Sanitation in Rural India- Myth, Reality and Equity

A Dissertation

submitted in partial fulfilment of the requirement for the degree of M.A. in Governance and Development

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Summary

In India, 67% of rural population defecate in open (JMP, 2012). This is after the implementation of Total Sanitation Campaign (TSC) by Government of India (GoI) since last 13 years. In TSC subsidy is given for construction of toilets to rural Below Poverty Line (BPL) households. Till 2011, TSC reported provision of toilets facilities to 114 million rural households. However, Census 2011 reported presence of toilet in only 51 million rural households implying difference of 63 million toilets. That is, 63 million toilets reported to have built by TSC are actually not present on ground as per Census (2011).The poor have been excluded in the process because of elite capture. This research examines the evidences and discrepancies in data reported by TSC and Census. It assesses these issues and analyses the reasons for myth, reality and inequity and proposes practical and policy implications for betterment of services.

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Preface

India is lagging behind in the world in achieving its sanitation target. The condition is worse in rural India. GoI has been implementing Total Sanitation Campaign in rural India since last 13 years. As per TSC guidelines, it is a demand driven, subsidy based programmes providing subsidy for the construction of toilets to the rural Below Poverty Line (BPL) households. Till the year 2011, TSC reported the provision of toilets facilities to 114 million rural households. But, the Census 2011 reported the presence of toilet in only 51 million rural households. The comparison of TSC data with Census data implies over reporting of construction of 63 million toilets in rural India. That is, 63 million toilets reported to have built by TSC are not actually present on ground. On addition to this, a study by UNICEF (2010) reported the exclusion of poor and has raised the equity issues. This highlighted the cases of elite capture and exclusion of the poor-'the intended beneficiaries' in the entire campaign.

The present research examines the evidence and discrepancies in data reported by TSC and Census. It aims to assess the myth generated by TSC about provision of toilets to rural poor in comparison to closer to reality figures as indicated by Census 2011 data. It also assesses the equity issues and analyses the reasons for myth, reality and inequity and proposes practical and policy implications for betterment of services.

The research is based on secondary data. The reasons identified for the distortion of the data have been verified with the realities suggested by the field evidences done by researchers earlier.

I am grateful to Dr Robert Chambers, for having agreed to supervise the research. It was his commitment towards the improvement of the rural sanitation which I first witnessed when I attended one of his workshops,

which became one of the factors that led me to do my research in this subject.

I am thankful to Mr Andrez Gonzalez and Mr Brian Bell for sharing their primary research reports with me without which the ground truthing of the field based evidences would have been difficult as I was conducting a secondary research.

I am thankful to Mayank Joshi (my husband) and Ushi Joshi (my daughter) for their unconditional support through the entire course of the study.

Abbreviations

APL	Above Poverty Line
BP	Block *Panchayat*
BPL	Below Poverty Line
CLTS	Community –Led Total Sanitation
CRSP	Central Rural Sanitation Programme
DoDWS	Department of Drinking Water and Sanitation
DHLS	District Household Level Survey
DM	District Magistrate
GDP	Gross Domestic Product
GP	*Gram Panchayat*
GoI	Government of India
HH	Household
HP	Himachal Pradesh
MDG	Millennium Development Goal
MP	Madhya Pradesh
NBA	*Nirmal Bharat Abhiyaan*
NG	*Nirmal Gram*
NGP	*Nirmal Gram Puruskar*
NGO	Non-Government Organisation
NHFS	National Health and Family Level Survey
OD	Open Defecation
ODF	Open Defecation Free
PRI	*Panchayati Raj* Institutions
Rs	Rupees
TSC	Total Sanitation Campaign
JMP	Joint Monitoring and Planning
UNDP	United Nations Development Programme
UNICEF	United National International Children Education Fund
UP	Uttar Pradesh
WHO	World Health Organisation
WSP	Water and Sanitation Programme

'No act of terrorism generates devastation on the scale of the crisis in sanitation and water' (Human Development Report 2006)

Chapter 1

Introduction

According to World Health Organisation (WHO, 2010a), Sanitation has been referred as the provision of facilities and services for safe disposal of human urine and faeces. Scarce sanitation facilities form one of the major causes of disease worldwide. Almost 2.5 billion of the world population lack the access to proper sanitation facilities (JMP Report, 2012). Although, a global decline in open defecation (OD) has been recorded from 25% in 1990 (1.32 billion) to 17% in 2008 (1.14 billion), but 1.1 billion people that is 15% of the world population still defecate in open, of which India alone accounts for 59.4% of the population (JMP Report, 2012). Open defecation not only pollutes surroundings but also forms the major source of water and food contamination. It has been reported that unsafe disposal of faeces results in spread of diseases like typhoid, diarrhoea, hepatitis, hookworm, polio and tropical enteropathy (UNDP, 2006).

Earlier, sanitation has been considered as the 'last taboo' (Black and Fawcett, 2008). Although the decade from the year 1981 to 1990 was declared by the United Nations as 'International Drinking Water Supply and Sanitation Decade', but the focus was on water while sanitation was neglected. In 2002, sanitation was added to safe drinking water during the second Earth Summit at Johannesburg. In order to address the issues of OD and its impact on health and environment, sanitation was setup as one of the Millennium Development Goal (MDG) goal to '*halve, by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation*'. But the current trend shows that the MDG sanitation target will be missed by 1 billion populations still lacking the sanitation facilities (UN, 2010). In fact, it has been the most off-track target as compared to the other MDG targets.

Sanitation in India

Defecating in open is a traditional behaviour especially in rural India. Sanitation as a development priority has been neglected in India as until the end of 1990's only one in five rural households had access to toilet facility (Census, 2001). In addition to that little awareness about hygienic behaviour has made achievement of the sanitation targets even more challenging for India. The challenge is higher in rural areas (UN, 2010). Nearly two in five humans live without basic sanitation, majority of them being natives of Asian countries and sub Saharan Africa.

In fact, India has been seen as the leading sanitation offender. Out of the total world population, India has the highest percentage of 59.4% people defecating in open (Figure 1). Within India, although there has been a decline from 75% population defecating in open in 1990 to 51% of the population in 2010. Still, 67% of rural population are devoid of toilet facilities and practice OD (Figure 2). Inadequate sanitation also effects the economic growth of the country, costing 6.4% of its Gross Domestic Product (GDP) (WSP, 2011).

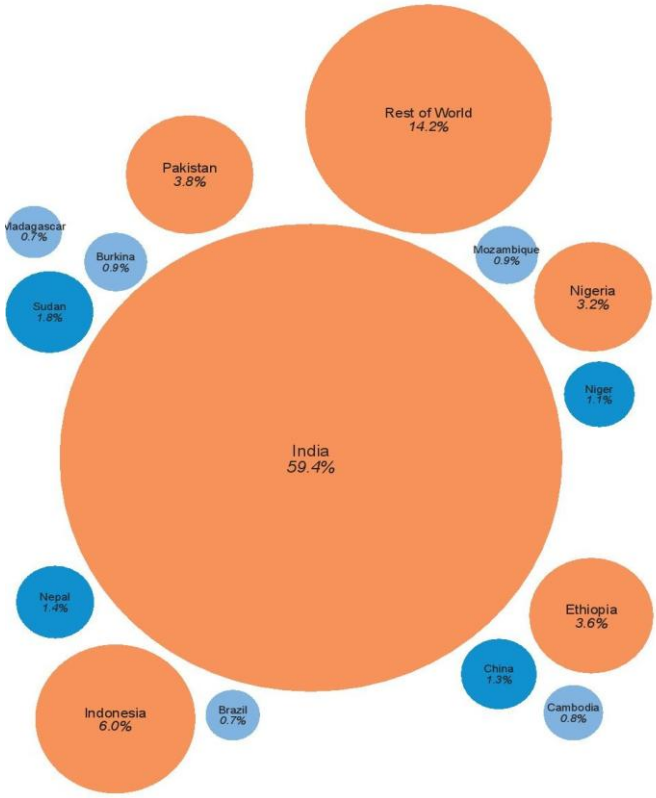

Figure 1: % people defecating in open Source: Figure 23, JMP 2012 report (http://www.wssinfo.org/)

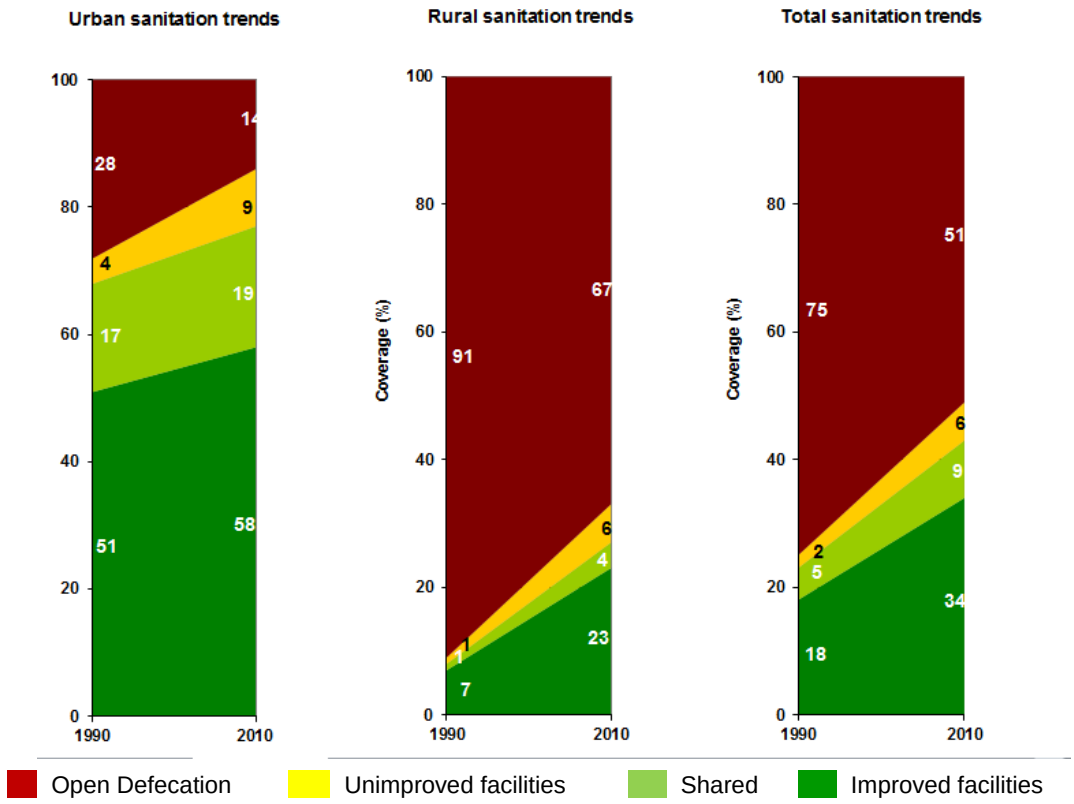

Figure 2: Sanitation trends in urban and rural India from year 1990 to 2010
Source: JMP Report 2012 (indiasanitationportal.org)

Interventions by Government of India

In the year 1986, Ministry of Rural Development, GoI launched the Central Rural Sanitation Programme (CRSP) for provision of toilets in rural India (Water Aid, 2008). CRSP adoption marked an important milestone toward improving rural sanitation, but slow progress resulted. The Government realized their supply-led, subsidy-based approach was failing (GoI, 2007; Kumar, 2008). In 1999 the Government initiated Total Sanitation Campaign (TSC) (Water Aid, 2008). TSC was designed to be an incentive-based, 'community led,' and 'people centred' programme (GoI, 2010). It emphasizes sanitation awareness and demand generation through information, education, communication (IEC), supply of materials via local supply chains, and provision of incentives to motivate latrine construction (GoI, 2010; Pattanayak, 2009). To further enhance TSC, the Government initiated the *Nirmal Gram Puraskar* (NGP) award programme in 2003 to incentivize sanitation achievement to all those

Gram Panchayats[1] *(*GP), blocks and districts which attain Open Defecation Free status (ODF). By 2011 TSC had reached 607 of 611 Indian districts (TSC, 2011).

