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RURAL SANITATION PROGRAMMES IN INDIA: A REVIEW

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ABSTRACT:

India ever since, its independence in 1947 has been putting in great strives for improving the sanitation situation of the country. This article presents a review of rural sanitation programmes in India. The thematic review covers various themes like sanitation planning and policy making in India, the policy formulation and implementation, the planning phases for improving the rural sanitation in India, Central Rural Sanitation Programme (CRSP), Total Sanitation Campaign (TSC), Nirmal Bharat Abhiyan (Clean India Campaign) and Swachh Bharat Mission.

KEYWORDS: *Central Rural Sanitation Programme (CRSP), Total Sanitation Campaign (TSC), Nirmal Bharat Abhiyan (Clean India Campaign) and sanitation planning and policy making, Swachh Bharat Abhiyan.*

INTRODUCTION :

Sanitation is associated with safe management and disposal of waste. It helps in reducing burden of disease, ensures better quality of water and a cleaner environment consequently resulting in a better quality of life (DDWS, 2008). Lack of proper sanitation negatively impacts health, dignity and security. It is also associated with many negative externalities especially for women andchildren. Inadequate sanitation and open defecation is the leading cause of child mortality and many diseases like diarrhea, microbial infections around the world. (DDWS, 2007)

Provision of safe sanitation is a major challengein many parts around the world. Globally around 2.5 billion people lack improved sanitation. Almost 1 billion of which, practice open defecation making open defecation a global concern. According to the Joint Monitoring Programme (2015) of the WHO and UNICEF, about 524 million people still defecated in open especially in rural areas (MDWS, 2018). The issue of open defecation is even more significant in Indian context as it is home to more than 60 percent of the world population who choose to defecate in open. DDWS, 2007; Bonu & Kim, 2009; Spears, 2012-13; Barnard et.al.2013;Hueso & Bell, 2013; Rana & Aggrawal, 2017).

SANITATION PLANNING AND POLICY MAKING IN INDIA

Sanitation has always been a fundamental concern in India even in the ancient times. Importance of Sanitation and hygiene were discussed in ancient Indian scriptures as well (Ganguly, 2008). Right from Indus Valley civilization, public sanitation was given great importance (Dutta & Bhaskar, 2017). Evidence of elaborate drainage network, bathhouses and toilets has been found in Indus Valley Civilization and the subsequent dynasties like Mauryan Empire, Gupta Empire (Bharati,2019). However, after colonization sanitation especially rural sanitation did not receive much prominence in the policy making. The country struggled for proper sanitation for decades with rampant outbreaks of cholera and plague (Rana and Agrawal, 2017; Dutta & Bhaskar, 2017).

Colonial interest in sanitation was rather limited to the needs of military and elites and the eradication of epidemics. No elaborate steps were taken to improve the sanitation situation. Due to the negligence shown towards sanitation less than 1 percent of the rural population had access to sanitation when the country became independent in 1947 (Dutta & Bhaskar, 2017).

Mahatma Gandhi was the torchbearer of sanitation campaigns in India. He was among the first person to emphasise the importance of cleanliness. He regarded 'Sanitation 'even more important than political Independence' (Rudd, 2019) and a 'Swachh Bharat' was his dream. He organized the first mass sanitation campaign to educate the masses about the significance of cleanliness and its impact on health (Rana and Agrawal, 2017).

After independence rural sanitation plan and programmes were included in the policy making process. The government of India through its successive five years plans tried to improve the sanitation situation of the country. However, no significant achievement could be made. The increase in sanitation coverage was very slow all throughout the seven decades until, the launch of Swachh Bharat Mission in October 2014.

The Swachh Bharat Mission brought about a landslide change in the sanitation landscape of the country. The dream of Swachh Bharat envisioned by Mahatama Gandhi was brought to reality by the efforts of PM Narendra Modi with the Swachh Bharat Mission, making India open defecation free and by achieving 100 percent sanitation coverage in the country by October 2019.

The Policy Formulation and Implementation

Rural Sanitation is a state subject, hence it is the responsibility of state government to make plan and polices towards it. "At the same time rural sanitation was recognized as a development priority, hence the Government of India provides major share of investment through Centrally Sponsored Schemes" (CSS) (WSP, 2016).

