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Public Provisioning For Making India Open Defecation Free And The Implication Of Swachh Bharat Mission (Clean India Campaign)

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Abstract

A direct correlation exists between the practice of safe sanitation and good health. Unsafe sanitation and the open defecation (OD) are some of the major causes of infectious diseases such as diarrhea, cholera etc. Sanitation and personal hygiene are the matters of public concern in India as an unsafe and inadequate sanitation system exists throughout the country. About half of the population practice OD. To address the sanitation problem and to make India ODF, the Prime Minister of India introduced the Clean India Mission on 2nd October 2014, which is popularly known as Swachh Bharat Mission (SBM) and the targets of this programme were to be achieved by 2019. However, the achievement of ODF India through SBM is in question and the difference between prediction and progress is mismatching. Here in this study, SBM has been examined to know its outcomes and success in the context of providing subsidized toilets in the rural areas and the extent of people switching over to toilets and change in their defecation habits from outdoor to indoor to make India ODF. The issues have been addressed based on the evidence from the field in Odisha.

Key Words: Sanitation, ODF, SBM,Community Participation, Delivery Deficit.

1. Introduction

Sanitation is generally defined as access to and use of facilities and services for the safe disposal of human excreta (WHO 2018). It refers to the maintenance of a hygienic environment to prevent diseases. The word sanitation is derived from the Latin word *sanitas*, which means to protect and promote the health of human beings by providing a clean environment. Inadequate and unsafe sanitation is a major cause of infectious diseases like diarrhea, vector-borne diseases, cholera, etc. (Van den Berg et al 2013;Holmes et al 2016). It also contributes to stunting and impaired cognitive function and it has adverse impacts on well-being of the under-five children (Danaei et al 2016). It affects about one fourth of the under-five children world-wide (WHO 2018; UNICEF,WHO and World Bank 2018). According to UNICEF, sanitary measures are necessary for improving and protecting the health and wellbeing of the people. Unsafe sanitation has an adverse effect on health and it creates social problems related to women safety, dignity and social prestige (Doron and Jeffrey 2014). Safe sanitation promotes proper disposal of human wastes, other solid and

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liquid waste management as well as proper use of toilets and to quit open defecation (hereafter OD). It prevents diseases and promotes human dignity and well-being.

Sanitation is one of the important and priority sectors of UN Sustainable Development Goals (SDGs) adopted in September 2015[i]. The right to water and sanitation is foundational to several SDGs. After decades of neglect, the importance of access to safe sanitation for everyone everywhere, is now rightly recognized as an essential component of universal health coverage by the UNO in its SDGs (WHO 2018).

The issue of sanitation has not received importance by the policymakers in India till recently. About half of the population practice OD (Doron and Jeffrey 2014: 72), 59.4% in rural and 8.8% in urban areas (GOI 2016:35), nearly four times of the global rate (globally 15% do OD). Unsafe sanitation and OD lead to the transmission of many diseases and these cause adverse health outcomes especially to the under-five children affecting them with diarrhoea, stunted growth, cholera etc. (Crane et al. 2015; Richard et al. 2013; Pattnaik and Pfaff 2009). To address the sanitation problem and to make India open defecation free (hereafter ODF), Government of India implemented various programmes like Central Rural Sanitation Programme (CRSP) in 1986, Total Sanitation Campaign (TSC) in 1999 followed by Nirmal Bharat Abhiyan (NBA) in 2012, but with no effective policy outcomes. It is with this big challenge in mind to make India ODF by October 2019, Prime Minister of India Shri Narendra Modi introduced Clean India Mission on 2nd October 2014 (the 145th birth anniversary of Mahatma Gandhi), known as Swachh Bharat Mission (hereafter SBM).

The Prime Minister launched the programme to achieve universal sanitation coverage and to put a focus on sanitation, aiming to achieve the goal by 2019. In the SBM there are two components, urban and rural. For the rural section, the nodal Ministry is the Ministry of Drinking Water and Sanitation. The goals of the mission include bringing improvement in the general quality of life in the rural areas by promoting cleanliness, hygiene and eliminating OD, accelerating sanitation by involving Gram panchayats to adopt sustainable sanitation practices and facilities through awareness creation and health education.

India being a federal state, there is a division of power and subject domain as per the schedule seven of the constitution. As sanitation is a state subject, implementation of policy and operational mechanism for this are to be decided by the state.