However, in implementation of these sanitation programmes, subsidy formed an integral component. In CRSP, the subsidy was Rs 2,250 ($50) for above poverty line (APL) households, Rs 2,275 ($51) for BPL households from the year 1986 to 1999. Since CRSP did not have desired results it was transformed into TSC in 1999 and there was a shift to a low-subsidy approach. Yet from 1999 to 2010, the subsidy under TSC has increased from Rs 500 ($11) to Rs 2,200 ($49) for BPL households by the Central Government. The State Governments were allowed to further increase their share of subsidy depending on their budget (TSC, 2010). APL households normally have not received subsidies for sanitation since 1999, though states provided them if they desire. As the GoI has been under pressure to achieve targets it continued to give and increase subsidies. Recently, TSC has been further upgraded to *Nirmal Bharat Abhiyan* (NBA) and the subsidy has been increased to Rs 9,900 per toilet for both APL and BPL households.

Scope of the Study

Despite 13 years of implementation of these programmes with several modifications, India seems to have missed out on having adequate toilet facilities for as high as 67% of its rural population (JMP, 2012). Although, open defecation has reduced from 91% in 1990 to 67% in 2010, yet there has been a meagre change in the absolute numbers from 599 million then to 574 million presently (Chambers, 2012). Recent evidence indicates that India is witnessing a major sanitation crisis in the coming years. For example, nearly half of India’s population has no toilet at home, but more than half of India's people own a mobile phone (Census, 2011).

On addition to that, on comparing Census 2011 data with TSC 2011 data, many discrepancies are evident. According to TSC only 30.7% households lack sanitation

[1] Local self-government at village level

facilities but as per Census 2011, 68.3% rural households' do not have toilets. Thereby, reflecting a gap of 37.6% accounting to 63 million toilets in rural households in India. As per TSC, in 2011, 100% rural households had access to toilets in state of Himachal Pradesh (HP) which is just 66.6% as per Census. The differences in the presence of toilets in states like Haryana, Madhya Pradesh (MP) and Uttar Pradesh (UP) are 35%, 50% and 59.5% respectively. Furthermore, field studies indicate that even the use of existing toilets in rural areas is very low (Finish, 2010). Over last 13 years GoI has disbursed Rs 81.81 billion for toilet construction, and reported to have built toilets for 87441108 rural households. That is provision of toilets to 69.46% of the rural households until 2012 (TSC, 2012) which is much higher than what is reported by Census 2011.

The prime beneficiaries of the TSC subsidies were supposed to be the rural poor but reports suggest that in the process of provision of sanitation, poor have often been excluded, which raises the issue of equity. In 2008, the poorest quintile was 47 times more likely to rely on open defecation than the richest quintile (WHO/UNICEF, 2010b). In rural India, around 95% poorest defecate in open as compared to only around 15% elites (UNICEF, 2010). The hardware subsidies have tended to be captured by the wealthy and middle class, for many reasons, and do not reach the poor who need it most (Jenkins 2006).

This research probes the evidence and discrepancies in the statistics of the sanitation in rural India. The TSC data appear to have generated myths about latrine coverage and the achievement of Open Defecation Free conditions. This is in the light of what may be closer to the reality, regarding the actual presence and usage of toilets in rural households as mentioned by the Census 2011. However, the Census data can also not be absolutely reliable and so far no international census rating index has been generated but the degree of vested interest of Census survey would be lesser compared to TSC figures.

This study would explore the reasons for the discrepancies in two datasets. It will perform critical assessment of data, comparisons between data sets, insights into how distortions may have arisen, and ground truthing with the realities suggested by field and other evidence. It would also look into the equity scenario in sanitation as it was intended to benefit the BPL but appears to have missed them as well. This will be illustrated through the studies done in India in general and the states of Haryana, Uttar Pradesh, Madhya Pradesh and Himachal Pradesh in particular.

Research Objective

- To find out the reasons for discrepancies between the data sets and to assess the reality
- To analyse the causes of gaps in implementation of rural sanitation interventions by the government in corroboration with different monitoring system
- To analyse the equity parameters - reasons for the exclusion of poor (intended beneficiaries) in the process.

Structure of the Dissertation

The dissertation has been divided into seven parts. After introduction about sanitation condition in rural India and objective of the research in chapter 1, theoretical background has been discussed in chapter 2. Methodology to conduct the research has been briefly presented in chapter 3. In chapter 4, a detailed assessment of the generation of myth about the progress of TSC in rural India in terms of provision of toilets to poor households has been done. Then, the reality has been assessed with finding from primary research, Census 2011 and other data's focusing on India in general and UP, Haryana, MP and HP in particular. The next chapter zooms in on the factors that are responsible for generation of myths which are far away from reality in rural sanitation. Chapter 6 discusses the practical and policy implications in order to improve the sanitation services so that the present myth is not created again. Finally in chapter 7 conclusions are drawn based on the analyses.

Chapter 2

Theoretical Framework

Sanitation is important for poverty reduction and economic development (Mehta, 2004). As per Ecosan (2010), good household sanitation ensures more children attending school and good sanitation facilities in school ensures children, especially girls, are more comfortable attending the school. Sanitation is central to human development. Although its centrality is easily approachable but its achievement does not seem to be straightforward. As the world is failing to achieve the MDG (Bracken, 2005) and on top of that in Indian scenario the reported achievement in TSC becomes questionable when compared with Census 2011 report, both the reports are prepared by the government.

Sanitation is also important as a human right and public good. As per Khurana (2009), all human right treaties propose access to sanitation should be equitable, non-discriminatory, participatory and transparent. Realization of the right should also meet criteria of accessibility, availability, quality, affordability, acceptability and accountability. While Governments are expected to create environments conducive to equitable sanitation, individuals are legally responsible for attaining it; they are expected to participate and to contribute financially or in-kind (GTZ, 2009; Water Aid, 2009b). Though the challenge here is that the involvement of government might accompany corruption with it, which often reduces the effectiveness of public goods provision.

TSC is a government programme. According to Wilson (1989) in most of the government programmes the focus is on outputs rather than outcomes. ‘The problem of shirking in principle is even greater in a government agency’ (Wilson, 1989, pg 155). Shirking attitude of the government employees’ results in poor monitoring of programmes thereby supporting leakages. He has also theorised that the output of such organisations often remain unknowable and the programmes often show progress in papers rather than on field as the principal agents have other financial,

political and professional preferences. Such organisations where only outputs in terms of targets achieved are observed and outcomes are neglected have been described as Procedural organisations by Wilson (1989). The aim to achieve the targets also results in inflation of results reported and affects the quality (Pardeshi et al, 2008).

In addition, as per Long (1994), top-down approach is often adopted in government programmes which have also been described as the blue print approach (Korten, 1980). That is, development occurs in bureaucratic ways from central government to state and then at local level. As a result “where this top-down approach is still practiced, a positive impact on the lives of local people is unexpected and the chance of the poorest benefiting is slim” (Frans, 2004, 37). The top-down development thinking was the norm until the 1990s when, at least at an academic and policy level, emphasis shifted towards participatory, bottom-up approaches (Elliot, 2006). Even in the sanitation programmes in India, changes were made accordingly adopting the Learning approach as were described earlier (Korten, 1980). In actual practice the change is difficult to put in practice when the same working culture has prevailed for ages.

According to Wade (1992) most politician, bureaucrats and their machinery down the hierarchy work in order to maximize their own personal interests and are not interested towards achievement of goals. In India corruption enjoys a popular legitimation as it is key channel of social mobilisation (Mehta, 2003). Kolstad and Wiig (2009) stated that corruption is common in development projects and involves multiple actors from local level to bureaucratic to political level. Misappropriation, mismanagement, leakages, corruption and lack of transparency are other major problems which results in improper implementation of government scheme (Dreze, 2003). Klitgaard et al (1996) defined corruption through a simple formula: *Corruption is equal to Monopoly plus Discretion without Accountability,* this is also relevant for the assessment of myth behind the missing toilets. The ubiquitous scapegoat has been identified as `poor implementation' - a catchall expression for corruption, leakages, selection bias, parochialism, vested interests and power. According to Sen

(1999), corruption is also evident in programmes where monitoring procedures are not effective and stringent.

Apart from the above, subsidies have always been a part of the sanitation programmes in India. When subsidies are involved, they must be efficiently targeted and distributed so that the neediest is benefited. For effective implementation, such provisions must also be transparent and well-monitored (Evans, 2010). ‘Big budgets and pressures to disburse have linked with hardware subsidy’ (Chambers 2009 pg 33). Adverse power relations, politics, discrimination, or poorly planned wealth assessments results in marginalisation of the poor and the subsidies reach less needy households (Evans, 2009).

Equitable and sustainable sanitation outcomes require all humans have access to sanitation. Conversely, in rural sanitation marginalized people are often excluded from interventions and benefits. In turn access and usage of sanitation may be unsustainable. Equitability is especially important in household sanitation because the lack of it for any part of the community leads to a risk of contamination and consequences for all. Inequalities exist in all societies, and villages seeking sanitation are no exception. A focus on equitability is valuable in sanitation because achieving total sanitation requires an entire community to construct, maintain, and use toilets. If any household does not have and use a toilet, the human right to sanitation and public good of a clean environment are not possible. Equitability is also important because when a sanitation intervention is not equitable, not only are marginalized groups excluded, but also they often suffer the consequences most severely (Evans, 2009). There have been cases of elite capture as well in such projects (Platteau, 2004). Further, the complex relationship between decentralisation and corruption as described by Kolstad and Fjeldstad (2006, in Shordt, 2006 pg, 9) results in capturing of the services by the local elite.

