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Sanitation Strategies in Karnataka: A Review

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SANITATION STRATEGIES IN KARNATAKA: A REVIEW

Veerashekharappa[1] and Shashanka Bhide[2]

Abstract

Because of lack of proper sanitation, communicable diseases spread causing considerable loss and disabilities to human resources. Considering this, the international community has set the provision of sanitation as part of the Millennium Development Goals, aiming to reduce the number of those without adequate sanitation facilities to half by the year 2015. To achieve this, various strategies are designed by the Government of India and the state governments. It is observed that the strategies involving non-government organisations are more effective than the ones involving exclusively the state in promotion of sanitation.

Introduction

Globally, 2.4 billion people do not have access to adequate sanitation and most of them tend to be victims of poverty (Myles, 2003). Further, in the developing world 50 per cent of the population is without adequate sanitation (World Bank, 2003) and suffer with diarrhea, trachoma and schistosomiasi (WHO and UNICIEF, 2000) leading to considerable loss and disabilities of human resources. Considering this, the international community set provision of sanitation as part of the Millennium Development Goals, to reduce to half by the year 2015, those without adequate sanitation facilities. Considering all parameters, this means that an additional 350,000 people have to be covered every day with improved sanitation services by 2015 (IRC, 2003).

In India, the severity of sanitation problem has a long history. In 1935 British troops suffered due to sanitation related diseases (Ramasubban, 1982). Bhore (1944) and Environmental Hygiene Committee (1948) recommended better sanitation services and this became a blueprint to make budgetary allocation during the First FiveYear Plan (1951-56). But the sector again came into limelight 20 years later, during the emergency 1975, and latrine construction was given priority. The Fifth Five Year Plan endorsed priority to sanitation by stating that, "the elimination of abject poverty will not be attained as a corollary to certain acceleration in the rate of growth of the economy alone, but improvements in drinking water and environmental sanitation have direct correlation with levels of living". Thus, providing public health facilities became part of poverty alleviation programme. This is, in fact an eye opener for the policies regarding sanitation services.

With the commencement of the *International Water and Sanitation Decade,* the Government of India drew up new policies with the support of the United Nations (UN) and other external agencies. As part of this, the Central Rural Sanitation Programme *(CRSP)* was launched in 1986. Following this, various diversified programmes were introduced by the Ministry of Rural Development in 1990s, to suit the local needs. These new policies and new strategies have shown a marginal impact in coverage (Annexure 1). Finding sluggish progress in the implementation of CRSP, reforms were introduced and programme was renamed as Total Sanitation Campaign (TSC, 1999), which includes latrines plus services such as, provision of latrines, disposal of liquid and solid waste and domestic as well as environmental hygiene. This approach is 'demand driven', the beneficiaries have to share a marginal capital cost and be part of its implementation (GOI, 2002). This new concept has been developed based on baseline survey findings 'On Knowledge, Attitudes and Practices in Rural Water Supply and Sanitation' by Indian Institute of Mass Communications (1996-97). According to survey results, 55 per cent of

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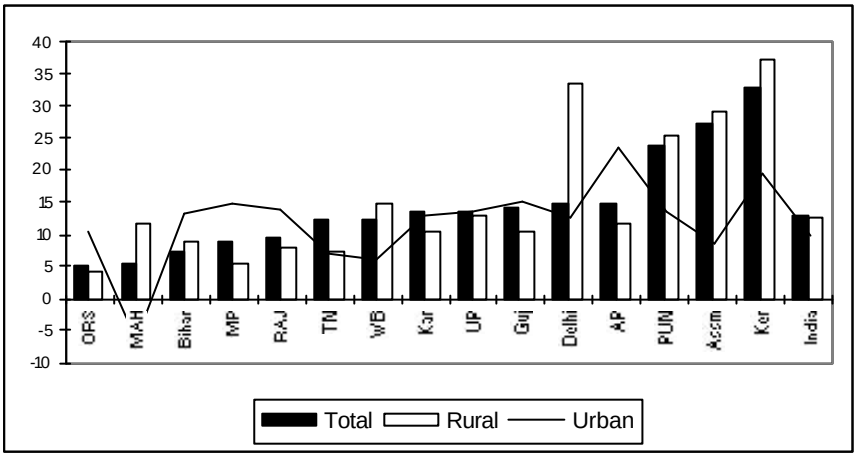
those with private latrines were self-motivated and 51 per cent of the respondents were willing to spend up to Rs 1000/- to acquire sanitary toilets (GOI; 2002).