This paper attempts to focus on the implementation of SBM (Gramin) and its implication on the elimination of OD to make India ODF. Delivery of services in a time-bound manner with greater efficiency and effectiveness are the hallmark of good governance. Formulation of good policy will not automatically realize its objectives. It involves well implementation and good management, which includes community participation, proper phase-wise evaluation, and monitoring. The study attempts to evaluate the outcomes of SBM in the context of availability, accessibility, and use of latrines by the rural people. This study investigated the implementation of the toilet building programme of SBM and people's switching over to the use of latrines from OD, through a fieldwork in a gram panchayat in Odisha.

The article is mainly divided into three parts. Section one includes introduction, objectives of the study, methodology adopted, and the public provisioning for ODF India (objective of SBM). Second section deals with the empirical study. For the microscopic and critical look and evaluation of the impacts of SBM, field study was conducted to know the reality as per the policy provisions. The third section of the article deals with the policy implication, the findings regarding household choices, and the net benefits of the SBM policies; it includes issues and concerns, achievement and aspiration, and way ahead to achieve the goals of SBM.

2. Objectives of the Study

During the first five-year plan in 1954 rural sanitation programme was introduced for the first time in India. In the journey from the first five year plan (1951-1956) to the twelfth five year plan (2012-2017), rural sanitation policy has included many programmes such as CRSP 1986, TSC 1999 and presently landed at SBM 2014 (GOI 2014). Despite various programmes and policy packages, data reveals that more than half of the households in India (59.4% in rural and 8.8% in urban areas) do not have access to toilets and those people practice OD (GOI 2016: 35). In Odisha, 78% of the households do not have access to toilets out of which 85.9% belong to rural and 35.2% to urban areas (GOI 2012: 405-407) and they practice OD. This is happening despite the Indian government spending billions of rupees since the introduction of TSC in 1999.

This article investigates the role of public provisioning for ODF India and its implications. It evaluates the performance of SBM in terms of its achievement of policy objectives and reaching the target population in providing toilets. The paper attempts to explore how this policy has benefited the rural people for the elimination of OD and use of latrine along with other sanitation facilities. These have been examined with fieldwork evidence from Kansar Panchayat of Balangir district in Odisha.

3. Methodology

This article is based on an empirical study with an intensive fieldwork and also desk research work. The paper attempts to evaluate how the state-driven approach and subsidized supplies of the toilets have helped the people in quitting the habit of OD thereby improving the sanitation and public health. After examining the secondary sources, fieldwork had been carried out in Kansar GP. Both primary and secondary sources have been used for the collection of data on sanitation facilities that the people have access to. Both descriptive and analytical methods have been adopted while discussing the problems. The SBM has been examined in its entirety. Field survey interviews of beneficiaries, concerned officials, people's representatives in the panchayat and focus group discussions had been undertaken. For sampling, 216 beneficiary households had been selected by probability proportionate to size (PPS) method based on whose toilets were either fully constructed or construction is in progress in the four villages namely, Kansar, Bhejipadar, Kechhomuhan and Dumermunda (table 1).

Table 1: Sampling Design

SN	Name of Village	No. of Toilets Sanctioned	No. of Toilets Completed	No. of Toilets in Progress	Number of Toilets taken as samples		
					completed	in progress	Total
1	Kansar	475	465	10	94	10	104
2	Bhejipadar	127	120	7	24	7	31
3	Kechhomuhan	154	154	0	31	0	31
4	Dumermunda	215	181	34	37	13	50
Kansar GP as a whole		971	920	51	186	30	216

Source: (i) Field work (ii) Official Information provided by the Water and Sanitation, Department, Saintala Block, GOO.

4. Public Provisioning for ODF India

Due to inaccessibility to toilets, the people defecate in the open fields, roadsides, pond sides, under bushes and such other places. This practice is called as 'open defecation' (OD) (Dickinson et.al. 2015). OD is a public health concern causing many diseases including diarrhoea, giardiasis, and stunted growth (Richard et al. 2013; Pattnaik and Pfaff 2009; Pandey 2013). India loses more than 1000 under-five children due to diarrhoea every day (GOO 2015: 03). Safe sanitation has a direct connection with good health and unsafe sanitation has adverse health outcomes. OD is a rampant practice in rural India with 59.4% population relieving themselves in an open space (GOI 2016).