In the present study an attempt has been made to apply the above described perspectives to address the research questions.

Chapter 3

Methodology

India is a big country with 28 states, 6 Union Territories and 1 National Territory. TSC is being implemented in 28 states and two Union Territories. Each state functions differently, with varied bureaucratic and political linkages. This research had to be carried out in a short duration and was mainly based on secondary data as it would have been practically difficult to analyse all states in detail. Four states namely Haryana, UP, MP, and HP, have been identified for detailed inspection. There are some differences in mode of implementation in these states described in next chapter. They have been performing well as per the TSC reports but when compared with the Census 2011 data, huge discrepancies have been witnessed. The availability of secondary data for these states was another reason as primary studies have been carried out by researchers.

The first phase of research included collection of quantitative data from websites of TSC, Census 2011, Department of Drinking Water and Sanitation (DoDWS), Water Aid, UNICEF and JMP. Secondly, the data was tabulated and analysed to formulate the research questions. Further, data was compared and assessed to carry out the research.

The second phase of the research included extensive literature review available online and in the library. The main purpose of the literature review was to finalise the research objective, theoretical framework and methodology to carry out the research. Initial meetings were conducted with my guide Dr Robert Chambers who is an expert in this field. A meeting with Mr Andrés González was done, who has previously done primary research in HP and MP. Emails with Mr Brian Bell, another researcher who did his research in Haryana and UP were exchanged. The primary research done by these two researchers has been referred widely in order to coincide with the reality.

Limitations of the Study

The present study is an effort to find out the reasons for creations of myth about the reality and exclusion of the neediest in provision of services. The absence of primary research done by the author herself is a limitation to the study. As primary research would have resulted in attaining more data and practical exposure to the modus operandi of the government organisation and verifications at field level. The past experience of the author as consultant with the government in Integrated Low Cost Sanitation programme was put into use to design the study. The short duration of the study escalated the magnitude of funding requirement posing a deterrent to carry out primary research.

Chapter 4

Assessment of Myth, Reality and Equity in Sanitation in Rural India

In order to make sanitation facilities available to all, GoI has been revising the guidelines of sanitation programmes beginning with its inception for better implementation in rural India. As per achievements reported on TSC website, the progress in provision of toilets in rural households appears to be at a fast pace. Under TSC, till the year 2011, 114.49 million toilets reported to have been built in rural India. According to Census 2011, only 51.46 million rural households have toilet facilities implying that nearly 63 million toilets are missing (Figure 3).

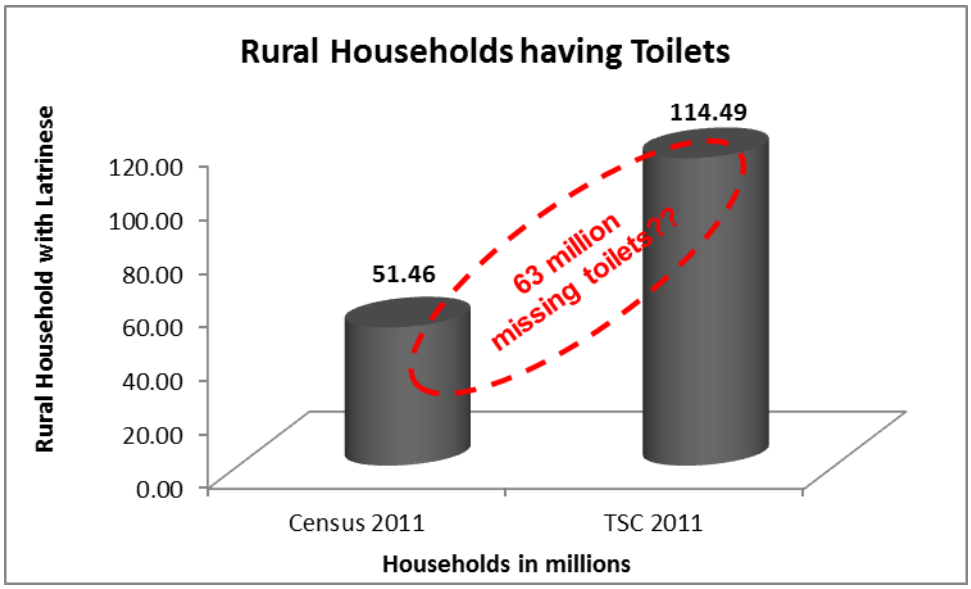

Figure 3: Rural household in India having toilets as per TSC 2011 and Census 2011 data.
Source: TSC data available from http://tsc.gov.in/Report/Physical/RptPhyAchinTimePeriod_net.aspx and Census 2011 data available from censusindia.gov.in/2011census/hlo/Data%20sheet/Latrine.pdf

In addition, Census data would have also counted the toilets that already existed or were made by the households themselves but under TSC these toilets are not counted in TSC data. This implies bigger discrepancy than the above assessed difference of 63 million toilets. TSC seemed to have over reported the presence of toilets in rural areas many of which are actually not present as per Census 2011 data. The state wise comparison of data from both the reports has been done below in the table 1.

Table 1: Number of rural households with toilets as per TSC data (2011) and Census data (2011)

S.No.	States	Figures in Million			Figures in %		
		TSC-2011	Census-2011	Missing Toilets	TSC-2011	Census-2011	Missing Toilets
1	ANDHRA PRADESH	10.01	4.59	5.42	70.3	32.2	38.1
2	ARUNACHAL PRADESH	0.16	0.10	0.05	79.4	52.7	26.7
3	ASSAM	4.23	3.20	1.03	78.8	59.6	19.2
4	BIHAR	5.22	2.98	2.25	30.9	17.6	13.3
5	CHHATTISGARH	2.05	0.64	1.42	46.8	14.5	32.3
6	D & N HAVELI	0.01	0.01	0.00	16.1	26.5	-10.4
7	GOA	0.10	0.09	0.01	82.1	70.9	11.2
8	GUJARAT	5.59	2.23	3.36	82.6	33	49.6
9	HARYANA	2.70	1.66	1.04	91.1	56.1	35.0
10	HIMACHAL PRADESH	1.39	0.87	0.52	105.9	66.6	39.3
11	JAMMU & KASHMIR	0.87	0.58	0.30	58.4	38.6	19.8
12	JHARKHAND	1.82	0.36	1.47	38.9	7.6	31.3
13	KARNATAKA	5.20	2.23	2.96	66.1	28.4	37.7
14	KERALA	5.14	3.82	1.32	125.4	93.2	32.2
15	MADHYA PRADESH	7.04	1.46	5.59	63.3	13.1	50.2
16	MAHARASHTRA	8.83	4.95	3.88	67.8	38	29.8
17	MANIPUR	0.33	0.29	0.04	98.2	86	12.2
18	MEGHALAYA	0.33	0.23	0.10	78.2	53.9	24.3
19	MIZORAM	0.15	0.09	0.06	141.6	84.6	57.0
20	NAGALAND	0.30	0.20	0.10	104.3	69.2	35.1
21	ORISSA	4.39	1.15	3.24	53.9	14.1	39.8
22	PUDUCHERRY	0.02	0.04	-0.02	18.6	39	-20.4
23	PUNJAB	1.87	2.33	-0.46	56.4	70.4	-14.0
24	RAJASTHAN	4.93	1.86	3.07	51.9	19.6	32.3
25	SIKKIM	0.15	0.08	0.07	161.4	84.1	77.3
26	TAMIL NADU	7.85	2.22	5.64	82.1	23.2	58.9
27	TRIPURA	1.02	0.50	0.52	167.7	81.5	86.2
28	UTTAR PRADESH	20.71	5.55	15.16	81.3	21.8	59.5
29	UTTARAKHAND	1.05	0.76	0.29	74.5	54.1	20.4
30	WEST BENGAL	10.77	6.41	4.36	78.5	46.7	31.8
	Total	**114.49**	**51.46**	**63.03**	**68.3%**	**30.7%**	**37.6%**

Source: TSC data available from http://tsc.gov.in/Report/Physical/RptPhyAchinTimePeriod_net.aspx and Census 2011 data available from censusindia.gov.in/2011census/hlo/Data%20sheet/Latrine.pdf

There can be some anomalies with Census data as well bearing in mind the population and density of India, there could be considerable undercount or double count while collecting the Census data (Bose, 2008). The quality of data collected by the surveyors may also vary. But data from other surveys like National Family Health Survey (NFHS) and District Level Household and Facility Survey (DLHS) are more close to Census data than TSC data indicating over reporting by TSC[2]. The Census 2011 report has broken the myth about the availability of toilets to rural poor as has been reported by TSC. TSC data has appeared to have generated a myth about

[2] Analysed ahead in thesis on pages 22, 23, 24 and 25

improvement in sanitation condition in rural India where the Census data has shown the reality to some extent about the over reporting by TSC, lack of monitoring and verification on ground has questioned the authenticity of data produced by such programmes in India.

In order to assess the reality; the trends and practices in TSC, like the impact of *Nirmal Gram Puraskar* on the implementation of TSC, the analysis of the allocation and utilisation of funds, the inclusion or exclusion of the poorest will be discussed in the chapter. The status of TSC in four states – Haryana, UP, MP and HP will be assessed in detail in order to find possible reasons of over-reporting by TSC.

Nirmal Gram Puraskar **(NGP)**

It was introduced by GoI in 2003 to incentivise the villages to become ODF. Until the year 2002, toilets were built for 23% rural households. After the introduction of NGP, there appeared to be a steep rise in provision of toilets in rural India and attainment of ODF status. The toilet coverage increased from 23% in 2003 to 65% in 2010 (Figure 4).