Currently at the central level Ministry of Drinking Water and Sanitation (MDWS) (erstwhile Department of Drinking Water and Sanitation under Ministry of Rural Development) is the nodal ministry responsible for formulation and implementation of policies regarding sanitation. At the state level, the government can choose the implementation and planning as well as nodal agency ranging from Public Health Engineering Department to Local Self Government (WSP, 2016).

The Planning Phases

Since the time of independence to present, the whole planning and policy making for improving the rural sanitation in India can be divided into three phases:

Phase 1: Low Priority Phase (1947- 1980)
Phase 2: The Moderate Priority Phase (1981-1999)
Phase 3: The High Priority Phase (1999 –Till Present)

Phase 1: Low Priority Phase (1947- 1980)

The first phase of planning and policy making for sanitation and related issues began after Independence, mostly with the first plan period of 1951-1956. The country at that time was focused primarily on building capital and economic base. Hence, issues like sanitation could not gain much ground and adequate budget could not be directed towards it.

The rural sanitation programme was added to the national agenda in the very first five-year plan in 1954.The first programme introduced in India for improving the water supply and sanitation situation of the country was the '**National Water Supply and Sanitation Programme in 1954,** following the recommendation of Environmental Hygiene Committee (1948 – 49). The primary objective of this programme was to provide safe water supply and adequate drainage facilities for the rural and urban population of the country (De, 2019).

The programme however, was not able to bring any mark in the sanitation situation of the country as it lacked a sense of priority among the implementing authority. Moreover, the fund allocations were quite limited as other subjects outweighed the issue of sanitation. In the subsequent plan periods also the issue of sanitation especially rural remained secondary and negligible funds were directed towards it (MDWS, 2008; Ganguly, 2008; Baroka, 2019).

Phase 2: The Moderate Priority Phase (1981-1999)

The second phase of Moderate Priority began after 1980. In this phase the significance of sanitation was recognised and was considered to be detrimental for a quality life. In this phase the programmes and policy were centred around infrastructural interventions.

The concern for sanitation started gaining prominence from the Sixth Plan Period (1980-85) onwards with the declaration of **International Drinking Water Supply and Sanitation Decade** in 1980 (MDWS, 2008) which unequivocally recognised the issue of sanitation as a global concern. "India became a signatory to the resolution and pledged full support to the action plan under the International Decade (MDWS, 2016)".

At that time,rural sanitation coverage in India was a meagre 1 percent (Ganguly, 2008). The Indian government recognising the significanceof sanitation for quality of life, for the first time set targets for improving the water supply and sanitation situation. The government aimed to achieve 100 percent rural and urban water supply and attain 50 percent sanitation in urban areas and 25 percent in rural areas (Bonu & Kim, 2009). Additionally, the responsibility for rural sanitation was shifted from Central Public Health and Environmental Engineering Organization to the Rural Development Department (DDWS, 2008;Baroka, 2019).

Consequently, the Ministry of Rural Development introduced the first national wide rural sanitation programme under the name of 'the Central Rural Sanitation Programme (CRSP) in 1986'.

Central Rural Sanitation Programme (CRSP)

The first nationwide sanitation campaign was launched with the primary objective of improving the quality of life of the rural people and to provide privacy and dignity to women (DDWS, 2007; Ganguly 2008). It was a supply driven and highly subsidised programmes with a stress on construction of twin-pit-pour flush household toilet. The programme was based on hardware subsidies for demand creation of toilets(DDWS, 2007; Ganguly 2008).

The programme was, revised based on recommendations of the National Seminar on Rural Sanitation in September 1992, with a greater stress on Information, Education and Communication (IEC) for awareness and demand generation. An integrated approach was implemented which emphasised personal and household hygiene and health (GOI, 2006). India also received support from international orgaisations like UNDP, WHO and UNICEF for technical and capacity development for implementing the programme (Ganguly, 2008).

Under this programme, the government invested more than US$370 millionconstructing more than 9.45 million individual subsidized latrines all over the country mostly for poor household (Ganguly, 2008). However, the programme was able to bring only a marginal change in the rural sanitation situation of the country. The rural sanitation coverage increased from 1 percent in 1981 to 8 percent in 1991. Between 1981 and 1991 the sanitation coverage increased with an annual increase of mere 1 percent (GOI, 2006; Ganguly 2008; DDWS,2011; Baroka, 2019). In the subsequent years also despite the revision in the programme, the pace of sanitation growth remained slow and unsatisfactory (MDWS, 2016).