An Overview of Open Defecation

According to the WHO, health is the state of complete physical, mental and social wellbeing and it is not merely the absence of diseases or infirmity[ii]. Public health can be defined as protecting the safety and improving the health of the communities through awareness and policy intervention by the state. Article 21 of the constitution of India guarantees the fundamental right to life and personal liberty. The expression 'life' means a life with dignity and not merely survival and simple breathing, including right to life, standard of living, hygiene etc…[iii]. The right to health is intrinsic to a life with dignity and Article 21 shall be read with Article 47 and the preamble of the Constitution to understand the nature of the obligation of the state to ensure the right to health.

Though the constitution does not mention the right to health under fundamental rights, it directs the state to take measures to improve the condition of health care of its citizens. As per the 73rd Constitutional amendment act and so far the constitutionality of PRIs are concerned, it is the liability of the Panchayats to improve and protect public health. Article 243G says

'...the legislature of a state may, by law, endow the Panchayat with such powers and authority as may be necessary to enable them to function as institution of self governance…'(GOI 2010:88).
Article 243G (b) reads as 'the implementation of the schemes … as may be entrusted to them including those in relation to the matters listed in the eleventh Schedule' of the Constitution (GOI 2010: 88).

The entries in the eleventh schedule have direct relevance to health requirements such as: drinking water, health, sanitation etc. The Indian Judiciary has pronounced in its various judgments that health has a direct correlation with right to life (Article 21) and thereby, it is of fundamental nature.[iv] The health of the citizens is the responsibility of the state. Keeping this in mind the above-mentioned objectives both union and state governments have been making and implementing various programmes and policies on health and sanitation.

Objectives of SBM

There is a direct correlation between sanitation and good health. Proper sanitation helps to reduce diseases and on the other hand lack of basic sanitation facilities has adverse health outcomes and creates diseases (Waddington et al 2009; Pattnaik and Pfaff 2009). Unsafe sanitation has an adverse effect on women's modesty, psychological stress and sexual violence (Sahoo et al 2015). The overall goals of SBM (G) are as follows:

- 'Bring about an improvement in the general quality of life in the rural areas by promoting cleanliness, hygiene, and eliminating OD.
- Motivate Communities through PRIs to adopt sustainable sanitation practices and facilities by creating awareness and health education.
- Encourage cost-effective and appropriate technologies for ecologically safe and sustainable sanitation.
- Accelerate sanitation coverage in rural areas to achieve the vision of SBM by 2nd October 2019…' (GOI 2014: 3).

Major Components and Features of SBM
Since sanitation is a state subject, read as 'Public health and sanitation…'[v], it is left to the state to decide on their mechanism and strategy of implementation taking into account the specific nature and requirements of the locality. The programme components and activities involved in the implementation of SBM are as follows: start-up activities, information-education-communication activities, capacity building, construction of individual household latrines, providing sanitation materials, provision of revolving fund in the district, microfinance for construction of toilets, community sanitation complex, solid and liquid waste management, and maintaining administrative charges (GOI 2014).

- Start-up activities include preparation of programme implementation plan (PIP) at the state level, preparation of district plan which includes orientation packages for state

functionaries and preparation of baseline survey to know the primary information and to assess the sanitation and hygiene practices in the locality. As per the guidelines of SBM, it will be updated in April every year by the concerned state so that the update status of households in the context of possession of latrines will be known (GOI 2014:9).

- Information, education and communication (IEC) activities are parts of the crucial components of SBM. To create awareness among the masses by providing information and creation of health and hygiene awareness among them (GOI 2014) about the health benefits of the use of latrines and its correlation between health, hygiene and diseases. The social benefits of the use of latrines like women's safety and ensuring their privacy, dignity and security provided by latrines have to be highlighted to motivate the masses to switch to latrines from OD which various studies have found (Jenkins and Curtis 2005; Kar 2003; Cornes and Sandler 1994; Dickinson et al 2015; Pardeshi 2009). OD is a shame and affects female modesty, which is linked with social prestige. This issue has to be communicated to the rural people to change their behavior of sanitation and make the demand of latrines. IEC is not a onetime activity. It involves both the pre and post ODF phase of the intervention. As it is an area-specific and community targeted programme, in the initial period of pre ODF phase SBM programme has to make people aware about the benefits of the use of latrines in a campaign mode. In the second phase, once the latrines are gradually being put in place, the focus would be on the sustained use of latrines as a vital intervention by the state to make ODF India sustainable (GOI 2014). It will be done through interpersonal communication, peer pressure, door to door campaign, using mass media as well as participatory social mobilization involving Swachh Doot/Sanitation Messengers, panchayats, local representatives and other field functionaries such as: ASHA, Anganwadi workers, SHGs, NGOs etc. There is a specified fund for the performance of these tasks of IEC in the SBM programmes (GOI 2014).