The TSC, in addition to households, extends support for community Sanitary Complexes, which will have multiple facilities such as toilets, washing platform, bathing rooms, etc. The unit cost is up to Rs 2 lakh and shared by the GOI, State Government and the community in the ratio of 60:20:20. However, the percentage of households covered with latrine is just 22 per cent (Census 2001). In other words, 78 and 26 per cent of the households in rural and urban areas do not have access to latrines (Annexure 1). The variation across states show that states like Kerala, Assam, Punjab, Andhra Pradesh, Delhi, Gujarat, Uttar Pradesh and Karnataka have better facilities, which is shown in the chart below in descending order. The reason for the better performance of these states was attributed to better intervention of State..

Chart 1. Progress in the Adoption of Sanitary Latrines at the Households Level
(Change in percentage points between 1991 and 2001 Censuses)



There were a number of factors attributed for poor coverage and usage. Chief among these were religious beliefs and cultural factors (Pathak, 2003), lack of awareness on health and hygienic practices, lack of own resources, improper designs and technology (Veerashekharappa, 2002) and lack of people's initiative and involvement (Roy MN, 1996). However, the low coverage also requires study and explanation. An attempt has been made here to study the issue, by way of reviewing policies, strategies and programmes implemented. Most of the inferences were based experiences in Karnataka. Following are the objectives of the study:

Objectives:

- To examine strategies in provision of latrines
- To examine the constraints in evolving demand for toilets; and
- To examine stakeholders role and impact in provision of sanitary services.

To operationalise these objectives, we used data mainly from Census 2001, National Sample Survey (NSS), Plan documents, Economic Survey, Central Statistical Organisation (CSO) and data by various published and unpublished studies that we were made available. In addition to this, valuable insights came from the field visits to Tamil Nadu and Maharashtra to observe and study the best practices. This paper is presented in four sections. The second section evaluates sanitation policies and programmes. The third section examines the

demand-driven policies by State and other agencies, followed by fourth section which draws conclusions based on study results.

Section 2

Programmes and Coverage

The CRSP initiation was a precursor to many such programmes in Karnataka such as Nirmal Grama Yojane (NGY, 1993), Integrated Rural Water Supply and Sanitation programme (IRWSS1993) and Swatcha Grama Yojane (SGY 2000). However, initially in Karnataka, the policies on rural sanitation were focusing on two areas, viz, construction of storm water drains and provision of community toilets. The community toilets were built mainly to provide privacy to women, but they were unused to a large extent due to the absence of proper maintenance system (GOK, RDPR 2000). Even usable individual toilets were not being used and put to other uses as households did not prioritise sanitation services as a part of health profile (Veerashekharappa 1999; GOK, DES, 2000; Rajasekhar and Veerashekharappa, 2003). However, in the State, the coverage of households with latrine facilities is better both in rural and urban areas compared to national average (Table 1).

In Urban areas, the sanitation services were provided by the Urban Local Bodies (ULBs) traditionally. Later, the Government of Karnataka decided to provide these services through centralised utilities and established the BWSSB and the KUWSDB for the Bangalore Metropolitan Region and other urban areas in the State. After the 74th Constitutional amendment (1992), the responsibility of providing municipal services, including sanitation services, reverted back to the ULBs. Presently, in Urban areas, due to insufficient machinery and manpower the local government is unable to control the overflow sewage and garbage piled up (KUIDFC, 2003), which affects the environment and human beings.

Table 1: Per cent of Households with sanitation facilities (2001)

Sanitation Services	Karnataka			All India		
	Total	Rural	Urban	Total	Rural	Urban
Type of latrine within the house						
Pit latrine	13.38	9.48	20.70	11.5	10.3	14.6
Water closet	18.64	4.67	44.86	18	7.1	46.1
Other latrine	5.48	3.25	9.67	6.9	4.5	13
No latrine	62.50	82.60	24.77	63.6	78.1	26.3
Type of connectivity for waste water outlet						
Closed Drainage	17.26	4.28	41.64	12.5	3.9	34.5
Open Drainage	33.97	31.11	39.33	33.9	30.3	43.4
No drainage	48.77	64.61	19.03	53.6	65.8	22.1