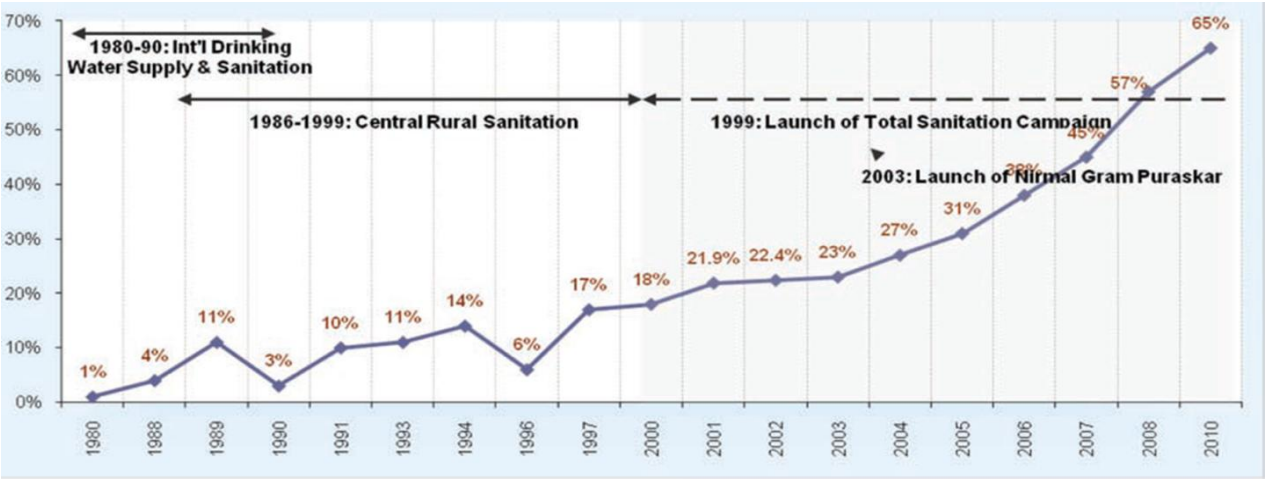

Figure 4: Indian rural sanitation trend – Comparison of increase in % HH having toilets during CRSP, TSC and launch of NGP Source: *GoI, 2011b [DDWS, 2010]*

From the year 2005 to 2011, 28002 GPs, 181 Blocks and 13 Districts have been awarded (NGP, 2011). The award ranges from Rs. 50,000/- to Rs 50,00,000/- depending on population of the villages, blocks and districts. Winners are awarded at

the Parliament House by the President of India. During the first award ceremony for the year 2004-2005, 40 GPs from six states were felicitated. In consecutive years, winners increased at fast pace from 769 PRIs representing 14 states in 2006 to 4959 PRIs representing 22 states in 2007 and 2857 in 2011. The maintenance of NGP spirit and quality of the award has been a challenge (TARU 2008). When verification process is associated with financial rewards, it leads to deception, corruption and other abuse (Kar with Chambers, 2008)

The verification process, standards and procedures have been same from 2004-2008 (Lukenya notes 2011). In the early years the application process was strict. In consecutive years the high number of applications for the award, led to contracting of the verification and certification process to NGOs by the Government. The NGOs subcontracted the task to other smaller NGOs which further subcontracted to individuals on a cost much less than the original approved remuneration (Kar with Chambers, 2008). The cases of evaluators taking bribes were also reported (Chambers, 2009). This resulted in false-reporting and the whole process of verification, certification and reporting has been described as a 'joke' by 'one well informed source' (Kar with Chambers, 2008 pg 55)

According to a study conducted by TARU (2008), out of the total GPs awarded till 2008, 20% reported 60-80% OD, 29% reported 40-60% OD and 39% reported 20-40% OD after attainment of NGP (Table 2). Most of the GPs have failed to maintain OD status post award or ever achieved. Out of the total 162 GPs studied by TARU only 6 maintained ODF status. This indicates a lack of behavioural change amongst the community to adopt the use of toilets instead of defecating in open.

Table 2: % Nirmal Gram villages practicing Open Defecation

Range of % Open Defecation	% of Nirmal Gram villages practicing OD
20%-40%	39%
40%-60%	29%
60%-80%	20%

In another verification process of 1018 GP applicants in 6 States (Jammu and Kashmir, Punjab, Rajasthan, Himachal Pradesh, Kerala and Karnataka) in the year 2008 and 2009, only 417 GPs and 3 BPs were certified. In the consecutive years the number of awardees declined with 1 out of 621 applicants in Haryana due to the online verification system[3] adopted by the government (Lukenya notes, 2011). The above analysis indicates lax verification process in early years of NGP (2003 -2007) and strict to stricter verification process thereafter.

The monitoring procedures and systems were reported to be more prompt and effective only during the NGP inspection period. While, GP have made rule like punishing the offenders in cash or even social outcasting them, for non-maintenance of ODF status but these have appeared merely on papers. The report by TARU suggests that NGP has led to the acceleration of TSC target achievement but the ODF status has not been maintained by many of the GPs. According to Snehalatha (2011), most of village after receiving NGP, practice open defecation. Even the prize money is not utilized in a constructive way for development of the village. The main reason behind this has been attributed to lack of monitoring and verification processes. Lack of accountability and transparency, poor quality of toilets constructed mostly of which have unfinished installations, no super structures and no behavioural changes amongst the people are some of the reasons for reverting back to OD (Snehalatha, 2011).

There is a variation in achievement of NGP across states and amount of funds utilized. For instance, between the years 2005 to 2010, most of the GPs in Sikkim and Kerala achieved ODF and received maximum number of NGP and reported to have utilized 96% and 6% of the total TSC funds respectively. In the states like UP and Bihar, only 2% of the total GPs received NGP but have utilized 86% and 77% of the total funds allocated under TSC (Figure 5). The variation in budget utilisation in other parameters have been explored below

[3] A verifier from third party (NGO) inspects the ODF condition by staying overnight in applicant village. The required data is filled in an online system which determines the result.

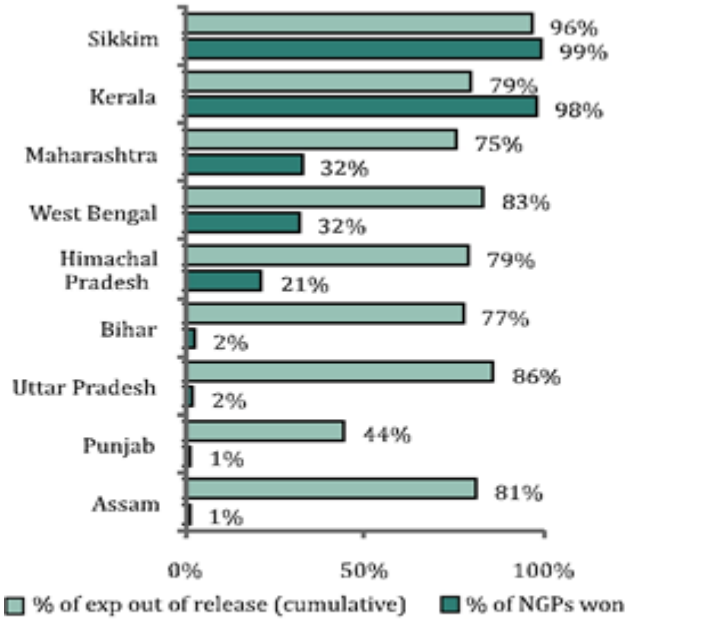

Figure 5: A comparison of budget utilization pattern and NGP awards
Source: Accountability Initiative 2012

Trend of budget expenditure in TSC across states in India

In the financial year 2011-12, budget amounting to only 0.02% of India's GDP was allocated to TSC. There appears to be no correlation between the budget utilised by various states and actual sanitation coverage as reported by TSC (Accountability Initiative, 2012). The reasons that restrict proper fund utilisation and probably have contributed towards the missing toilets in the TSC are explored ahead. For instance UP, MP, Haryana and HP have utilised 86%, 79%, 76% and 76% respectively of the total budget allocated to them (Figure 14). However, spending more money does not indicate better utilisation and outcomes. As the percentage of missing toilets are also amongst the highest in these states as compared to others.

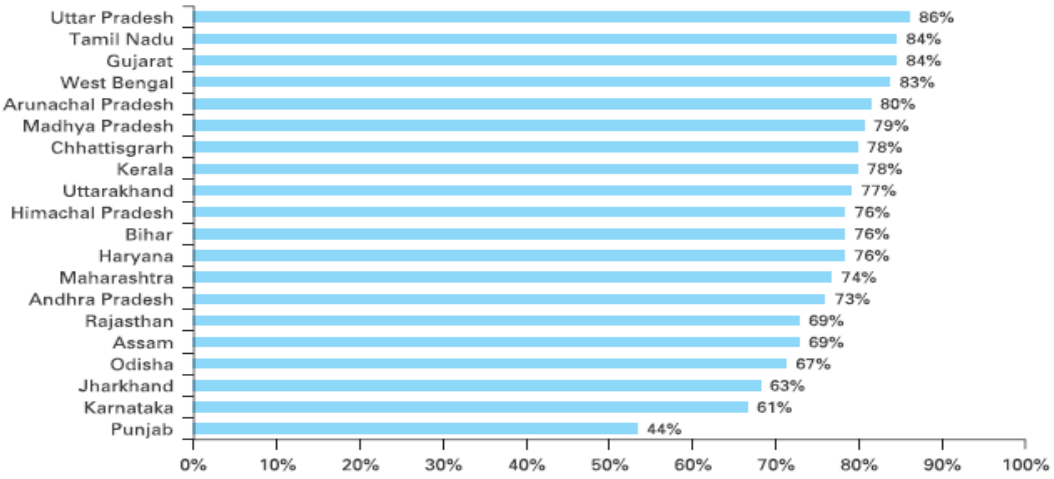

Figure 6: A comparison of fund utilisation across different states
Source: TSC website

Likewise, there is immense variation in cost of construction of individual toilets within various states in India as is evident from Figure 7. The average cost of construction of a toilet for the BPL in India under TSC is Rs 1528. Punjab spends the minimum amounting to Rs 171 per BPL toilet whereas UP spent the highest amount of Rs 2406. Haryana spent Rs 1258 per toilets whereas MP spent Rs 1686 per toilet for BPL families. Interestingly, UP and MP spent more amounts as compared to other states on constructing a toilet and has a maximum share of missing toilets as per Table 1.

