one teacher in each school must be trained in hygiene education who in turn should train the children through interesting activities and community projects that emphasize hygiene behaviour. The expenditure for this purpose can be met from the IEC fund earmarked for the project.

Anganwadi Toilets:

In order to change the behaviour of the children from very early stage in life, it is essential that anganwadis are used as a platform of behaviour change of the children as well as the mothers attending the anganwadis. For this purpose each anganwadi should be provided with a baby friendly toilet. One toilet of unit cost upto Rs 5,000 can be constructed for each anganwadi or balwadi in the rural areas where incentive to be given by government of India will be restricted to Rs 3,000. Additional expenses can be met by the State government or the panchayats. Since there are a large number of anganwadis operating from private houses, following strategy may be adopted:

a) In all the anganwadis, which are in government buildings, baby friendly toilets should be constructed from out of the TSC funds to the extent laid down.

b) Those anganwadis, which are in private buildings, the owner must be asked to construct the toilet as per design, and, he/she may be allowed to charge enhanced rent for the building to recover the cost of construction. Alternatively, the toilet may be constructed under the TSC and, suitable deductions made from the monthly rental paid to the owner to recover the cost over a period of time.
c) For new buildings, which are going to be hired for anganwadis, buildings having baby friendly toilet facility only should be hired. More than 10 percent of the total government outlay can be utilized for school sanitation and anganwadi toilets.

(f) Administrative Charges:

The administrative charges include money spent on training, salary of temporary staff deployed during project period, support services, fuel charges, vehicle hire charges, stationery, monitoring & evaluation of TSC project. However, in any case no additional posts shall be created nor separate vehicle purchased for the implementation of the TSC project. But in order to implement the projects professionally, specialist consultants from the fields of communication, human resource development, school sanitation & hygiene education and monitoring may be hired for the project period. The fees of the consultants may be paid from the administrative charges. Administrative charges should not be used for buying vehicles, etc. Purchase of one computer with accessories is permissible per district.

2.4.6. Role of Panchayati Raj Institutions

As per the Constitution 73rd Amendment Act, 1992, sanitation is included in the 11th Schedule of the Constitution of India. Accordingly, gram panchayats have a pivotal role in the implementation of Total Sanitation Campaign (TSC). The TSC will be implemented by the panchayati raj institutions at all levels. They will carry out the social mobilization for the construction of toilets and also maintain the clean environment by way of safe disposal of wastes. Community complexes constructed under the TSC will be maintained by the panchayats/voluntary organizations/charitable trusts. Panchayats can also contribute from their own resources for school sanitation over and above the prescribed amount. They will act as the custodian of the assets such as the community complexes, environmental components, drainage etc. constructed under the TSC. Panchayats can also open and operate the production centres/rural sanitary marts.

2.4.7. Role of Non-governmental Organizations (NGOs)

The NGOs have an important role in the implementation of TSC in the rural areas. They have to be actively involved in IEC (software) activities as well as in hardware
activities. Their services are required to be utilized not only for bringing about awareness among the rural people for the need of rural sanitation but also ensuring that they actually make use of the sanitary latrines. NGOs can also open and operate production centres and rural sanitary marts. NGOs may also be engaged to conduct base line surveys specifically to determine key behaviours and perceptions regarding sanitation, hygiene, water use, etc. Selection of NGOs should be done following a transparent criterion.

2.4.8. Nirmal Gram Puraskar

To add vigour to TSC implementation, government of India has separately launched an award scheme called the Nirmal Gram Puraskar for fully sanitized and open defecation free gram panchayats, blocks and districts. The Nirmal Gram Puraskar scheme will have the following ingredients:

**Eligibility:**

(i) Gram panchayats, blocks and districts which achieve 100 percent sanitation coverage in terms of:
   (a) 100 percent sanitation coverage of individual house holds,
   (b) 100 percent school sanitation coverage,
   (c) free from open defecation, dry latrines and manual scavenging, and
   (d) clean environment maintenance.

(ii) Individuals and organizations, who have been the driving force for effecting full sanitation coverage in the respective geographical area.
Incentive pattern:
The incentive pattern will be based on population criteria and will be as follows:

Table 2.4
Incentive Pattern under Nirmal Gram Puraskar

(Rupees in lakh)

<table>
<thead>
<tr>
<th>Sl. No.</th>
<th>Particulars</th>
<th>Gram Panchayat</th>
<th>Block</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Population Criteria</td>
<td>Up to 5000</td>
<td>Up to 50000</td>
<td>Up to 10 lakh</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5001 and above</td>
<td>50001 and above</td>
<td>Above 10 lakh</td>
</tr>
<tr>
<td>2.</td>
<td>Cash Incentive Recommended</td>
<td>2.0</td>
<td>10.0</td>
<td>30.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.0</td>
<td>20.0</td>
<td>50.0</td>
</tr>
<tr>
<td>3.</td>
<td>Incentive to Individuals</td>
<td>0.10</td>
<td>0.20</td>
<td>0.30</td>
</tr>
<tr>
<td>4.</td>
<td>Incentive to Organization/s other than PRIs</td>
<td>0.20</td>
<td>0.35</td>
<td>0.50</td>
</tr>
</tbody>
</table>

Source: http://www.ddws.nic.in

(c) Selection Procedure:
Selection procedure will be followed as under:

(i) State government will identify and select gram panchayats, blocks and districts, which are fully covered and conform to the eligibility criteria. After selection they will send the report to the government of India.