- Construction of Individual Household Latrine (IHHL) is another step. The swachhata mission aims to ensure that all rural families have access to latrines and make the rural areas ODF by 2019. Household sanitary latrines shall consist of a toilet unit, a super-structure of water facility and hand wash basin. Where there is no possibility of construction of IHHL (due to lack of homestead land or anything else), the state will provide row toilets and (sanitation) complexes for a group of families (GOI2014). The state provides budgetary incentives under the SBM schemes for the construction of IHHL. The incentives are available to all below the poverty line families (BPL) and the identified above poverty line (APL) households belonging to SCs/STs, small and marginal farmers, landless labourers, households headed by women and physically challenged persons etc. The incentive amount per unit is Rs.12000/- for both BPL and APL households to construct the toilet. The sharing of the incentive is in the ratio of 75:25 between the central and the state governments except for the special status

states (GOI 2014: 13). Preferably the construction activities should be taken up by the beneficiary himself/herself with the support from the involved agency in the village. The left out APL households those who are facing financial problems to construct latrines may be assisted by the state through the revolving fund as mentioned in the SBM guidelines or through low cost financing from NABARD, bank or other financial institutions (GOI 2014:14).

- Available of Sanitation Materials: To help and encourage in building IHHL the state supplies low cost quality toilet construction materials and trained masons through rural sanitation marts, production centres and SHGs. It is an initiative of a commercial venture with social objectives. This is a very important requirement as poor quality materials used in the construction can significantly derail the SBM programme. In all cases, the involvement and the role of gram panchyat is very crucial in the construction of toilets (GOI 2014).
- Micro Finance for Construction of Toilets: SBM has the provision for financing for the construction of toilets to be provided to those households which are not eligible for the direct incentives under the scheme. This finance is through the bank, recognised financial institutions etc. (GOI 2014).
- Community Sanitary Complex (CSC): Where there is no space to construct IHHL in the village, SBM has a provision to construct CSCs with an appropriate number of latrines, bathing cubicles, wash basins etc. Gram panchayat initiates the demand for its construction and it will be approved by the state-level schemes sanctioning committee. After construction, it is the responsibility of the panchayat to maintain the CSCs (GOI 2014).
- Administrative Charges include the expenditure on temporary staff and agencies deployed for the implementation of SBM at different levels such as State, District, Block and GP levels and for the support services, vehicles hired and the fuel charges. Monitoring and assessment of the schemes including other administrative components to be utilised annually under the scheme, would be up to maximum 2% of the programme expenditure in a financial year (GOI 2014:19).

II

5. Profile of the Study Area

This section deals with the empirical observations to know the outcomes of the SBM for Kansar Gram Panchayat (GP). It is one of the twenty GPs of Saintala Block of Balangir District in Odisha. This GP comprises four revenue villages, namely Kansar, Bhejipadar, Kechhomuhan and Dumermunda as given in table 2.

Table 2: Population Profile of GP

Village	Total Population	% SC Population	%ST Population
Kansar	2224	25.44	15.96
Bhejipadar	871	14.58	26.06
Kechhomuhan	632	6.64	16.45
Dumermunda	862	5.10	11.60
Kansar GP as a whole	4589	16.97	17.12

Sources: (i) Author's estimation based on census 2011 (Odisha), Government of India (ii) Information provided by the Block Office, Saintala Block.

Kansar is a large village with 641 families. As per the 2011 census, Scheduled Castes and Scheduled Tribes population in the village are 25.44% and 15.96% respectively. Bhejipadar comprises of 235 families and has a population of 871 people. Among them 14.58% are SCs and 26.6% are STs. Kechhomuhan has 168 households and SCs and STs constitute 6.64% and 16.45% respectively. Dumermunda comprises 225 households and 862 persons with 5.1% SCs and 11.60% STs population. This GP as a whole consists of 1269 families with 34.10% SCs and STs (SC 16.97 and STs 17.12%). Among the non-SCs/STs population in the panchayat, majority belong to the Other Backward Castes (OBCs).