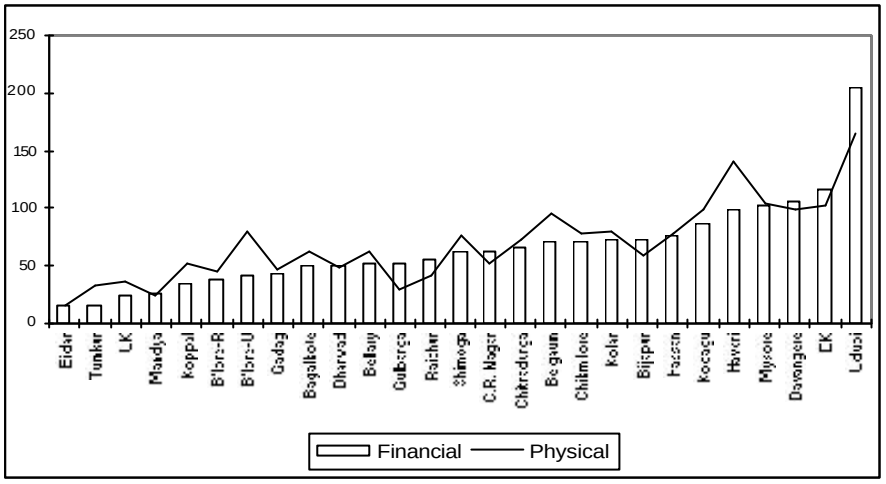
Source: Census 2001

Though policies were drawn and targets fixed to cover specific number of households under different programmes, the set targets were not achieved in many districts. The low achievement was synonymous among the backward districts. (Chart 2). There were many social as well as economic factors which hampered the programmes. In fact economic factors dominated social factors. For instance due to poverty and the lack of awareness, many people had no idea about sanitation-related diseases. They gave sanitation facilities a low priority because of this. Hence, there is a need for intervention by the State and Non-Governmental Organisations who should act simultaneously to change the mindset on sanitation services and provisions. In this

context, various governments across the country (Central, State and local governments), NGOs and CBOs have designed strategies to aid the promotion of sanitation services. These measures have been discussed in the following section.

Chart: 2. Meeting Targets on Latrine Construction:

Financial and Physical Indicators in 2001 (Actual as % of Targets)



Section 3

Promotional Strategies by Various Organisations

From the earlier section, it is clear that rural sanitation lacks demand due to social and economical backwardness of the household. Moreover, the services provided to the poor households are of low quality and members of the household do not prioritise in using them. Hence, the primary objective is to educate and motivate people to adopt hygienic practices using funds made available in the programmes. At the same time, the State should have the multiple options to provide better facilities, which should be environment-friendly and usable by household members. The Government, NGOs and other agencies have to develop strategies based on Information, Education and Communication (IEC). Some of them are discussed in following paragraph.

3.1. Information, Education and Communication (IEC)

The IEC strategy evolved out of a combination of several methods of dissemination of information and education on public health. They are used not only for sanitation services, but also to prevent disease outbreaks. The materials used in IEC include, Audio-visual aids, video recording and screening; display of photographs related to best practices on personal and home hygiene, street plays with the script developed in communicable / folk local language and providing training to the youth to make presentation. As mentioned earlier, the cost is met from respective programmes. For instance, under CRSP and TSC, 15 per cent of budgetary resources were earmarked for this. The earmarked resources were shared between GOI and State Governments with ratio of 80:20. Similarly, 10 per cent of the total project cost under Nirmal Karnataka and Swatch Grama Yojana (RDPR, GOK 2000) was earmarked for IEC activities.

The IEC developed instruments are project specific and hence most of them are based on local requirements of the programme. For instance, under TSP and NGY programmes, the IEC strategies targeted to motivate the people to adopt household latrines and develop hygienic practices, whereas, in SGY and IRWSS, the community had to mobilise resources to share partial capital cost of the project, additionally. Since large amount

needs to be mobilised to share the capital cost of the IRWSS programme, an NGO is being appointed to implement IEC activities. The instruments designed for this will contain the existing scenario in the village on health and hygiene practices and the likely burden on households if sanitation-related diseases break out.

The instruments are carried by NGO functionaries for door to door campaigns while some of the instruments are displayed at public places. Shramadana (voluntary labour) were organised in logged areas to inculcate the habit of managing good drainage. Jathas by school children and street plays were also organised through local folk media to create awareness. As mentioned earlier, there may be variation across design and use of instruments. However following IEC methods are commonly adopted in TSC, NGY, SGY and IRWSS programmes.