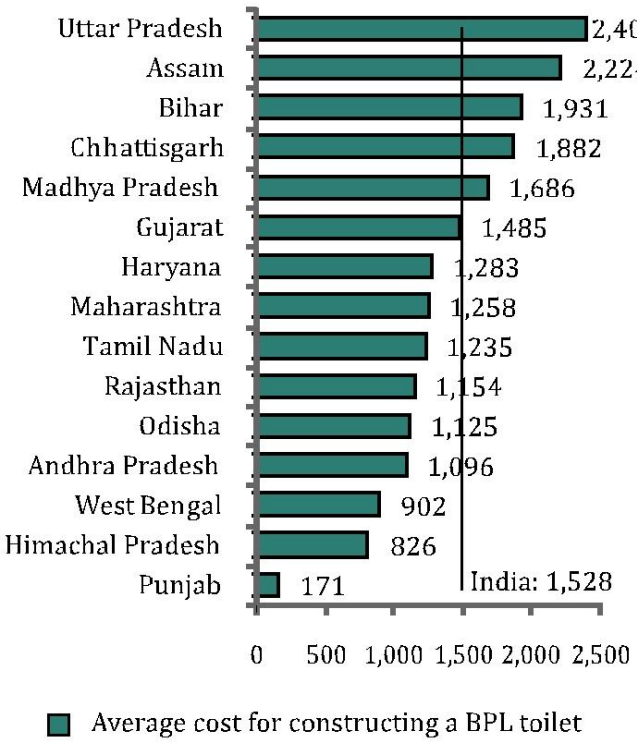

Figure 7: Toilet construction cost comparison
Source: Accountability Initiative 2012

For the achievement of the ODF status, India spends approximately Rs 4.3 million lakhs per GP. On one hand state like Punjab, Sikkim, Maharashtra, Tamil Nadu and Kerala spend below the average, while on the other hand UP and Bihar spend Rs 24.5 million and 33.9 million which is 5 to 8 times more than the average. Irrespective of the cost incurred the achievements remains unpredictable. The above analysis can have three universal inferences. One, if the budget is disbursed to beneficiaries then proper monitoring and verification is not done at field level. The amount disbursed is reported as target achieved. Second, there are cases of leakages and corruption. Third, when there is marked variation in the amount for the toilet construction, then the quality and sustainability of such toilets are also questionable.

Equity issues in sanitation programme

Sanitation is not mere presence of toilet in a household but has also been associated with a life with dignity. As basic sanitation and hygiene results in prevention of

various diseases, child malnutrition and stunting, contributes to gender equality, fosters economic growth thereby reducing poverty. It is important to provide sanitation services to all the sections of society. In TSC, subsidy policy was formulated for the poorest (BPL) while in practicality there is a wide gap between provision and accessibilities of services between rich and poor. For example in India 166 million people gained access to improved sanitation from 1995 to 2008, but very little progress was made in the poorest households (UNICEF, 2011). According to UNICEF (2010), 95% of the poorest defecate in open as compared to only 2% richest in India in the year 2008. Toilet facilities have improved for only 2% of the poorest as compared to 7%, 15% and 31% of the people up the ladder (Figure 8).

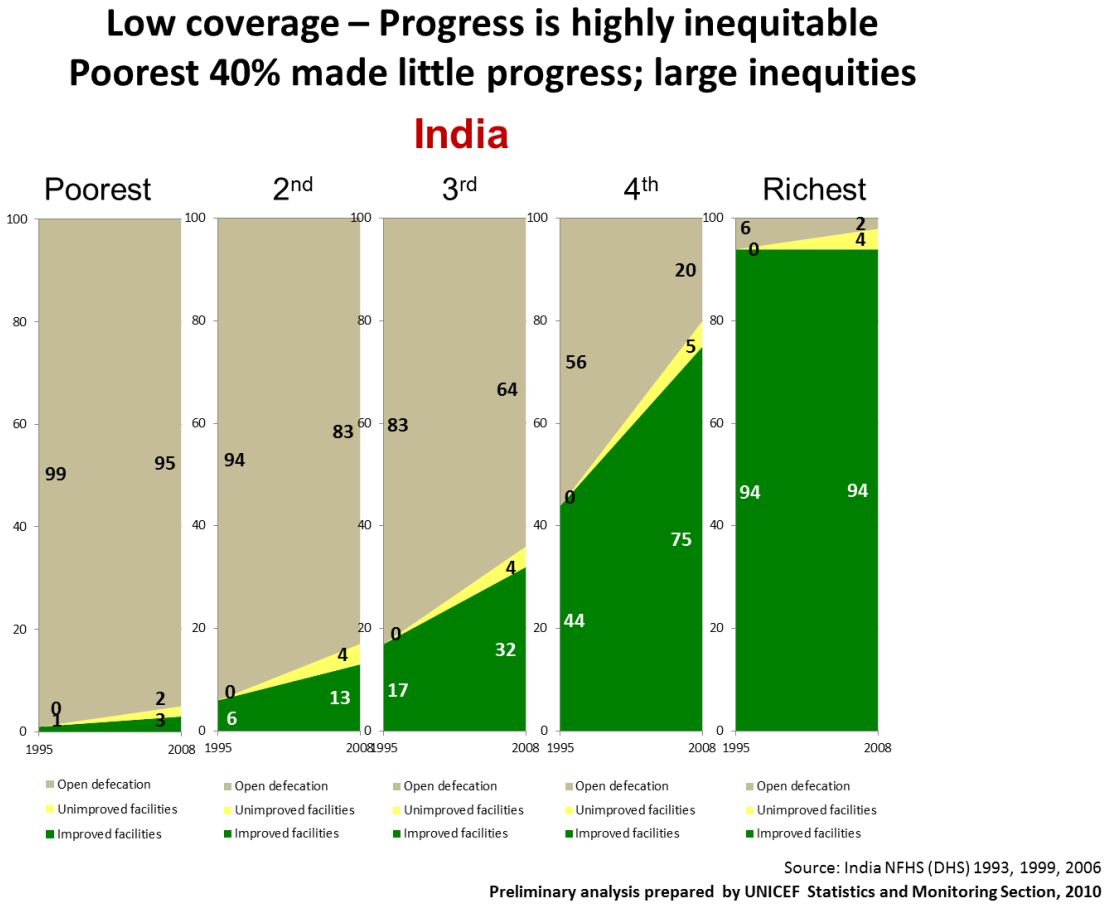

Figure 8: Equity comparisons in provision of toilet facilities to rich and poor

One of the biggest challenges in implementation of TSC on ground has been to cater to the sanitation need of the poorest (Water Aid 2008).

As per TSC guideline, subsidy is provided for the construction of basic toilet unit to BPL households. Households above poverty line are supposed to incur their own expense to construct toilets. Thus indicating that budget spend under TSC would reflect maximum toilets build for the BPLs. However, on an average only 53% of the toilets constructed are for BPL households (Figure 9). Only 46% toilets in UP, 37% in Maharashtra and 24% in Rajasthan are constructed for BPL. According to Jha (2010), above all this it is likely that the real scenario is even shoddier as all the above figures are estimated on physical infrastructure delivered rather than on observations of actual practice of using the toilets for defecation. This is further critical when the census 2011 data shows even less number of physical structure present in reality then reported by TSC.

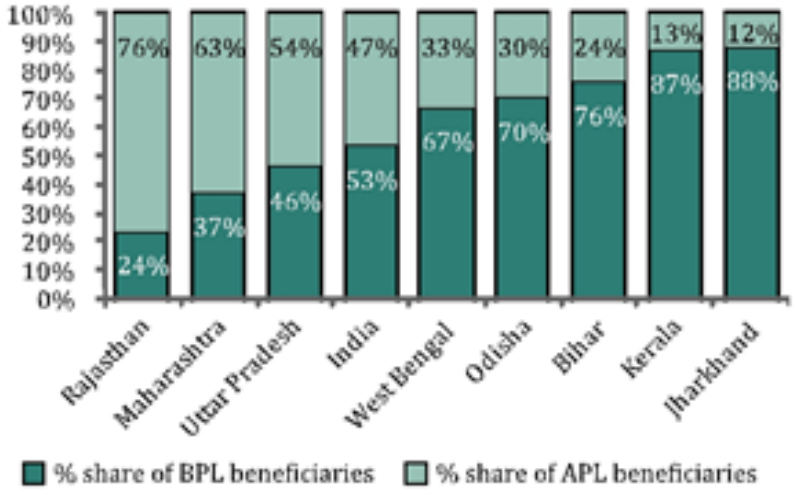

Figure 9: Percentage BPL and APL beneficiaries of TSC
Source: Accountability Initiative 2012

Also, many a time's undeserving families are given BPL cards and deserving one's are left out. In UP, it was reported that some less poor families had BPL cards, other less poor families did not had BPL card but had received toilets, other poorest family despite of having BPL cards did not receive toilets (Bell 2011). The main reasons associated with the exclusion of poor are elite capture, leakages of the funds in between the transfer from top to bottom, improper identification of the BPL, lack of proper monitoring and verification process, corruption, lack of knowledge about rights amongst the poorest. These issues will be dealt in detail in the next chapter which analyses the reasons which lead to the missing toilets and equity issues in

TSC. Before that groundtruthing of the above has been done with field evidence from Haryana, MP, UP and HP in the section ahead.

Groundtruthing with field evidence

In Haryana, TSC is being implemented since the year 2000 with reported improvement in sanitation condition. However, coverage estimates vary with different assessments. According to TSC, rural sanitation coverage was 29% in 2001, 79% in 2008 and 91% in 2011. Meanwhile, other surveys (NHFLS and DHLS) show household toilet access to be 23% in 2001, 44% in 2010. This is further verified by Census 2011 which reported 54% household toilet access (Figure 10). Thereby, suggesting that TSC has over-reported the construction of 1.04 million toilets in Haryana in comparison to Census 2011 data.

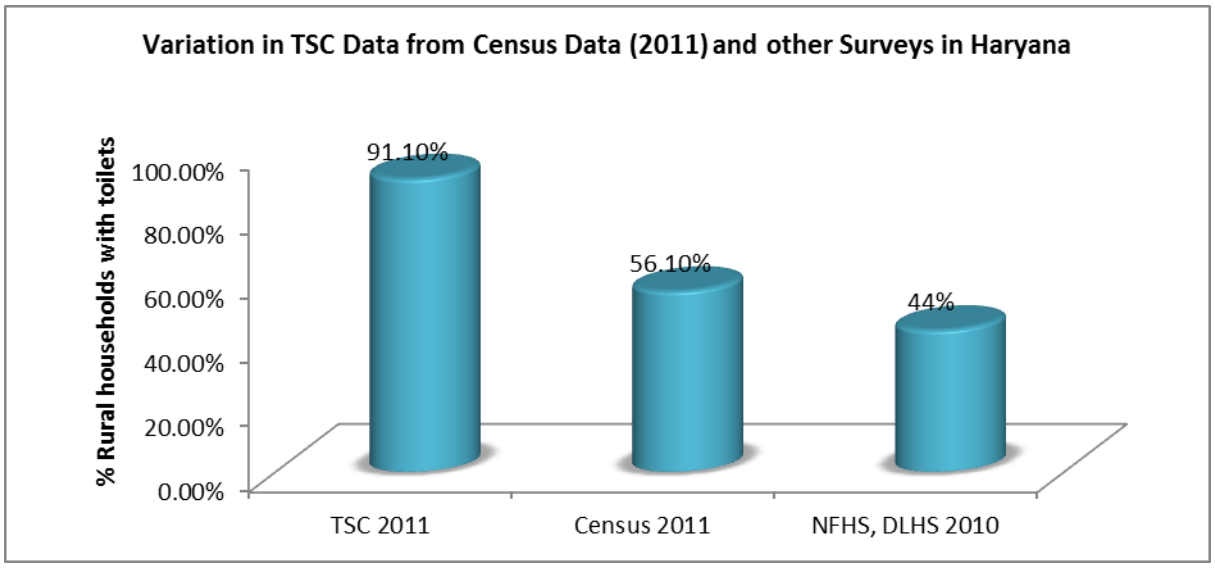

Figure 10: Variation in TSC Data from Census Data (2011) and other Surveys in Haryana
Source: TSC data available from http://tsc.gov.in/Report/Physical/RptPhyAchinTimePeriod_net.aspx, Census 2011 data available from censusindia.gov.in/2011census/hlo/Data%20sheet/Latrine.pdf and NFHS and DLHS 2010 data accessed from UNICEF 2010 report

As per Bell (2011), reason of over-reporting is that the coverage is assessed based on reporting by GP without physical verification of access or usage of toilets at the village level by external agents. After assessing the ground reality, Bell (2011) also reported that even the estimates for aspects of household sanitation provided by

Pradhans[4] often varied from collected and observed realities in GPs. As in village *Namuda* in *Panipat* District, the access gap of household toilets estimated by *Pradhan* was 26%, whereas Bell (2011) on field verification reported 45% access gap.