The programme was not successful in resolving the sanitation crisis of the country and bring-forth the intended outcome. The entire campaign was based on a flawed assumption that mere construction of toilets would lead to a sustained toilet usage and will motivate people to stop defecating in open (DDWS, 2008; DDWS, 2011). Moreover, various studies reflected that there was a lack of felt need for toilet among the masses (DDWS, 2007). The programmes thus, did not pay adequate attention on awareness generation and demand creation for improved sanitation.

There was lack of community participation and poor utilisation of toilets due to lack of awareness, misconceptions, poor construction standards, high cost designs, absence of participation of beneficiaries and so on. Even if the toilets were constructed they remained largely unused or were used for purposes other than excreta disposal like storing firewood, fodder, or keeping animals. (GOI, 2006; Ganguly, 2008).The programmes rather than whole population laid greater stress on encouraging the Below Poverty Line (BPL) households for toilet construction. Most of the States also did not assignadequate priority to the sanitation programme.

The CRSP did not pay adequate attention towards school sanitation, which was recognised as one of the vital components of increasing sanitation in rural communities and significant for wider acceptance. It also failed to develop linkages with various local institutions like ICDS, Mahila Samakhya, women, PRIs, NGOs, research institutions, SHGs, etc. (Ganguly,2008) .

The main approach adopted in this phase to solve the sanitation crisis was provision of hardware and subsidy. However, lack of improved sanitation facility and open defecation is deeply rooted social and cultural issue which required more intensive approach directed towards creating demand for sanitation facility which was mostly lacking among the rural masses. It was recognised that toilet construction is not sufficient for securing toilet usage and especially a sustained toilet usage. Even high subsidy was not efficient in increasing toilet uptake (GOI, 2006). Different studies bear evidence to the fact that subsidy does not guarantee a regular and sustained toilet use. It is not an effective motivator for behaviour change (Ganguly, 2008). Also, satisfactory health outcome cannot be achieved until and unless the whole community adopts improved sanitation. Hence, a traditional approach of hardware subsidy widely used during this phase did not prove to be an efficient solution for Indian sanitation crisis (MDWS, 2016).

Phase 3: The High Priority Phase (1999 –Till Present)

This phase is recognised with a more intensive approach towards sanitation crisis of the country. There was a significant improvement in the budget allocations; technical innovations with greater capacity building, community participation and more importantly demand generation for toilet usethrough IEC activities.

According to 2001 Census, the rural sanitation coverage stood at 22 percent recording a remarkably slow growth of 1 percent annually. However, from the year 2001 the sanitation sector received a major boost as a result of the Sector Reforms bought in the year 1999. There was a significant increase in the government allocations along with support from international organisations such as UNICEF, International Water and Sanitation Centre (IRC), different NGOs, SHGs and even private sector. They gave assistance in human resource development, capacity building, reviews, monitoring, communications and even management (Ganguly, 2008).

Moreover, the CRSP was reintroduced as Total Sanitation Campaign in the year 1999. The tradition approach of hardware subsidy was given away, to a more integrated and systematic approach. Steps were taken to increase ownership of toilets among individuals by emphasising on issues such has safety, security and dignity of women, prestige of family, health hazards of open defecation and so on (Ganguly, 2008).

Total Sanitation Campaign (TSC)

In view of the poor performance of CRSP and based on the recommendation of Second National Seminar on Rural Sanitation, The Total Sanitation Campaign (TSC) was introducedin the April,1999. The programme advocated for improving the rural sanitation environment by ending open defecation

and encouraging safe sanitation practises with safe disposal of human excreta and solid and liquid waste management(Mukherjee & Pani, 2012). Hence, the programme in policy was not restricted to just toilet construction rather improving the overall rural quality of life and achieve access to sanitation to all by 2012 (DDWS, 2007).

The Total Sanitation campaign followed the principles of community-led, people-centred, demand-driven, and incentive-based sanitation programme (Hueso &Bell, 2013; Rana &Agrawal, 2017). It shifted from an infrastructure based approach of previous programme and stressed on stimulating behaviour change (MDWS, 2008). The capital subsidy was also replaced by incentives. It marked a shift from a high to a low subsidy system, with an objective of generating household demand andinvolvement for constructing individual household latrines (DDWS, 2006; Barnard et.al.2013).