- Participatory Research Appraisals exercise being conducted to find out status of public health in the villages.
- Audio-visual Programmes on hygiene and sanitation
- Jathas by School children, street plays, Shramadans
- Involving elected members and eminent persons for mobilising support for the programme
- NGO involvement to create awareness and facilitate the implementation of the programme

3.2. Demonstration and Individual Communication

The demonstration and effective individual communication or contact strategy is crucial to reach the underprivileged, particularly the women folk. These approaches are practiced to educate and motivate people, who stay within the house. The demonstration activity is carried out by displaying, constructing and installing the available sanitary product/ services at the public places, such as Grampanchayat offices, Auxiliary Nurse and Midwife (ANM) quarters, schools, hospitals, religious places and in the locality of weaker sections so that the demonstration programme is made accessible to the public. Apart from this, the female members are employed as a 'health facilitator' to communicate and convince women folk for latrine construction. The materials promoting the programme are provided to health facilitators which will resolve specific problems at household level through individual communication. Further, they accompany women members to the GP office and ANM quarters to perceive and use the latrines constructed there.

3.3. Legislation Mandatory

As elected members in the rural areas play an important role and to make him agent of change or role model, an amendment was brought to Karnataka Panchayath Raj Act 1993[3], in 1997, making it mandatory for GP member to construct Individual Household Latrines (IHL) in his /her house for family use, failing which the member would forgo the membership. Further, it was made mandatory to contest the GP elections. To cover large number of public representative, this was later extended to Taluk Panchayath members (Table 2).

[3] The Karnataka Panchayat Raj Act, 1993 lists "maintenance of general sanitation, cleaning of public roads, drains, tanks, wells and other public places, and construction and maintenance of public latrines" among the functions of the Gram Panchayat (section 58 and Schedule I, Entry XVIII). " Implementation of Rural Sanitation Schemes" and "Promotion of drinking water and rural sanitation programmes" are also listed among the functions of Taluk and Zilla panchayats respectively (Schedule II Entry IX and Schedule III Entry X)

Table 2: Mandatory Functions of GP and TP in Sanitary Services

Gram Panchayats	Taluk Panchayats
1. Providing IHLs ten per cent of the additional households every year and achieve full coverage as early as possible.	1. Construction of individual and community sanitary latrines.
2. Constructing adequate number of community latrines for the use of men and women, and maintaining them.	2. Providing adequate number of class rooms and maintaining primary school buildings in proper condition with water supply and sanitation; and
3. Providing sanitation and proper drainage; and;	3. Acquiring land away from dwelling houses for locating manure pits in the villages (Section 145) of Karnataka Panchayath Raj Act, 1993.
4. Earmarking places away from the dwelling houses for dumping refuse and manure (Section 58, Karnataka Panchayat Raj Act. 1993).	

3.4. Involvement of Community-Based Organisations and Women

The local Community-Based Organisations (CBO) have repository infusion and could help in efficient delivery of services. Based on this concept, multilateral (World Bank) and bilateral (DANIDA) assisted programmes involved Community-Based Organisations (CBO) such as Village Water Supply and Sanitation Committee (VWSC) in all stages of implementation of the projects and maintenance during 1990s. The committees consist of both elected and selected members from the local bodies (GPs) and the community, respectively. The non-elected members are eminent personal in the village, served in education and health departments. Similarly women are given due weight while constituting the committee, considering their role in hygiene maintenance at the household-level. From the constituted group, a small executive committee was formed to monitor day-to-day activities and the secretarial assistance is obtained from local government (GPs). These CBO will have their own by-laws for effective function and carry out assigned task at various stages, such as planning, implementation and operation and maintenance of assets created under the programme.

Similarly, state-sponsored programmes such as NGY, SGY, the Nirmal Grama Yojana Committee and Swachcha Grama Yojana Committee were formed. These CBOs are considered as an extended arm of the GP, under section 61A of Karnataka Panchayat Act. Women have been given priority in the CBOs by reserving a proportion of seats to them; considering their important role in maintaining household hygiene and their success in taking care of hand pump in different states (World Bank, 1998). The women Self Help Groups (SHG) has been very successful in maintenance of sanitation services such as cleaning the roads and drainages in Bijapur of Karnataka (Lathamala, 1996). Similar successes were observed in Tamil Nadu and Andhra Pradesh in managing Integrated Sanitary Complex scheme. In addition to this, they play a significant role in motivating others around to use and adopt more hygienic practices and create demand for sanitation facilities within the village.