Table 3: Number of BPL and APL Families in the GP

Village	Total No. of Households	No. of AAY Households	No. of BPL Households	No. of APL Households	% of BPL Households (BPL +AAY)
Kansar	641	52	285	173	52.57
Bhejipadar	235	17	105	97	51.91
Kechhomuhan	168	10	72	97	48.80
Dumermunda	225	25	95	100	53.33
Kansar GP as a whole	1269	104	557	467	52

Note: BPL- Below Poverty Line, APL- Above Poverty Line, AAY- Antodaya Anna Yajana

Source: Block Office Saintala and Kansar Panchayat Office record.

Data in table 3 reveals that more than 50% of the families in all the study villages are living below the poverty line (BPL). Among the social groups, the SCs and STs in all the four villages are more prone to poverty than the other social groups. The total number of households, and the BPL, APL and AAY putting together are not matching. This is happening as most of the families belonging to SCs in this GP are going outside of the state in search of work (as seasonal migrant labour) and when the survey was conducted they were not enumerated by the government officials[vi]. Secondly, there is an error of exclusion too.

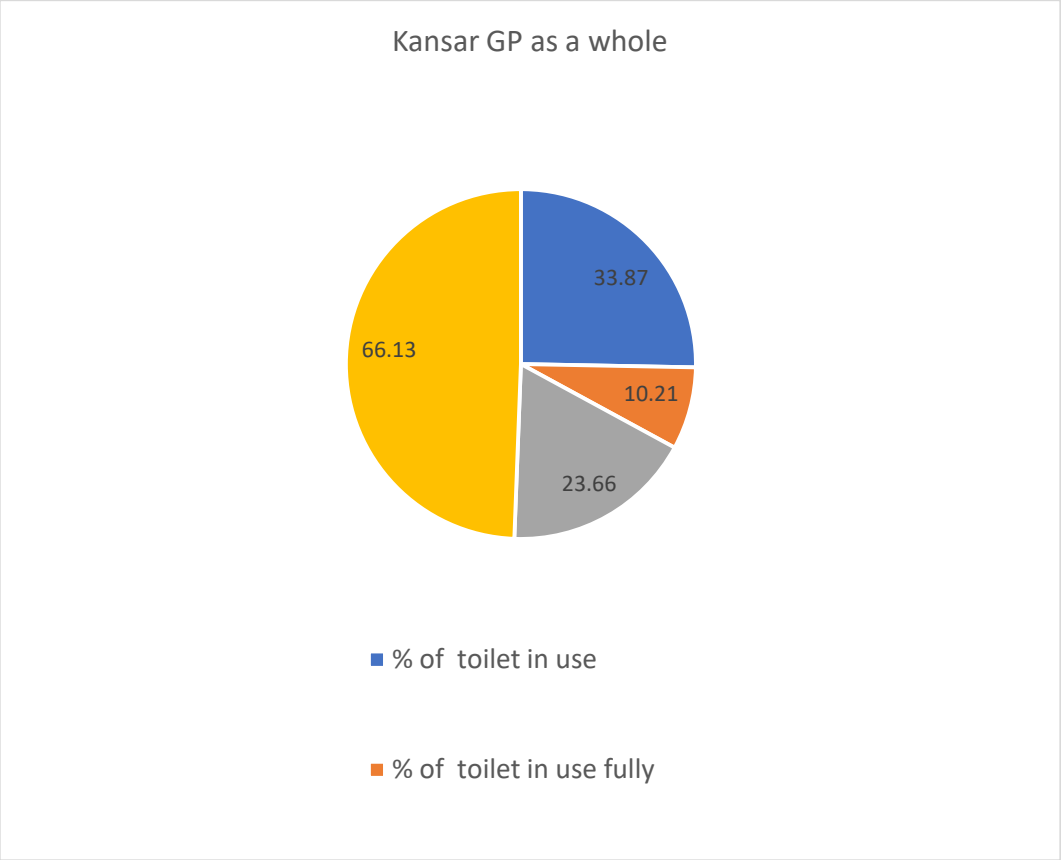
Table 4: Percentage of Households Using Toilets (Among the Samples)

Grampancyat	No. of toilets Construction completed	% of toilets in use	% of toilets in fully use	% of toilets in use Partially	% Household having OD
Kansar GP as a whole	(100%) 186	33.87 (63)	10.21 (19)	23.66 (44)	66.13 (123)

Source: Field work.