A post construction incentive of rupees 1200 was provided to BPL households, which was further increased to 2200 in the year 2007 (Hueso &Bell, 2013; Barnard et.al.2013).In addition, to the individual incentive, a community incentive system was put in place under the name of Nirmal Gram Puruskar (Clean Village Award) (introduced in 2003). Under this scheme a cash reward ranging from Rs. 50,000 to Rs.5 Lakhs was given to Gram Panchayat (depending on size of population) upon achieving 100 percent open defecation free status (MDWS, 2008; Barnard et.al.2013).

The campaign stressed on the use of Information, Education and Communication (IEC), Human Resource Development (HRD) and Capacity Development and mobilisationamong Gram Panchayat members, co-operatives, women groups, self-help groups, NGOs, to stimulate community participation,to increase awareness among the rural people, demand generation for sanitary facilities and for encouraging sustained toilet use (DDWS, 2007; Hueso &Bell, 2013; Barnard et.al.2013; Rana and Agrawal, 2017).

The campaign also laid emphasis on training of masons, provision of sanitary marts and production centres for availability of building materials. It also laid a strong thrust on promotion of sanitation and hygiene education in schools for wider acceptance of sanitation by rural masses (DDWS, 2007; Rana and Agrawal, 2017). A robust online monitoring system was also put in place for tracking physical progress and improving implementation and most importantly upholding transparency and accountability (DDWS, 2007).

The programme set a goal of having Sanitation for All by 2012 by constructing

- 108.5 million individual household latrines
- 11.2 million schools latrines
- 0.4 million toilets for child care centers
- 28,000 community sanitary complexes
- 4,000 rural sanitary marts/production centers

The total budget allocation for the programme was US$2,983.10 million including a community share of US$ 445.18 million. Provision was also made for additional resources for incentives for well performing local governments (DDWS, 2007).

Under the programme, around 90 million individual household latrines were constructed. The rural sanitation coverage increased from 21 percent in 2001 to about 44 percent in 2007 and 68 percent in 2011. The average growth rate was more than 3 percent in first five years of the programmes while the growth rate in the 2006-07 has been more than 6 percent (MDW, 2012). More than 20,000 Gram Panchayat became the recipient of Nirmal Gram Puruskar (Mukherjee &Pani, 2012).

A study by Government of India showed a high usage varying between of 60-80 percent across different states (DDWS, 2007). While another study estimated that on an average about 2.8 million individual household latrines (IHLs) were constructed annually over the period of 2001-2005.Moreover about 0.4 million school toilets, 0.15 million child care centertoilets, and 8,000 rural sanitary marts were also constructed (DDWS, 2007).

Given the achievements of the programmes, the well-crafted policy of Total Sanitation campaign was supposed end open defecation in rural areas (DDWS, 2007). However, it was able to bring only a

modest increase in the rural sanitation coverage, and was not very effecting in reducing open defecation (Rana and Agrawal, 2017). It was neither successful in creating demand or bring behaviour change towards toilet use among the masses. (Mauro, 2015; Routray et al. 2017)

A study by Planning Commission stated that 25 percent of the constructed toilets were not being used. While other studies pointed that the low latrine usage was due to inadequate awareness towards significance of sanitation, substandard toilet construction and costly toilet designs (MDWS, 2008). Apart from this campaign also suffered from many structural inadequacies and drawbacks.

The campaign was effective in increasing the sanitation coverage but it was not universal. There was large scale inter-state disparity in the outcomes (Mukherjee & Pani, 2012). Moreover, the campaign prioritized the construction of toilets among BPL household through incentive, as a result there was significant increase in the latrine coverage among them, while the other classes of people were overlooked. Furthermore, there was lot of slippage and lack of sustained use. The TSC campaign thus, was able to construct the toilets but it did not put in adequate efforts for securing their usage (Barnard et.al. 2013).

Hueso & Bell (2013) asserts that campaign was hardware oriented and target driven rather than people centred and demand driven focussing individually on toilet construction like the previous campaigns. The implementing body emphasised on subsidised construction of the toilets completely ignoring awareness generation, behaviour change and motivating the community for sustained toilet use. The IEC activities were hence given a backseat in the campaign.

The campaign is also alleged to be government led rather than community led. It was supposed adopt a bottoms-up approach in its implementation with a strong involvement of Gram Panchayat members and the community. However, the implementing body were undertrained, overworked with low motivation and were underpaid. In many states like Uttar Pradesh and so on evidences of haphazard and top-down implementation with extremely low community participation focussing mainly on toilet construction were observed (Hueso & Bell, 2013).