3.5. Programmes in Urban Areas

In urban areas, the provision of services is the responsibility of the urban local government. But in recent years, there has been a shift in provision of services under different models/collaborations/arrangements (public-Private partnership or public and community partnership). The Integrated Sanitation Programme (ISP) is being implemented by urban local government in collaboration with NGOs across the country. For instance, during our visit to Trichy City, we found very successful collaboration efforts with public and private participation in maintenance under the ISP. The government, Non-Government Organisations (NGOs) and Women Self Help Groups (SHGs) are joined together in construction and maintenance of sanitary complexes. Three NGOs (Sevai,

Scope and Gramalaya) have taken up ISP activities in different locations. The SHGs are maintaining 28 ISP complexes and 311 community toilets in the City. They take care of the complex; maintain accounts and run small shops in the complex while the NGOs support them in upgrading skills and capacity building activities. Some of the SHGs are even involved in production of sanitary marts. The construction cost of the ISP complex was about Rs. 10-12 lakh, 50 per cent of which was born by the government and remaining cost by SHGs, by availing bank loans. However, the government provides required land, free electricity, and water and UGD system to the complex. These complexes serve the people living in slums who cannot afford their own latrines and bathrooms. Hence some families make monthly payments, and the amount is decided based on number of people using it.

Sulabh Public Toilet Complexes are the initiative of Sulabh International, working in the field of community health promotion. In fact these complexes are seminal in pay and use concept and contributes to a large extent in keeping cities clean as well reducing the risk of outbreak of sanitation-related diseases. The complexes are located at public places like bus stands, hospitals, markets, slums, etc. The Sulabh International takes responsibility of construction, operation and maintenance of the complexes and plays the catalyst role between the official agencies and the users of complexes. The system has proved to be an important solution for the local bodies in keeping the towns clean and improving the environment. This is a unique example of partnership between local authorities and non- governmental organisation. The local governments pay for construction (or acquisition of land); Sulabh constructs the system and guarantees the maintenance for at least 30 years from user charge.

In Karnataka, state-sponsored 'Nirmal Nagar' programme was implemented in selected towns to help the poor. The ULBs take the responsibility of toilets construction on BOT basis and construction work is assigned to Karnataka Land Army Corporation (KLAC). The maintenance is outsourced in consultation with District Urban Development Cells (DUDC). The contracting out will be done in a package, clubbing non-revenue areas with revenue areas with priority given to existing SHGs under SJSRY for maintenance. If need, the training is also imparted to the group members.

3.6. Household latrines *vis-à-vis* Group latrines programmes

As mentioned earlier, under CRSP, IHLs were given priority. After the reforms in TSC programme, priority was given for setting up sanitary complexes in a place acceptable for both men and women. The prescribed unit cost is up to Rs 2 lakh, shared by GOI, State Government and the community in the ratio of 60:20:20. However, the community contribution can be made by the local governance from its budget (GOI, CSRS 2002). This approach directly provides subsidy to communities rather than individuals. Though many households are inclined positively to have IHL, the scarcity of space, the traditional taboos (Veerashekharappa, 1999) have become a constraint for construction of IHL. To overcome such constraints, the integrated Community Latrines Complex (ICLC) becomes a substitute. The maintenance cost of the community sanitary complexes has to be met by the Panchayats/voluntary organisations/charitable trusts/Self Help Groups and not the committee set up by local government.

3.7. Community Contribution vis-à-vis Subsidy provision

To promote public health in various programmes, the subsidy is supplanted as an incentive to construct the IHLs. But the initiated reforms are intended to reduce overall subsidy in the sector and create demand drive for the services. This concept has been supported by various multilateral and bilateral agencies, for instance, the World

Bank sponsored IRWSS programme is based on this concept. At the beginning of the project, the community-based organisation VWSC will estimate the demand for the environmental sanitation services and sources of investment, through PRA exercises. The expected investment for sanitation has to be met by both community as well as the State in the ratio of 30:70, respectively. The work in the village is tendered once the VWSC mobilises 25 per cent of the agreed amount. If the VWSC mobilises higher the agreed amount, then the state will release additional grant to match it. Thus, the capability of the VWSC is the deterministic factor to take up the integrated sanitary work in covering the village.