Data in table 4 depicts that only 33.87% toilets are being used out of the total construction-completed toilets taken as samples for the study. Out of the used toilets, 23.66% are partially being used. Beneficiaries are not using the toilets throughout the year. They use it at the time of harvesting season when all the fields are cultivated and occupied by crops. During the rest of the year, they do not use it for the reasons including lack of water connection, not feeling comfortable as its size is too small, small waste storage capacity of the toilet etc. Only 10.21% of the toilets are fully being used by the beneficiaries. They revealed that at the time of the construction, they spent extra money in addition to the government subsidy to make the toilet usable. More than one-third population of the GP constitutes of poor dalits and adivasis. More than half of the population belongs to BPL (52%) as shown in table 3. They could not bear the expenses of the construction of the toilet to make it usable, and the toilet which has been provided by the government is almost dysfunctional. Hence the availability of toilets did not encourage the use of it. Therefore, just having a toilet did not ensure its usage. As the toilet is not in a usable condition, 66.13% of households among the samples are still practising OD (table 4 and figure 1). It is found that the construction of many toilets was stated to be completed on paper but those are still under construction. As a result the target to make rural India ODF by October 2019 was not achieved in India in general and in the studied region in particular.

Figure 1: Number of Toilets Constructed and in use in the GP (Among the Samples)



Source: Based on Table 4

III

6. Policy Implication: Issues and Concerns

This section will focus on the policy implication of the SBM. An attempt has also been made to evaluate the policy outcomes, issues and concerns in terms of providing subsidised latrines to the rural poor and the extent of making the studied panchayat ODF.

The success of any policy depends upon both the policy design as well as its proper implementation. How policy is being designed to reach the target group also matters. Even if the policy is well designed, if it is not implemented properly in the field (project areas) it cannot achieve its desired objectives. The government of Odisha has been implementing the SBM to make India ODF and to provide better sanitation facilities. Let's have a look on a few issues which the study has found in the field.

Does access to toilets ensure usage?

The study found that simply providing a toilet has not ensured its usage and the people have not suddenly abandoned their age-old practice of OD. The study shows that out of the samples, 66.13% households are still practising OD (table 4). This is one of the pertinent policy questions of SBM in the context of making India ODF. Should the Government focus more on the construction of toilets that leads to increased access to toilets, or should it focus more on encouraging the people to use the toilets by addressing the socio-behavioural change? Both these issues are equally important to achieve ODF India. Without having toilets, the usage cannot be imagined. Accessibility is important. But without changing peoples' mindset and behavior, it is not certain that they would use the toilets. Hence both shall be given policy priority by the state to achieve the goal of making India ODF. Also, there are so many factors interrelated with the use of toilet which include: availability of water, location of the toilet, convenience and comfortability, awareness and knowledge of sanitation, health and hygiene issues, awareness and knowledge of the use of benefits of toilets (both health and social), cultural factors, social behaviour etc.

As found in the field, among all the toilets provided to the beneficiaries in the panchayat, there is no connectivity and supply of water. When the author posed the question to the beneficiaries about why they are not using the toilets as the toilets are available to them, 35% beneficiaries (among samples) told that there is no water supply to the toilets and it is uncomfortable for them to use toilets, hence they preferred OD. 20% of the respondents preferred defecation in open rather than their toilets because of the distant location of their toilets. They have constructed a toilet in their farming land due to lack of availability of space near to their homes. They said,

'During the monsoon, there is a problem of OD as all the fields are cultivated and occupied with crops, during that time we thought to use our toilets but it could not be possible as there was water lagging in the toilet as it has not been constructed properly and poor quality materials are used for it. At times other than the monsoon, there is a lot of space available for defecation in open. The toilets are away from home and no water connectivity is there. We feel easy and comfortable to relieve ourselves in the open'.[vii]

Few of them said that the size of the toilet building is so small that it is very difficult to sit properly. Non-availability of water is an issue for the non-usage of toilets. The issue of lack of water supply along with other problems are cited as the reasons for not using toilets in rural India by the study of Mehrotra and Pattnaik(2008). If there would have been water supply to the toilets, there is every chance that they might have used the toilets. Hence, it should be incorporated in the policy provision for compulsory supply of water. It has been observed in the field that many beneficiaries did not construct their toilets though they are entitled to it because of lack of space. Community sanitation complex (CSC) may be able to address this problem. The author did not find the construction of any CSC in the studied GP. When the issues were discussed with the Sarpanch, he said that he was planning to construct at least two CSCs, one in Kansar and another in Bhejipadar village as many IHHL are not

constructed in these villages because of lack of space. He said that there is non-availability of public land and no one is either donating or selling off their land for the same.[viii]