Under the programme the financial allocations for sanitation by the state governments were not adequate due to lack of priority given to the programme. The states where sanitation received higher priority, decent results were realized. Moreover, in many states the incentives were given upfront which was a deviation from the Guidelineswhich called for post construction incentive dispersal(Hueso &Bell, 2013).

The outcomes of the campaign were thus 'short lived and exclusionary' (Hueso &Bell, 2013, pp. 1008). There was also an absence of strong political will and required capacity at different levels to implement the behaviour change. Sanitation was not priotised and was unsuccessful in bringing sanitation to mainstream discussion (Hueso &Bell, 2013).

The TSC was also accused of erroneous monitoring system and arbitrary reporting. In many states the coverage were reckoned on the basis of subsidy fund released from block rather than actual verifications. This was main reason behind inflation of coverage data. The Department of Drinking Water and Sanitation (DDWS) was also reported to inflate the progress made by the campaign. A jump of 44 percent in the rural sanitation coverage from 22 percent in 2001 to 68 percent in 2011 was reported by the ministry. However According to the Census 2011 the actual rural sanitation coverage was just 31 percent with a meagre increase of 10 percent between 2001 and 2011 census. The progress made by the campaign was infact even less than the previous sanitation programme of CSRP(Hueso &Bell, 2013).

Construction of toilets in school was one of the main thrust of the campaign. However, according to ASER Report (2010) 90 percent of the constructed school toilets were wither locked or were non-functional (Aiyar, 2011). Most of the school toilets suffered from lack of maintenance making them unusable. Scholars are also of the view that the campaign did not invest adequately for IEC activities considering its significance in not just demand creation but also adoption of toilets and its sustained use.

The Nirmal Gram Puruskar, a fiscal initiative introduced in the year 2003 has been the most successful component of the TSC. It effectively contributed in improving the outcomes of TSC by

promoting the role of Gram Panchayats and local communities (DDWS, 2008). It strongly propagated that the benefits of behaviour change required for transforming the sanitation situation can be realised when the whole community is made part of it rather than individual beneficiaries. By the year 2011, about 28002 Gram Panchayats, 181 block panchayats and 13 district panchayats were awarded NGP (MDWS, 2016).

However, NGP Gram Panchayats suffered from the issue of sustainability. There was lot of slippage in the status of NGP villages, with many gone back to old ways of open defecation. A study by Unicef in 2008 revealed that only 6 of the 162 Gram Panchayats studied were still using their household toilet while the rest have started defecating in open.

Nirmal Bharat Abhiyan (Clean India Campaign)

In 2010 a new campaign called the **Nirmal Bharat Abhiyan** was introduced to replace the Total Sanitation Campaign**.** The objective of the programme was to accelerate the sanitation coverage in the rural areas, end open defecation and achieves sanitation to all by the year 2022 (MDWS, 2018).

It aimed at achieving Nirmal in other words a clean and sanitary village by involving the local government bodies (MDWS, 2012; MDWS, 2016). This programme intended to bring about a behaviours change among rural folk by building awareness towards adoption of safe and improved sanitation measures (Sharma, 2014). This Abhiyan like the previous programmes followed the principles of community-led total, demand driven, people oriented, and incentive-based sanitation programme. However, a greater emphasis was directed towards community mobilisation, collective and behaviour change (Routray et al., 2017). It focused on covering the entire community for a more saturated outcome with a greater stress on awareness creation and bringing sustainable behaviour change among the rural masses for creation of Nirmal Grams (Clean Villages) as an outcome (MDWS, 2012; De, 2019).

Intensive IEC Campaign was made the cornerstone of the Campaign banking on Panchayati Raj Institutions, ASHA Workers, Anganwadi Workers, SHGs, NGOs, Cooperatives and women Groups with active people participation. Private sector was also widely involved (MDWS, 2012). To further strengthen the IEC component Swachhata Dooots or sanitation Messengers were also enegaged at panchayat level (Routray et al, 2017).