However, under State-sponsored programmes, such as NGY and SGY, the subsidy programme is continued in some form or the other. In these programmes, the subsidy is based on individual household economy. The households below poverty line (BPL) are provided relatively higher subsidy compared to others. The subsidy component is felt necessary, under SGY, to promote sanitation services such as drainage, soak pits, etc. But, this incentive is being misused, because of the joint family structure. In a joint family, the ration cards are obtained by individual families and the subsidy is obtained using individual ration cards, recording the same IHL. For instance, in Kembliganahalli of Bangalore Rural District, subsidy is claimed by 31 families against to 18 latrines constructed (Veerashekharappa, 1999).

Under demand-driven approach, one cannot but cite the success of Midnapur project in West Bengal, which changed the mindset of household on open defecation. The project, aimed at changing of the habit of open defecation without provision of subsidy (World Bank, 1998). The emphasis was on defining a process and direction, which set the pace for achieving the physical targets of the programme. Project planners sought to create awareness and presented a range of technical options. Subsequent arrangements were made for producing, delivering and installing hardware and for administrative and accounting requirements. 127 villages and 3 gram Panchayats were covered under the IHL and declared 'Sanitation Villages' and 'Sanitation Gram Panchayats', respectively. The success of the project demonstrates that with proper guidelines and processes, even the poor can finance their own latrines and subsidy may not be necessary component. This approach was replicated in Maharashtra with small modification as 'Total Sanitation Campaign' in the name of Sant Gadge Baba Clean Village Sanitation Campaign (SGBVSC). These programmes are creating an atmosphere, which motivates people to become the driving force in sanitation efforts, while promoting new habits that could be sustained thereafter, without much financial support.

3.8. Integrating latrine with other sanitation services

As mentioned earlier, the individual latrine programmes have replaced integrated programmes and Swatcha Grama Yojana (SGY), in Karnataka (2001) is also a part of it. This programme includes five main components 1.Paving of internal roads in the village; 2. Constructing sewage systems and storm water drains; 3. Shifting manure pits from residential areas to compost yards; 4. Providing smokeless chulhas; and 5. Providing latrines for households, communities and schools. This programme has been named as Pancha Sutras in order to create a sense of ownership. The GP and community share 10 per cent of the total cost and take up following activities:

- All households, which have minimum space, shall construct household latrine.
- All new houses shall have an attached household latrine, including reconstructed houses.
- Houses constructed by the state under 'Ashraya' and similar housing schemes shall be constructed with household latrines.
- Group latrines with individual ownership.

The contract for construction activity shall be awarded after community mobilises the required amount and deposits them in a designated bank account. The construction work is assigned to The Karnataka Land Army to keep the uniformity in standards.

3.9. Combining sanitation with water supply programs

Similarly, the bilateral and multilateral agencies such as World Bank, DANIDA and Dutch agencies also designed IRWSS programmes and implemented across states in India. This programme provides the community a choice and a voice in selection of services and implementation.

The number of villages covered under each agency and the funds allotted is provided in Table 3. In the first stages, World Bank covered 1104 villages, followed by DANIDA and Netherlands in descending order. The environmental sanitation components include small side-surface drains for sullage, bathing cubicles, cattle troughs, washing platforms, individual latrines, dustbins and biogas pilot plants.

Table 3: Combining Water and Sanitation services.

Agency Name	Amount Allocated (Crores)	Districts Selected	Villages covered
World Bank	506	12	1104
Netherlands	88.71	5	201
DANIDA	63.63	5	719
Sector reforms (GOI)	120	3	1026*

Note: * Schemes,

Source: Annual Report, GOK, RDPR 2002-03.

3.10. Promotion through Reward system

To add strength to Total Sanitation Campaign (TSC), Government of India separately launched an award scheme (2003) naming it as "Nirmal Gram Purskar" for fully sanitised and free from open defecation Gram Panchayats, Blocks and Districts. The eligibility for this 'puraskar', is that the respective Gram Panchayats, Blocks and Districts should achieve 100 per cent sanitation coverage in terms of (1) individual households; (2) schools; (3) dry latrines and manual scavenging and (4) clean environment maintenance. Apart from this, the purskar is given to individuals and organisations, which have been the driving force for effecting full sanitation coverage in the respective geographical area. The incentive amount varies between Rs. 2 lakh to Rs. 50 lakh, which can be used for augmenting sanitation facilities by the concerned PRI (CRSP, GOI 2004).