The mode of fund transfer is from top to bottom i.e. funds are transferred from district to block development officials to GPs. During the transition period the funds are often leaked as a result of independent decision making at each level (Bell, 2011). He also reports that although the funds are meant to be given to BPL households but they are distributed to non-poor as-well, at the discretion of *Pradhan.* The state sanitation authority and local government officers establish strategies which guide interventions, but ultimately *Pradhans* and community workers decide how to distribute funding, what technical support to provide, what software activities to apply, and who to include or exclude. Hence, there remains a great deal of flexibility for village leaders due to disconnect between government sanitation officials and non-official village sanitation facilitators.

This flexibility and lack of oversight also leaves opportunities for village leaders to exclude marginalized households or to neglect important sanitation strategy components necessary to ensure successful outcomes. This mode of functioning also results in elite capture, thus excluding the neediest (Platteau, 2004). In *Dhindar* and *Namuda* villages, marginalised sections of the society were excluded (Bell, 2011). People often return to OD when the toilet pits get filled. In villages in *Panipa*t district, triggering as per CLTS[5] was done at the time of Dr Amit Agrawal (ADC) official who had interest in the issue. A special agreement between *Panipat* district and the Haryana government was done during his tenure. The agreement allowed district evaluation based on physical verification rather than on release of funds. But

[4] Leader of the *Gram Panchayat* elected every five years by the people

[5] CLTS stands for Community Led Total Sanitation which focuses on triggering the community and behaviour range and rejects subsidy

after his transfer the focus shifted as there had not been strong leadership or follow up (Bell, 2011).

Since 2007, 1578 GPs have won NGP in Haryana. Mohali village in Haryana received NGP in 2007. Upon post NGP verification of the ODF condition in the village, Dyalchand et al (2008) reported that out of 73% HH having access to toilets only 71% utilized toilets, remaining 27% defecated in open. Most of which were BPLs indicating that they were excluded. At times, the construction of toilets begins in villages only when the date of visit by the NGP evaluation team is known (Dyalchand et al, 2008). In one instance, speedy construction of toilets (most of which were not usable) was observed in villages in *Bapoli* Block in Haryana in order to pass the evaluation criteria (Dyalchand et al, 2008).

It was also reported that the NGP evaluation team focuses on counting the number of toilets structures constructed rather than on their usability. Cases of misreporting and manipulation to bag the awards and suspension of all the work of toilet construction after the village has been declared NGP awardee has also been evident (Dyalchand et al, 2008). Implying, when NGP becomes the key goal, interest and motivation wane immediately after receiving the NGP award.

The major issues with TSC in Haryana were leakages at all levels, wrong use of power and favouritism as the disbursement of fund is at the discretion of *Pradhan*, manipulation and mis-reporting in order to achieve NGP and weak institutional factors such as willingness of the district administration.

In Uttar Pradesh, rural sanitation coverage as per TSC was 28% in 2001, 57% in 2008 and 81.3% in 2011. Meanwhile, as per Census 2011, it is just 21.8% indicating absence of around 15 million toilets from rural areas of UP alone. Before census other sources have reported that the toilet access was 10% in 2008 and 15 % in 2010 (UNICEF, 2010). This variation has been shown in Figure 11.

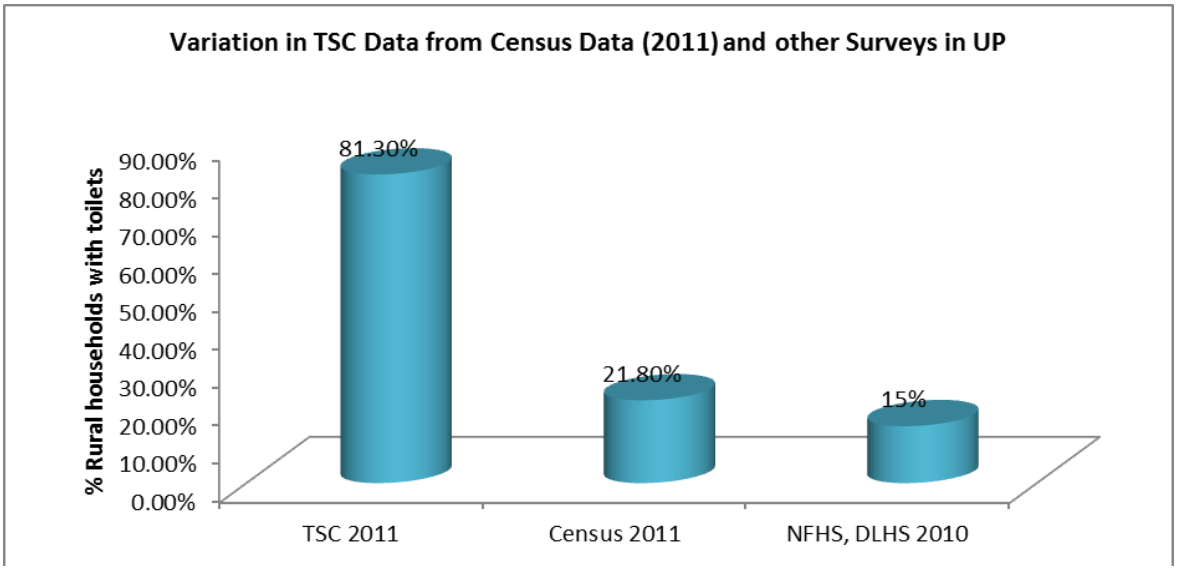

Figure 11: Variation in TSC Data from Census Data (2011) and other Surveys in UP.
Source: TSC data available from http://tsc.gov.in/Report/Physical/ RptPhyAchinTimePeriod_ net.aspx , Census 2011 data available from censusindia.gov.in/2011census/hlo /Data%20sheet/Latrine.pdf and NFHS and DLHS 2010 data accessed from UNICEF 2010 report

In UP, sanitation coverage is calculated based on funds released. Once funds are released, the Government assumes households receiving subsidies have achieved sanitation coverage (Bell, 2011). According to Chand (2004) the reporting and monitoring is only restricted to financial progress with little emphasis on quality of toilets and usage.

At village level, toilets were constructed with subsidy money which is given before the construction of toilets. For instance, in *Simra* and *Kaundada* villages, the subsidy money cheques were distributed by *Pradhan* and no verification of toilet construction is done later (Bell, 2011). In another case in *Mandaura* village, *Pradhan* collected the Centre, State and Beneficiary contribution, purchased the construction material and got made toilets most of which were unusable – without pit, without walls or with very small pits which got filled up thus rendering toilets to be closed.

Emphasis on behavioural change and awareness about safe and hygienic sanitation is lacking in UP. Although the subsidy amount is highest in UP (Figure 7), then also most of the poor in *Simra* village did not construct a low quality toilet. This can be attributed to little focus on awareness about importance of sanitation. Even after

receiving subsidy money, the toilet construction is stopped if the beneficiaries ran out of money and continue practice OD.

Funds disbursement procedure from top to bottom is same as in Haryana with *Pradhan* having the power at village level. Cases of leakages are also evident. For instance, in *Mandora* and *Simra* village, funds for 35 and 20 toilets were released in 2010 respectively but no construction was done at village level (Bell, 2011). Subsidy money is often distributed to APLs because of their political ties with *Pradhan* and the poor are often excluded resulting in elite capture (Bell, 2011). In another case, two toilets were constructed in a house for father and son who shared same kitchen in *Kaundada* village. Cases like this would result in counting of two toilets in TSC and one in census[6]. The villages studied have not received NGP.

The above analysis highlights the issues related to reporting, focus on funds disbursement, lack of focus on awareness, leakages, lack of monitoring and verification as the reasons for data discrepancy.

In Madhya Pradesh, as per TSC, the sanitation coverage is 63% while as per Census 2011 its only 13%. Indicating that 50% of the toilets reported to have been built by TSC do not exists in reality. In fact, even before the Census 2011 report, evidences from NFHS, DLHS data reported actual usage of toilet to be below 20% (Figure 12). This again implies the issue of

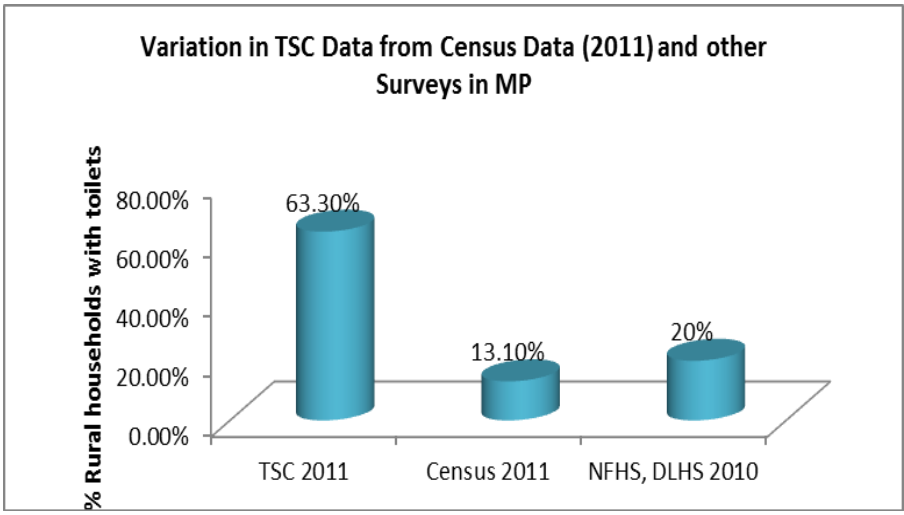

Figure 12: Variation in TSC Data from Census Data (2011) and other Surveys in MP
Source: TSC data, Census 2011 data and NFHS and DLHS 2010 data accessed from UNICEF 2010 report

[6] A household is defined as a group of individuals sharing a common kitchen (Census 2011)

over-reporting by TSC. This is further verified by low toilet usage even amongst the households with toilet (González, 2011). The state-level approach to rural sanitation has been top-down and based on the large-scale supply of sanitation facilities (Rosensweig 2008).