The budget of the Campaign was tremendously increased from the last campaign. There was infact five-fold increment in the budget from INR 6540 crore during the 11th Five year plan to INR 34377 crore during the 12th five year plan. The budgets were significantly increased in the subsequent plans as well (GOI, 2015-16). Considerable resources were allocated towards IEC activities and recognised the influence of peer pressure, interpersonal contact and motivation for bringing behaviour change. Additional financial support was also obtained through convergence with Mahatama Gandhi National Rural Employment Gurantee Scheme (MNREGS) (MDWS, 2012).The Cost of toilet construction was shared between the central government, state government and the beneficiaries (GOI, 2014-15).

The cash incentive was provided to BPL household post construction. It was increased from rupees 2200 to rupees 4600 from the previous campaign. The criteria of incentive dispersal were also modified. “Along with BPL households, incentive was further extended to APL households belonging to SC and ST, small and marginal farmers, landless labourers with homestead, physically handicapped and women headed households” (Barnard et.al.2013). On the other hand other APL families were supposed to self-finance and construct their own toilet construction (Routray et al, 2017).

The campaign in its brief duration was able to create a renewed enthusiasm towards rural sanitation but like previous programmes it was not successful in meeting its gaols. According to 2011, only 31 percent of the total rural population had access to sanitation facilities. There was slight improvement in the rural sanitation coverage but over 60 percent of the rural population still lacked sanitation facilities, which was confirmed by the Baseline Study of NBA in 2012. On an average 3 out of every 5 people did not have access to sanitation facilities. There was an increase of merely 6 per cent in rural sanitation coverage between 2012 and 2014 (GOI, 2014-15).

Even though IEC components were given due attention during the course of the campaign but it was not quite intensive. In many states, construction of toilets had greater precedence over behaviour change strategies. In fact, More than 75 percent of the total allocations were directed towards toilet construction. Only a small share of the total budget were utilised for IEC activities with wide variation across different states. In many states, the allocations under IEC component remained underutilised (GOI, 2014-15; WSP, 2016).

Moreover, the programme suffered from planning level weakness (Khanna, 2015) and practical implementation difficulties due to its convergence with the MGNERGA (De, 2019). As the funding came from different source there was a mismatch in the release of the funds which proved to be hindrance in timely completion of projects (MSWS, 2016). The campaign was also marked with large gaps between planning and implementation process. There were marked wastage and irregularities in resource utilisation.

The NBA did could not being much acceleration in the sanitation coverage of rural India. Thus, the government of India replaced the Nirmal Bharat Abhiyan with a new campaign called the Swachh Bharat Abhiyan in 2014 with a renewed policy and implementation strategy (Routray et al, 2017).

Swachh Bharat Mission

The Prime Minister of India on 15th August 2014, launched the Swachh Bharat Abhiyan (Clean India Mission) to make India free of open defecation by 2nd October 2019. The SBM was launched as a tribute to the Father of Nation-Mahatma Gandhi to fulfill his dream of Swachh Bharat' (MDWS, 2016; Iyer, 2019). The primary focus of the mission is to improve the level of cleanliness though solid and liquid waste management and bring behavioral change among the people to adopt safer and better sanitation practices and end the practice of open defecation especially in rural areas (MDWS, 2016; De, 2019).

The Mission has two sub- divisions: Swachh Bharat Mission (Gramin) and the Swachh Bharat Mission (Urban). It is being coordinated by Ministry of Drinking water and Sanitation (De, 2019; Sinha, 2019). However, the responsibility of implementing the Mission lies entirely with the state government and the local self-government (GOI, 2017; Mehta, 2018; Baroka, 2019).

This Mission like the previous programmes followed the principles of community-led total, demand driven, people oriented, and incentive-based sanitation programme (De, 2019). However, unlike the previous programmes, it is outcome oriented with a primary focuses on eradicating open defecation and encouraging people for sustained use of toilet. It emphasizes on making an entire village responsible for maintaining the ODF status rather than stressing on individual beneficiaries (MDWS, 2016).

The Mission also acknowledges the fact that the practice of open defecation cannot be eradicated by mere construction of toilet (Haque, 2019) rather the basic necessity is to inculcate the habit of sustained toilet use and address cultural barriers and myths associated with defecation practices (Das, 2019). Hence, the mission has made behaviour change through intensive IEC activities as its cornerstone for implementation and achieving its goal.

Information, Education and Communication **(**IEC) activities have been extensively deployed for bringing mass scale behavior change, demand generation for sanitary facilities, mobilising and nudging communities and triggering mindsets for sustained toilet and and for Solid and Liquid Waste Management (Debroy, 2019). Civil society, NGO, National and International organization working in social sector are also involved in triggering and capacity building activities (Curtis, 2019).