Borban – A 'Hagandari Mukt Gaon'

Borban is a small community of about 185 families in Sangamner Taluka of Ahmednagar district in Maharashtra. This village bagged second prize at the district level competition. Each household constructed a household toilet. Leadership of village Sarpanch, who stood guarantee for the material and the district administration which made low cost technology available to them, has contributed to their success. In fact the village now imposes a fine if anyone is seen continuing the old practice. The community solidarity and status has become a model for the entire district.

Source: Notes from field visits by ISEC Team under the Project on Restructuring Local Environment Management in Karnataka, January 2004.

Since October 2003, this programme is being implemented in Maharashtra under the name 'Sant Gadge Baba Village Sanitation Campaign'. This programme is extended and now includes water supply, personal hygiene and family welfare. These come into play now while evaluating performance under Gram Swachhata Abhiyan. Gram Panchayats which actively participate in the campaign shall be awarded cash prizes which will go to first 3 Gram Panchayats from each district. One Gram Panchayat will also be declared as the cleanest in the State. The prizes will be given in the name of 'Rastra Sant Tukodji Maharaj'. Borban, one of the villages which received the second prize, is featured above.

3.11. Review Outcome

A quick review of the different strategies mentioned above brings out that the programmes have not created enough awareness to prioritise sanitation services on par with other needs, such as water, electricity, etc. For instance, since 1986 around 9 lakh IHLs were constructed, among them the largest number was constructed under NGY, which stands at about 6.9 lakh (GOK, DES, 1998).

Apart from coverage, when it comes to use of latrines, it is distressing to note that many households do not use even the existing ones. A field study by the State government pointed out that 13 per cent of constructed latrines were misutilised and 3 per cent non-utilised. It is significant to note that misutilisation of latrines stands higher in Bijapur (69 per cent), Gulbarga (56 per cent) and Raichur (51 per cent). While in Raichur, around 40 per cent of the latrines were found to be in use as bathrooms, in Gulbarga 34 per cent were put to other uses (GOK, DES, 1998). An impact study by a research scholar revealed out that many latrines constructed under IRWSS as well as under housing programmes (Janata, Ashraya) were being used as storage rooms (Veerashekharappa, 1999). This was supplemented by another study which stated that out of 19 villages studied, six villages in Gulbarga, Dharwad and Belgaum districts do not have even a single latrine (STEM, 2001). The studies on individual sanitation facilities have revealed that demand and inclination to have IHLs largely depends on social and economic factors. Use of private latrines is found only among Brahmin, Lingayats, Vokkaliga and Muslims (NICD, 1991). This observation was reviewed by an ISEC study which came to the conclusion that there is a positive relation between caste hierarchy and adoption of private household sanitation facilities and connection of water Tap (Veerashekharappa, 2003). Another argument explaining the relatively poor demand for the IHL was that, in rural area 85 per cent of the households do not assign high priority to latrine construction (Lathamala, 1996; Veerashekherappa, 1999). Thus, despite the subsidy, the achieved targets are low. For instance Table 4 shows that the progress is very slow. In the last seven years, there has only been an addition of 20 per cent coverage of households under rural sanitation-an average of 3 per cent per year. Financial expenditure shows that the amount spent each year on allocation is insignificant. For instance, under total sanitation project the total budget was Rs 594 crore for the year 2005-06 and the amount released Rs 130 crore. The amount spent by March-end of 2006 is Rs 11 crore and by March 2007, Rs 73 crore in cumulative. Thus, the implementation of the programme by government is very slow.

Table 4: Coverage of household with toilets (Per cent)

Description	Year	Total Households	Total Households with Toilets	Total Households without toilets	Coverage in Percentage
Census	2001	66,75,175	1161259	5513914	17
Base Line Survey	2004	69,62,238	1553195	5409043	22
Department	March 31, 2007	69,62,238	2544190	4418048	36

Source: Government of Karnataka , RD & PR Annual Report 2006-07, P 42.