In addition to reported discrepancies, 1856 GPs have received NGP yet subsequent surveys have shown that only few of them could maintain the ODF status. According to Gonzalez (2011), GPs which have received NGP were never ODF. On field verification, it was found that sanitation campaign in villages was driven by high pressure from above (block and district) to build toilets in a short time span in order to achieve NGP in 2008 (Godfrey, 2008). For instance in *Killod* village, 44% HHs practice open defecation three year after attainment of NGP (Gonzalez, 2011). Though Water and Sanitation Committee have been set up at the village level but they appear more on the papers as at the village level *Pradhan* has all the discretionary powers.

In *Killod* and *Manjarkui* villages the toilets build under TSC were unusable owing to filling of septic tank or unfinished toilet structure. In *Budni* block where CLTS approach was followed, sanitation coverage was more and the practice of reverting back to ODF was much less (Gonzalez, 2011). On physical verification OD in *Manjarkui* village in *Budni* block by Gonzalez (2011), 99.5% of the HHs used toilets for defecation. Discrepancies were evident in all other villages practising conventional approach.

The case of Himachal Pradesh is unique in itself. Since the year 2005, State Government has claimed to practise a demand oriented, outcome based approach with involving community right from the beginning in order to create ownership amongst the community for the sustainability of the programme. TSC was implemented following the core principles of CLTS (though mostly without using its triggering tools). Instead of individual subsidies, community incentives were distributed for the attainment of ODF status. The campaign has been reported to

very successful, probably a unique case in India at that scale, with a huge and sustained rise of toilet use and ODF GPs in a very short time span (Gonzalez,2011).

In fact, HP has also become one of the six states in India to have achieved 100% sanitation coverage as per TSC data. However, as per the Census 2011 data, the individual household sanitation coverage is 39.3% less than TSC data. Implying over-reporting of construction of half a million toilets by TSC which actually does not exist as per Census. In the year 2008, DLHS reported only 47% rural households having toilet again contradicting figures by TSC (Figure 13). Another survey conducted by Sanon (2010) showed 87% household has access to toilets facilities.

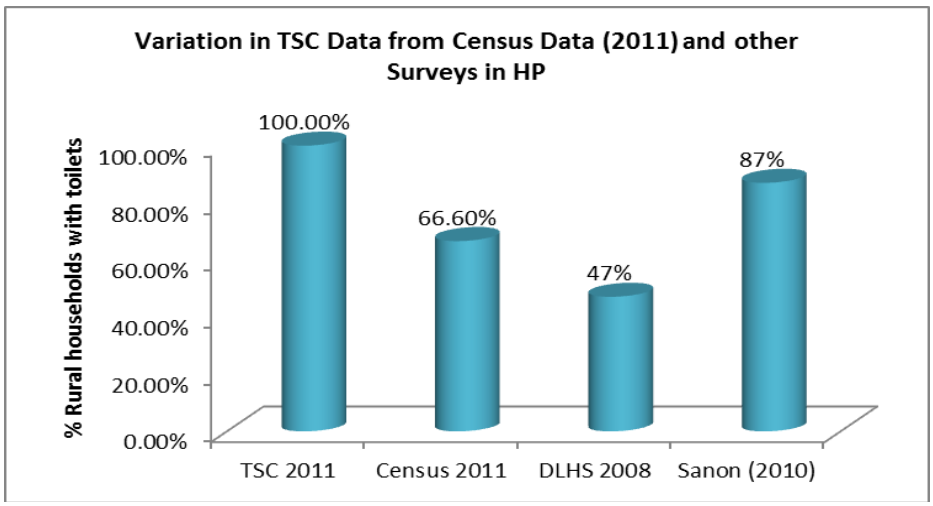

Figure 13: Variation in TSC Data from Census Data (2011) and other Surveys in HP
Source: TSC data , Census (2011) data available from, DLHS (2008) and Sanon (2010)

Upon field verification in two Blocks- *Mandi* and *Bilaspur* in HP, Gongalez (2011) reported gaps in the sanitation coverage due to lack of proper monitoring systems. For Instance, *Mandi* has claimed to be 100% ODF as per the report by Panda (2011), but the Census 2011 data shows 17% households practice open defecation and 24 households still have service latrines where night soil is removed by humans indicating prevalence of manual scavenging[7]. Till 2006, no GP in HP won NGP.

[7] It is a prohibited and a punishable offense

Interestingly, in the last 5 years till 2011 a total of 1011 GPs had won the NGP award. Thereby, indicating a sudden rapid attainment of sanitation coverage.

The political priority given to sanitation has been attributed as one of the keys of success. But it also indicates pressure from the top to bottom to achieve targets in order to win NGP. A sense of competition is also created where preferential treatment is given to NG *Pradhans* by the DM (Verma, 2010). This further add up to the reason to expedite the process for attainment of NGP amongst other villages. In turn result in over-reporting and manipulation of achievements than the actual numbers.

However, according to Subhashish Panda[8] (in an informal discussion), the TSC approach in HP is not about counting toilets per family but about every family having access to a toilet and thereby not indulging in OD. In a social milieu as in HP, there are many instances when several families (brothers and their families) staying in different portions of their ancestral house with all of them having access to the same toilet, so they do not indulge in OD, but census and other surveys would have identified all except one family as those without toilet.

According to Dyalchand et al (2008), underperforming districts were pressurized to achieve the targets in order to win NGP could have resulted in over-reporting. This was also not brought into limelight as the state has also not witnessed any independent evaluation of progress in sanitation coverage (Sanon, 2010). The discrepancies in data sets could have been because of over-reporting in order to show the achievements of targets, and not so much from corruption in disbursements, since no hardware subsidy was being disbursed. Lack of verification and monitoring are other factors.

[8] An IAS officer of Himachal Pradesh Cadre who served as the District Magistrate of Mandi and implemented TSC

To sum up, the implementation strategy is somewhat different in all states and within some districts in same states. In Haryana, emphasis is laid on awareness generation with adoption of no-subsidy approach in *Panipat* district whereas in UP, it is subsidy driven with no or little focus on awareness or behavioural change. In MP it's the same apart from *Khandwa* district with no subsidy and focus on behavioural changes. In HP the focus is on behavioural change and rejects subsidy but provides community incentives post ODF achievement. But, discrepancies were evident in all. Over-reporting, institutional factors, lack of monitoring and verification on ground, target oriented approach, construction of incomplete toilet structures which were not fit for use and the ambition to win NGP are some of the reasons in Haryana, UP and MP. Lack of focus on behavioural changes amongst the beneficiaries is another reason in UP. The main reason in HP is the political and bureaucratic pressure to achieve NGP resulting in manipulation and mis-reporting. These reasons will be discussed in detail in next chapter.

Chapter 5

The Analysis of Reasons for Discrepancies

This chapter would explore in detail the reasons for incongruity in data that were identified in previous chapter. The conditions which led 63 million toilets missing from the rural households in India will be assessed. Poor governance is main reason for data discrepancy. The main issues related to poor governance that has cropped up earlier are discussed ahead.

Institutional factors

Indian government mainly works on the Blue Print (top-down) approach (Korten, 1980). In TSC, learning approach (Korten, 1980) is also evident as different states implement the programme differently. Still, the analysis in the previous chapter showed that designing the guidelines for the implementation of the project, the disbursement of funds, method of reporting and verification were in the same top down manner, following the bureaucratic hierarchy. The programme implementation was also effected by the transfers of government officials specially the senior officers (Joshi, 2011) as was indicated in case study of Haryana.

In TSC, the budget is huge with maximum percentage allocated for the construction of toilets; only 15% is allocated towards IEC. Over the years the allocation in construction has increased and on IEC has decreased (UNICEF, 2011). Signifying, little emphasis was given towards awareness generation and behavioural change as was clearly evident in UP and MP (except *Budni* block). Hardware subsidy is associated with pressures to disburse funds (Chambers, 2009). It is verified from the case studies of Haryana, UP and MP. Often funds released and have been reported as utilised by TSC but never reached the poor and toilets were never built as reflected in the earlier chapter. Although TSC has reported an increase in the coverage of the sanitary services but WSP (2009), has reported of deficiency in terms of access, reliability and quality. These factors may also contribute towards the discrepancy of the data highlighted by Census 2011.

Corruption or Leakages

Amongst various other challenges in delivery of public services especially in developing countries, corruption is most prevalent (Davis, 2004). The huge amounts of money sanctioned for provision of basic services to rural poor goes into the pockets of corrupt politicians (at central, state, regional or local levels) and, government officials instead of benefitting the real beneficiaries.

According to a corruption study on provision of public services to BPL households conducted by TII CMS in 2007, UP and MP were ranked under the category of 'alarming level of corruption' while Haryana and HP under the moderate level category. Leakages have been evident in Haryana, UP and MP as discussed earlier. These case studies also fit the Klitgaard's Corruption formula[9]. As the *Pradhan* has the monopoly and discretion of selection of beneficiaries and disbursement of funds with no quality verification by the officials up in the hierarchy. The accountability measures like Right to Information Act (RTI), Citizen's Charters, e-governance, social audits and online reporting have not significantly reached to the poor. Even their capacities have not been built to utilise these tools to fight for their rights and services (TII CMS, 2007).

Elite Capture

Corruption, power exercised by *Pradhan* and political preferences results in elite capture. According to Jha (2010), contrary to perception of increase in participatory approach by decentralisation it has also resulted in empowering local elites who exercise the decision making power. It was also evident in the case studies of UP and Haryana. The poor often resist raising their voice against the capture by rural elite as the former are in a dependent position, fear more losses than gains from disclosing the fraud. For instance in Mandora village in UP, *Pradhan* got the funds sanctioned based on the BPL beneficiary list but distributed the money to APLs (Bell, 2011).Thus, benefits supposed to reach the poorest often do not and is distributed to

[9] Corruption = Monopoly+ Discretion - Accountability

non-poor rather than the poorest and so means intended to achieve equity can further divide communities, which Sen (2005, 214) calls ‘friendly fire’.