(ii) For districts, blocks and panchayats, the government of India may engage independent evaluator(s) or multi-disciplinary team(s) to assess the status of full sanitation coverage of the gram panchayats, blocks and districts.

(iii) There will be a National Committee on Nirmal Gram Puraskar constituted by the Central Rural Development Department to draw up criteria for annual selection of gram panchayats, blocks, districts, individuals and organizations for the Puraskar.
(d) **How the incentive can be used:**

The incentive for panchayati raj institutions can be used for improving and maintaining sanitation facilities in their respective areas. The focus should be on solid and liquid waste disposal, drainage facilities and maintenance of sanitation standard in the panchayati raj area.

### 4.5 TOTAL SANITATION CAMPAIGN IN HARYANA

Total sanitation Campaign in Haryana was not started with the inception of this campaign in India in 1999-2000 but in the next financial year and even that only in two districts. Later, in a phased manner, the Campaign caught momentum.

**TSC in Haryana**

The Total Sanitation Campaign in Haryana was initiated in phased manner. In the first phase in 2000, it was incepted in districts of Karnal and Yamuna Nagar. The following table shows the initiation of TSC in Haryana.

**Table 2.5**

<table>
<thead>
<tr>
<th>Sr. No.</th>
<th>Year</th>
<th>No. of Districts</th>
<th>Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2000</td>
<td>2</td>
<td>Karnal, Yamuna Nagar</td>
</tr>
<tr>
<td>2</td>
<td>2001</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>3</td>
<td>2002</td>
<td>2</td>
<td>Bhiwani, Gurgaon</td>
</tr>
<tr>
<td>4</td>
<td>2003</td>
<td>11</td>
<td>Ambala, Faridabad, Hisar, Jhajjar Kaithal, Kurukshtretra, Panipat, Rewari, Rohtak, Sirsa, Sonipat</td>
</tr>
<tr>
<td>5</td>
<td>2004</td>
<td>4</td>
<td>Fatehabad, Jind, Mahendergarh, Panchkula</td>
</tr>
<tr>
<td>6</td>
<td>2005</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>7</td>
<td>2006</td>
<td>1</td>
<td>Mewat</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20</td>
<td></td>
<td>--</td>
</tr>
</tbody>
</table>

Source: [http://www.ddws.nic.in](http://www.ddws.nic.in)
Physical Progress of TSC in Haryana

In Haryana, with the inception of TSC it was decided to construct 1785097 toilets (550500 for BPL households and 1234597 for APL ones). Out of the target, 1457106 (81.62 percent) has been constructed so far. Achievement for BPL toilets has been 458538 (83.29 percent) and for APL households 998568 (80.88 percent). At the same time objective to construct 7029 school toilets was fixed, out of them 7138 toilets have constructed whereas a target of 6531 anganwari toilets was set, out of which 5650 have been erected.82

OBSERVATIONS

Some observations that came out of the ongoing discussion are as follows:

- Historically, sanitation was a part of town planning even as far back as 3000 BC. Well laid out drainage and street system were present during Indus Valley Civilization. The earliest evidence of urban sanitation was seen in Harappa, Mohenjo-daro and the recently discovered Rakhigarhi.

- The British government introduced the first Sanitation Bill in India in 1878, which made the construction of toilets compulsory and also proposed the construction of public toilets.

- The McKenzie committee found that people were willing to submit to any sanitation measures calculated to promote health at pilgrim centres which were the main centres for the spread of diseases.

- The Environmental Hygiene Committee (1948-49) appointed by the government of India carried out an overall assessment and planning of environmental sanitation and recommended a 40 years plan to cover 90 per cent of the population.

- It was in 1954 that for the first time in India, a rural sanitation programme was introduced in the First Five Year Plan (1951-56) as part of the health sector. Under the programme 100 per cent grants-in-aid to implement the different water supply schemes for the ‘problem villages’ were provided by the government of India.

82 http://www.ddws.nic.in
In order to accelerate the pace of coverage of 'problem villages', the government of India introduced the Accelerated Rural Water Supply Programme (ARWSP) in 1972-73. During 1974-75 the Minimum Needs Programme (MNP) was introduced because of which the ARWSP was withdrawn but it (ARWSP) was reintroduced in 1977-78.

In the year 1977, the United Nations Water Conference separated the issue of drinking water and sanitation.

In August 1985, in India, the subject of rural water supply and sanitation was transferred from the Ministry of Urban Development to the Department of Rural Development.

The Central Rural Sanitation Programme was launched in 1986 with the objective of improving the quality of life of the rural people and to provide privacy and dignity to women.

The National Drinking Water Mission was launched as one of the five societal missions in the year 1986. The mission has been named as Rajiv Gandhi National Drinking Water Mission (RGNDWM) in 1991.

A baseline survey on knowledge, attitudes, and practices in rural water supply and sanitation was conducted during 1996-97 by the Indian Institute of Mass Communication, which showed that 55 percent of those with private latrines were self-motivated. Only 2 percent of the respondents claimed the existence of subsidy as a motivating factor.

The Total Sanitation Campaign (TSC) was launched in 1999 advocating a shift from high subsidy to a low subsidy regime, greater household involvement, and demand-responsiveness.

The Total Sanitation Campaign was initiated in a phased manner in Haryana. In the first phase in 2000, it was incepted in districts of Karnal and Yamuna Nagar.