To further augment the institutional capacities and efficiency of implementation of the behaviour change program a cadre of over 6 lakhs Swachhagrahis (Foot Soldier/Swachhata Doot) has been created. They play a critical role in bringing behavior change at the ground level through interpersonal communication with the village community (Debroy, 2019). ASHA, Aanganwadi workers, members of Women Groups, community based organizations, Self-help groups and so on have also been tasked for spreading the message of SBM. Apart from these people there has been active involvement of

people from all the sections of the society (Sinha, 2019). They have been motivating and urging the fellow countrymen to join and lead the programme to make the country ODF.

The SBM has been extensively useing mass media to run various campaigns, strongly supported by its brand ambassadors Amitabh Bachchan, Anushka Sharma and Akshay Kumar for dispelling myths and misconceptions associated with defecation and toilet use (Iyer, 2019). In the last 5 years swachata illuminating message has reached almost all the villages in rural India with the participation of crores of Indians and especially over 12 crore school childen, 10 lakhs Masons, 250000 Sarpanch700 district magistrate, 500 over young professional (Zila Swachh Bharat Preraks) and over 50 national Brand Ambassadors (Iyer, 2019).

To keep the buzz about SBM alive, mass campaigns and events like Chalo Champaran; Mahatma Gandhi International Sanitation Convention (MGISC) 2019; Swachhata Essay and Painting Competition; Swachh Bharat Summer Internship, 2018; Swachhata hi Sewa Campaign; Swachh Sundar Sauchalaya contest and go on were continuously organized years round (Iyer, 2019).

The mission has been publicizing the Twin pit toilet technology for most of rural India as it is more suited to the hydrogeology of the country and is easy to use and maintain (Das, 2019). At the same time, the states are independent to use any other safe sanitation technology like Eco-San, Bio-Toilets, Septic Tank and so on, depending on the topography, ground water level and soil conditions (MDWS, 2017).

The Mission encourages individuals for the construction of Individual Household Latrines (IHHL) by self-financing and constructing their own toilet or through alternate financing mechanism like the village Revolving Fund, low cost financing from NABARD, banks and financial institutions (MDWS, 2017). But at the same time, a provision of incentive of Rs 12000 has also been made for people Below Poverty Line (BPL) and Identified APL Families (SCs/STs,Small and marginal farmers,landless labourers with homestead, physically handicapped, women headed households and Widow /old age pensioners). The sole objective of incentive is to partially cover the total cost of toilet construction and facilitate self-construction of the toilets. Apart from IHHL, incentive up to Rs 2 lakhs is also provided to Gram Panchayats for the construction of Community sanitation complexes(MDWS, 2017; Mehta, 2018).

A strong monitoring system has also been developed to track the outputs as well as outcome of the Mission. Community led system like social audit; vigilance committees and so on are being used to monitor Open Defecation Free status of a village, construction and use of household toilets, school and Anganwadi toilets, and Community Sanitary Complexes as well as implementation of Solid and Liquid Waste Management projects (MDWS, 2017). Along with it regular visits from officers from the MDWS, periodic review meetings, video conferences and so on are being conducted with the authorities to review the physical and financial progress of the Mission (De, 2019).

In order to fulfill its ambitious goal of SBM,abudget of about “1.3 lakhs crore (over $20 Billion) was allocated to the Mission shared between the Centre and States at 60:40 ratio and 90:10 for special category states” (Jaitley, 2019). About 60 percent of the total budget is meant to be spent on incentive for individual household latrine, 8 percent on IEC components and 27 percent on solid and liquid waste management by the Gram Panchayat (Mehta, 2018) rest 2 percent is be spent on administrative costs (De, 2019). “About 5 percent of the total project outlay (maximum of rupees 1.5 crore) is to be used for Revolving Fund and also for funding the construction of rural sanitary mart and production centre by the Gram Panchayat” (De, 2019).