Target oriented approach

Although TSC guidelines indicate that the programme is demand driven and not supply led, the assessment of the implementation mechanisms in India and Haryana, UP and MP in particular indicate that the programme is more target oriented. In order to get the funds from up the ladder, targets are reported to be achieved on papers. The target of achieving ODF in order to receive NGP further increases data manipulations as analysed in HP, Haryana and MP. According to Jha (2010), the emphasis is laid mostly on meeting targets which is assessed in terms of infrastructure delivery instead of sustainability and often generates a myth about the improvement of sanitation facilities. The reality in terms of actual presence of functional toilets or usage is not assessed. The incomplete, unusable toilets are reported as been built TSC as the fund have been disbursed but not counted in Census.

The ambition to achieve NGP

Although recently, stringent verification process has been adopted for NGP, the lax approach earlier could not catch the data manipulation for attainment of award as evident in previous chapter. Now online verification software is used but earlier, verification was supposed to be done at block level, district level, state level and by third party (WSP, 2010). Even then after verification at so many stages, NGP villages have not found to be 100% ODF, and therefore the quality of verification is doubtful. The reversion to OD after winning NGP also shows lack of emphasis on behavioural change amongst the people and manipulation of achievements to grab the award.

The possible reasons for reverting back to OD are lack of understanding about the importance of sanitation and hygiene amongst the beneficiaries, construction of

unsustainable toilets, filling up of the septic tank, collapse of the existing toilet and unavailability of water.

Reporting issues

The reporting at village level is done by *Pradhan* and is cumulated at Block, District, State and National level. In order to make the reporting system efficient and transparent, the MoDWS had also developed a MIS system which enables online feeding of monthly financial and physical report. These reports are available over the internet and can be accessed by anyone. The data is fed in the MIS system by MIS experts at the district, state and national level. However, many of the implementing offices have shortage of staff and don't have these experts. I have personally[10] witnessed the manipulation of data in order to submit the online report on time. Practices like these lead to false reporting and generation of wrong figures.

Monitoring and verification issues

There are loopholes in the monitoring and verification systems. Although the process of funds transfer is very stringent and involves a lot of paper work in order to ensure proper disbursement and utilisation of budget. Procedures like submission of utilisation certificate, audit report, monthly progress and financial report, baseline survey report and review mission report are to be submitted for the release of the fund at each level (UNICEF, 2011). Yet, discrepancies are evident

Regular meeting of state secretaries are organised in order to review the progress, there is provision for constitution of a monitoring committee consisting of experts from various sectors with the aim to monitor the quality of implementation at ground level. Apart from the above, monitoring committees at the state, district and village level are also to be formed. But, the research results by Bell (2011) and Gonzalez (2011) indicate, that these committees appear to have been formed only on papers with no or weak action on ground. This also shows the shirking behaviour of the

[10] As a part of the Project Management Unit in a government project in India

government officials especially at the lower administrative level as described by Wilson (1989).The verification team is often bribed as evident in Haryana. Lack of staff at the project implementation units of TSC has also been absorbed in the state of UP by an evaluation report by UNICEF (2011) and has been identified as one of the factors contributing to lack of monitoring thus resulting in improper utilisation of the funds.

Behavioural Changes

The provision of subsidies alone for individual household toilet construction does not necessarily translate into usage (WSP, 2007). This is also evident from our case studies. For instance in UP when behavioural change was not emphasised, then the spirit of making and using toilets were lacking in people. As at times, beneficiaries receive subsidies but don't utilise it for purpose of the toilet construction. So they are reported as being built by the TSC but are not physically present when assessed by Census or other surveys. In addition to highlighting the loopholes in government procedures this also indicates corrupt behaviour of the beneficiaries. This is because they are so comfortable defecating in the open that they don't understand the importance of building a toilet rather prioritise using subsidy money for other purposes.

On the contrary in *Manjarkui* village in MP, where emphasis was laid on behavioural change by using triggering as per CLTS, 99.5% population used toilets (Gonzalez, 2011). The issues discussed above that led to the missing of toilets or over exaggeration of figures by TSC. It is important to address these issues as it does not only result in misreporting or mis-utilsation of public money but have practical and policy implication, which are highlighted in the next chapter.

Chapter 6

Practical and Policy Implications

Despite monitoring provisions and multi-tier reporting systems, it has become evident from the findings and analyses done in the previous chapters that reporting and data collection system requires improvement. The exaggeration of the achievements reported by TSC has generated a myth about scaling up of sanitation services in the rural India. The equity comparison of provision of toilets to the rich and poor as per figure 8 also indicates that the intention to provide the services to poorest of poor has also not fulfilled.

Over reporting to the magnitude of 63 million toilets is huge and implies that either the funds never reached the intended beneficiaries, or when it reached it was not used in toilet construction or when toilets were made most of them were not of sustainable usable quality or were not used. All these reasons also lead to the amplification of the achievements by TSC. This has happened when subsidy was provided by the government. In fact it will not be wrong to say that programmes like TSC which involves individual household subsidy does not translate into desired impacts (Chamber, 2011). As analysed earlier, subsidies also result in corruption or going to people other than the intended beneficiaries resulting in exclusion and inequity.

The up gradation of TSC to *Nirmal Bharat Abhiyan* in which the existing subsidy of Rs 3700 will be further increased to Rs 9900 could further magnify the existing problem. This is alarming because an increased subsidy may also mean more corruption, more over-reporting if the rest of the mechanisms and the functioning remains the same. In order to improve provision of the services especially to the poor and effective utilisation of the public money following practical and policy level implications can be adopted.

First, there is a need to make the monitoring and verification system more effective and efficient. The monitoring indicators should be revised with focus on usage and behavioural changes rather than just presence of toilet structure. Along with this, monitoring of the quality of construction should also be done.

Second, the programme implementation should adopt an outcome oriented approach rather than target oriented approach. The focus should not be reporting the number of toilets built but on the number of people or households using the toilets.

Third, it is needed to make the reporting system more effective. Especially if subsidy is involved than the reporting must be done at all levels starting from the village level. Social auditing[11] by the beneficiary must be done in-order to ensure proper utilisation of the subsidy fund. It would also result in increase in accountability.

Then, the active involvement of NGOs and media could also prove to be beneficial. NGOs should play a role in building the capacities of the beneficiaries for their rights and especially the use of Right to Information (RTI) which can be proved to be an effective tool to combat corruption.

Fifth, there is a need to increase accountability and transparency. As was evident, that the implementation process of TSC was deficient in both these components. As at village level the funds were distributed at the discretion of the village *Pradhan* with little oversight.

Next, there is an immense need to address the problem of leakages of funds. When subsidies are involved leakages become more prominent especially during purchase

[11] It measures social performance in order to achieve improvement as well as to report accurately on what has been done

of hardware for toilet construction. As mentioned earlier, social audits and use of RTI can prove to be beneficial to address this issue.

There is a need for reallocation of funds in the budget heads. As at present 75% of the total sanctioned budget is allocated for hardware subsidization while only 15% is used for awareness generation and administration purposes. This resulted in lack of emphasis on software like awareness raising activities. There is a need to increase the budget allocation for software for enhancing the impact of the programme.

Lastly and importantly, at the policy level, if the focus shifts on changing the behaviour of the community towards open defecation rather than provision of subsidies for toilet construction, then a long lasting sustainable change can be visualised. As analysed, the inclusion of subsidy resulted in diversion of the project into a hardware mode, with reduced emphasis on software, created dependency, and exclusion of poor. If no subsidy were given then achieving sanitation would have to occur through great software and technical advice alone.

However, subsidy amounts continue to increase in Indian sanitation despite their failure to bring about improvements. In order to address these issues, an approach like Community – Led Total Sanitation (CLTS) can prove to be successful. As it is dependent on zero subsidies and focuses on behavioural change. It emphasises on ‘facilitating communities to appraise and analyse their shitting habits and to recognise for themselves that they are eating each other’s shit’ (Chambers 2012). It basically triggers the community for the need for usage of toilets. Such triggering processes amongst the community in even among the poorest have motivated them to build low cost toilets on their own, thus ensuring sustainable use. In countries where it has been adopted, positive results have been evident without the involvement of subsidy where the people build toilets on their own. It represents a radical alternative to top down approach to sanitation (Kar with Chambers, 2008).

Chapter 7

Conclusion

Sanitation is of the most important requirement for a healthy and prosperous society. However, it has often been neglected both by government and people especially in India. The problem of OD is more pronounced in rural India and is prominent in poor families than in the richer. Although, GoI has been spending money for provision of sanitary facilities to rural inhabitants, still there are many issues associated with the proper utilisation of the budget allocated for these programmes and efficient implementation at the ground.

The comparison of achievement about provision of toilets by TSC to the Census 2011 data highlights discrepancy of 63 million toilets in rural India, which has further highlighted the implementation, monitoring and reporting issues. The government, the so-called beneficiaries, elites and other intermediaries were responsible for the generation of myths which are far from reality. At the government side, the issues were both at the implementation level as well at the policy level. Lack of proper monitoring and verification techniques, inefficient reporting practises, lack of transparency and accountability, the target oriented approach, more focus on outputs rather than outcome, elite capture, less emphasis on behavioural change, more dependency on subsidy and leakages (corruption) were some of the reasons that resulted in over-exaggeration and manipulation of data. Also, institutional factors, mode of functioning, transfers of the senior officials, pressure to disburse funds, affect the implementation and reporting of the programmes.

The subsidy money is often leaked; either does not reach the poor or even when it reaches, is not converted into toilets. This is because either the intention is lacking or the need or importance of having a toilet or safe sanitation is not realised by the community. This also results in false reporting. At times the structure is incomplete; toilets are without pits, walls or roof. However, as the money had been disbursed it is

reported as utilised by TSC, reflecting that toilets have been constructed which are actually present and are not counted in other surveys.

Expenditure of budget in development projects is a critical area. Government priorities must be accompanied by principles of equal access to resources and provision of services to all (UNICEF, 2011). As in sanitation, cases of exclusion, inequity were also visible. Although the TSC is meant for benefitting the poor but their benefits were found to be hijacked by elite.

It is important to address these issues as it results not only in mis-utilisation of the public money but also have implications on the health and prosperity of the people who are devoid of safe sanitary practices. Adoption of CLTS, more focus on increasing the accountability and transparency, capacity building of the people by active involvement of NGOs and media, social audits, use of RTI, making the process of reporting, monitoring and verification more efficient were some of the implications for efficient provision of such services to the poor.

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