Construction of toilets alone will not serve the purpose and it is not the solution of the problems. In addition to providing modern infrastructure like the toilets in the houses, the awareness creation for their usage and social acceptance must go hand in hand (Doron and Jeffrey 2014). Only then the people will accept the modern sanitation facility and switch to the usage of latrines. The state shall address the issue of behavioural change, through IEC method. Community participation is required through interpersonal communication and use of the IEC method. When the people will be aware of the benefits of sanitation, good health practices and hygiene through the use of toilets, they will start using the toilets. The people are needed to be made aware of both the health and social problems related to OD. When they will realise that OD is disgusting, dirty and shameful, particularly for the females, they will be convinced and start demanding the toilets. The state needs to ensure door-to-door campaign through the Swachh Doots, by the first line field staff like ASHA, health and Aganwadi workers, which is highly lacking in the study areas. It could have been done by providing incentives for them for the success of the mission. As observed in the field, it could not happen. Therefore there is a lukewarm response to the policy from the people.

Lack of Community Participation

Involvement of the people and the extent of participation is the key to the success of any policy and the determining factor for its outcomes. For the success of any community-level programme awareness among the people and stakeholders' involvement is highly required. As far as SBM is concerned, it failed to address these issues properly. Behaviour change is the key component of the SBM and it has to be done through the involvement of the community and IEC methods. But the funds allocated for it is just 8% out of the national allocation under SBM (3% is to be utilised by the Union Government and 5% by State (GOI 2014: 11). SBM simply becomes a target-based approach to reach the target by the construction of toilets without emphasizing its uses and delivery of functional toilets to the beneficiaries. The emphasis on the community and creating awareness among the people became secondary. Sometimes it evaporated also from the everyday routine works of the state functionaries. Tiny toilets without water facilities were constructed, but the focus on usage was neglected.

Building and using toilets is not a priority among the households and OD is widely accepted as a normal part of their culture and practices. In the studied Panchayat, many of the OBC households are the landowning class and they are economically well off, and they are the local power elites. Still they do not have safe sanitation habits or facilities, as observed in the field. They are yet to develop an awareness about sanitation. SBM's target should focus on them too in addition to the specified beneficiaries.

Partial Involvement of the Panchayat and its Representatives

As per the 73rd Constitutional Amendment Act 1992 and the entry number 23 into the Eleven Schedule, 'health and sanitation' is the responsibility of the Panchayat. SBM guidelines also

have a provision that the panchayat would play a key role in the implementation of SBM. It includes IEC activities of social mobilization for triggering the demand of toilets, construction of toilets and maintenance of clean environment (GOI 2014: 25). But it was found that the involvement of the panchayats and the Sarpanch are limited to the campaign activities. It is happening because of the over-bureaucratisation of the work and the state's functionaries are tactically trying to avoid the Sarpanch and other local elected representatives from being included in the process. Many times the Sarpanch took a voluntary effort to be involved and wanted to know the information such as number of IHHL completed, IHHL under construction, the total list of sanctioned funds etc. But the state's functionary did not allow him to know the information and asked him (Sarpanch) to convey in writing why he wants to know that. As shared by the Sarpanch, he had also reported the BDO about the apathy and non-responsive attitude of the concerned state functionary, but that was of no avail. It is nothing but the tactics to avoid sharing information and maintaining unnecessary official secrecy with the mala-fide intention of personal gain in an official capacity.

Corruption

Leakage, corruption and apathy of the state functionaries are the main reasons among others in non-achievement of the policy goals in India in any policy matter so also in SBM. Bureaucracy has a crucial role to play. Bureaucracy and its other line staff those who are dealing with it have an instrumental role in the success of SBM. As per the data gathered from the field, they have not played their role properly and there is no proper monitoring in the field, and proper supervision has not been done by the senior bureaucrats. This produced scope for corruption by the line/ancillary staff. In the field it was observed that two NGOs were involved in the construction of toilets in the GP. Many of the toilets were left incomplete, but on paper it has been shown as completed and money has been taken away by the NGO from the beneficiaries' accounts. It clearly shows that the state's functionaries were aware of the problem, otherwise without completion of the toilet work how were the bills approved by the concerned authority and total incentives have been given? In fact, the NGOs were neither involved in IEC activities nor any social awareness programmes, but they were just involved in the construction works where they can make profits. The beneficiaries also reported that NGOs used poor quality materials in the construction of toilets. They did not deliver functional toilets to the beneficiaries. The concerned state functionaries are avoiding disclosing the matter and information to the local public representatives like the Sarpanch etc. We cannot dismiss the possibility of nexus between the concerned state functionaries and the NGOs.