Efforts have also been undertaken for pulling funding from private sector, development agencies and even citizens. A Swachh Bharat Kosh made through contribution by individuals, Companies, and Institutions contributed around Rs. 1000 Crore for specific sanitation projects. Many private companies directly implemented Swachhata projects through CSR programmes especially in villages and schools surrounding their factories (Jaitley, 2019). Additionally, all Government Departments and Ministries mainstreamed sanitation in their respective sectors. They together committed a budget of Rs. 30,000 Crore for the year 2017-18 and 2018-19 to make swachhata an integral element in their existing and new schemes and programmes. The Mission has also obtained

funding and technical support from international organization like World Bank, UNICEF ,water aid and other support agencies (De 2019; Curtis, 2019)

Since 2014, over 97 million toilets have been constructed and millions of dysfunctional toilets have been retrofitted. More than 550 million people have changed their behaviour and stop defecating in open. This has increased the sanitation coverage of India from 39 in 2001 to 84 percent in 2018 recording an increase of over 45 percent and finally to 100 percent to by 2019(De, 2019). Over 5.6 lakhs villages and over 622 districts in the country have been declared as open defecation free as of June 2019. According to Annual Rural Sanitation Survey 2018-19 and 2017-18, more than 90 percent of toilets in the country are being regularly used by household members (Kant, 2019). Moreover, more than 85 percent of the newly constructed toilets have been geo-tagged and the pictures are available in the public domain.

SBM has become the biggest behavior change mass movement in the world (Iyer, 2019). Unlike the previous sanitation programmes which were demand oriented and focused mainly on building toilets. SBM used a multidimensional approach to solve the sanitation crisis of the country and achieve what none of the previous campaigns could do that too in just 5 years. The mission unlike any other government programme was backed by serious attention and resources. The strong leadership of Prime Minister of India Shri Narendra Modi served as the main element responsible for the huge success of the mission. He became the torch bearer and the chief communicator of the mission keeping a constant watch on the unfolding of the mission (Curtis, 2019).

The strong leadership helped in establishing clear institutional responsibility and set aside huge budget for sanitation and ensuring that all ministries and departments work together towards the set target of making the country free of open defecation (Sinha, 2019). The mission right from its formulation and implementation witness breaking of many social norms, professional ethics and usual business practices. Ministers and celebrities were widely seen with brooms sweeping roads, picking trash, emptying and digging toilet pits to break the taboos around toilet and cleanliness. The mission thus can be credited for mainstreaming the discussion about defecation and sanitation (Curtis, 2019).

India though the Mission has achieved remarkable progress in its drive to make the country open defecation free. The Mission is now moving in second phase where the top priority is to sustain the open defecation free status of the village and districts and to improve the level of cleanliness in rural areas through solid and liquid waste management activities making villages ODF Plus. The primary focus of this phase will be to make sure that all the new household constructed during this phase has safe sanitation and have access to solid and liquid waste management facilities. More stress will also be given to proper waste managements.

CONCLUSION

Open defecation is a major global concern, more so for India with over 60 percent of the population defecating in open (Spears, 2012-13). India ever since, its independence in 1947 has been putting in great strives for improving the sanitation situation of the country. In spite of, high priority sanitation programmes like Central Rural Sanitation Programme (CRSP), Total Sanitation Campaign and Nirmal Bharat Abhiyan, the sanitation journey has been very slow and and with modest gains. Even with large scale investment, the progress made has been unsatisfactory with a large share of population still lacking basic sanitation facility (Mukherjee & Pani, 2012).

Studies suggest that the greatest stumbling block in the direction of solving the sanitation crisis of the country has never been accessibility or availability of toilets rather it is the people mindset, and the deeply rooted cultural norm of open defecation which has been associated with the concept of purity. Most of the sanitation programmes focused entirely on toilet construction rather than changing the attitude towards open defecation and nudging communities for using toilets. So even if toilets were made, there was lack of sustained use (Hueso & Bell, 2013; Iyer, 2019). The policies failed to translate into practice and the outcomes were remarkably poor. However, The Swachh Bharat Mission launched on 2nd October, 2014 emerged as a watershed movement for sanitation in India and infact in the whole

world (Baroka, 2019). In just 5 years, the mission was able to achieve 100 percent sanitation coverage in the country and made it free of open defecation.

The success of SBM lies in that fact that it made sanitation everyone's business (Sinha, 2019) and primary agenda of the nation and its people. Termination of open defecation became much more than a government target. It was given a form of collective national responsibility to be taken up by each and every citizen of India. In this way the mission went beyond politics. It became a social revolution (Jan Andolan), a movement of the people, by the people and for the people transforming the sanitation narrative of the country. The Mission encouraged millions of people to take initiative to change their age old habit.

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