Problem of Fund

The government's incentive of Rs.12000/- is not adequate for construction of a good quality toilet. The beneficiaries were needed to contribute some amount from their pockets and in case of the BPL families, it was not possible for them to contribute money because of their poor economic condition. More than half of the households in the studied area are under BPL

(table 3). The study found in the GP that many toilets are in dysfunctional condition and the construction is not completed. Incentives and awareness have to go side by side. In the field, it has been observed that there is a mismatch of awareness and incentives. The incentives per unit cost is needed to be enhanced to minimum Rs. 17000/- to build a good quality toilet.

The gap between the Target and the Achievement

There is a huge gap between the target and the achievements. As per the SBM guidelines, its target was to provide a functional toilet to every BPL and specified APL households by October 2019 and to make rural India ODF (GOI 2014: 03). Despite money spent by the government and the given policy target, it is not going accordingly as observed in the field. Till March 2020, many of the sanctioned toilets (5.25%) have not been constructed and many targeted families are not having a toilet and they do practice OD. Non-seriousness of the bureaucrats, line staff and no stick direction from the concerned ministry in the state are observed during the fieldwork.

Delivery Deficit

Non-fulfilment of the target within the fixed time period and partial failure to provide toilets to every targeted household is the delivery deficit of the state both in terms of delivery of quality toilets to the eligible households and timely delivery of the same. It is one of the reasons for non-achievement of ODF within the specified time period.

7. Conclusion

Safe sanitation is necessary for good health and presently OD is directly harming public health. Government initiatives to address the sanitation issue by SBM within a time period is highly a matter of appreciation. However, the policy document itself will not work automatically to give the outcomes and to fulfil the goal. Achievement of the goal depends on how the policy is being implemented, which produces the outcomes. The success of any policy depends upon how well it is formulated and how well it is implemented with proper monitoring and participation of the people. Since the SBM is a community-based policy, its success depends upon the people's involvement, and this again depends upon the state's strategy, techniques and capability to include them through IEC activities. Awareness generation and stakeholders' involvement are highly required for the success of any community-level programme. So far the SBM is concerned, it could not address these issues properly as observed in the field. Though behaviour and attitude changes are the most challenging tasks in achieving the desired outcomes of the SBM, yet these can made possible with proper efforts. It could have been done if IEC activities would have been managed properly through local involvement. Poor design, lack of water supply and insufficient awareness contributed to the low toilet usage. Further bureaucratic apathy and non-monitoring, lack of proper supervision etc. created hurdles in the achievement of the goal of the SBM.

Undoubtedly SBM has achieved some success too and the government's initiatives have worked to some extent and few people have switched over to the use of toilets from OD. The

study found that at least 10.21% of the beneficiaries switched over to toilets and abandoned OD. If the implementation of the SBM would have been done properly taking proper care of the issues discussed earlier, it could have performed better and the policy objectives would have been achieved to a larger extent to actually make India open defecation free.

Notes

[i] United Nation Official Document the goals are contained in paragraph 54 UN Resolution A/RES/70/1 of 25 September 2015.See full report at http://undocs.org/A/68/970.
[ii] WHO (1946) The preamble of the Constitution of WHO, which was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (Official Record. WHO No. 2, P.100).
[iii]Government of India. (2010). *Constitution of India,* New Delhi: Ministry of Law and Justice; See State of Punjab v. Mahinder Singh Chawla, AIR 1997 SC1225.
[iv]Paschim Banga Khet Mazdoorsamity vs. State of West Bengal & Anr on 6 May, 1996 , AIR SC 2426/ (1996) 4 SCC 37.
[v] Schedule VIII of the Constitution entry No. 6 of list II (GIO 2010).
[vi] Respondents revealed to the author.
[vii] Respondents reveled
[viii] Sarpanch shared to the author that in many cases he is excluded and not making part of the implementation process except in campaign and IEC activities.

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