The 'demonstration effect' and the compulsion on elected member to construct latrines in their own houses have led to significant increase in latrine construction (GOK, 2000). However, the introduction of community share in capital investment, under SGY and IRWSS programme, did not show impressive results because in most villages the community contribution has come from political parties rather than households. For instance, based on the VWSC data, out of hundred sample villages, 10 to 70 per cent of the required amount has been mobilised from parties rather than from household contributions, viz., Grama Panchayats, Cooperative societies, shops and industrial establishments, fairs and festivals, property tax, and contractors (Veerashekharappa, 2003). Fifty per cent of the villages under the programme in Gulbarga and Belgaum districts did not mobilise the agreed amount (Rajasekhar and Veerashekharappa, 2003). Delays in the implementation of the scheme have also discouraged community contribution (Veerashekharappa, 1998). In fact, the total community contribution stands at Rs 130 million against the targeted Rs 300 million. Though factors influencing adoption of the IHLs may vary across the programmes and location, (Veerashekharappa, 1999), but the commonly observed factors are:

- Lack of space
- Closely built clusters of houses
- Non-affordability among poorest of the poor.
- Unsuitability of the site due to rocky strata or water logging.
- Reluctance of people to have latrines located next to or within their houses; and
- Low priority to the IHL, due to scarcity of drinking water.

Mavalankar and Shankar (2004), cite the following reasons to explain the failure of sanitation projects:

- Lack of political will
- Low prestige and recognition of the importance of sanitation
- Poor policy framework at all levels
- Inadequate and poorly used resources
- Inappropriate approaches
- Neglect of consumer preferences and low public awareness
- 'Women and children last' is the policy followed in many programmes and
- Plans lack of public health leadership

Lessons Learnt and Conclusion

There are several lessons learnt from the above programmes and strategies. However, the household-level awareness and cultural factors are the most important. The IEC is more effective if the village as well as the household has achieved a critical minimum level of development. Hence, the IEC materials have to be designed according to village requirements, at project initiation stage and at the intervention. The variation across households in deriving benefits from the programme depends on the design of the project as well as awareness of the household. Wherever the provisions of sanitation services were linked with the village/community contribution or private household connection (PHC) for water, the demand for sanitation is very insignificant. Further, the field-level observation and experience shows that the VWSC committee or persons involved in the process of implementation at the grass root level were functioning as licensing authorities instead of promoting the latrine construction. This abstained many poor from approaching authorities for sanitation services.

To encourage weaker sections, though seats were reserved for them in the CBOs, their representation is less than 20 per cent (supposed to be 33 per cent) and their participation is insignificant (Veerashekharappa 1999). Moreover, the decision to implement several interventions in a single program does not guarantee that they will advance at the same pace. Thus, though the programmes have been designed keeping the objective of "community-led" , "people-centered" and "demand-driven", with emphasise on IEC and Human Resource Development, the constraints have been observed at the design level and at the implementation stage. In nutshell, the following points emerge from the study:

1. The current awareness campaigns have not led to a change in the mindset of the households/people to accord high priority to latrine construction in all the cases where such campaigns were held.
2. Due to lack of efficiency in the implementation process, community contribution did not take place to the expected level (implementation delays discouraged construction)
3. Past experiences suggest that participation of bureaucracy and politicians in the latrine construction programme should be minimised.
4. As the space/land is major constraint in the construction of IHLs, the community sanitary complexes need to be promoted, based on the experiences of projects initiated in Tamil Nadu and Sulabh toilets.

Over the years, a variety of approaches have been used to motivate individual and communities to adopt better sanitation practices to reduce the sanitation-related disease. At the level of government, there is recognition of the need to promote household sanitation. But, the present pace of progress takes more then 50 years to have 100 per cent household coverage.

To ensure provision of certain minimum level of sanitation at the household level, multi pronged and sustained programme is needed. It is necessary to rationalise the present approach in terms of different programmes and strategies. The experience so far suggests that the role of education, leadership, finances and social mobilisation are all important factors in promoting sanitation practices by the households. Therefore, the multi-pronged strategy should include a strong and sustained mass education campaign, backed by efforts to mobilise communities to take it up as a mission rather than a programme.

Annexure 1: Percentage of HHs covered by IHL

NSS Round	Survey period	Per cent of HHs with access to IHL	
		Rural	Urban
1	2	3	4
28th	Oct 73 – June 74	4	24.1
38th	Jan – Dec 1983	5.9	26.8
44th	July 88 – June 89	8.2	36.7
49th	Jan-June 1993	10.2	40.4
54th	Jan – June 1998	13	46.1

Source: NSS 54th July 1999.

Privatisation of Sanitation Services

The Rural Sanitary Marts programme in Uttar Pradesh aimed specifically to shift from a subsidy-based programme to a privatised one. Over the years, it was noted that offering a much lower subsidy actually increased the sanitation coverage. This idea was replicated in several other States. In Allahabad, the RSMs went further to 'no subsidy'. Between 1993 and 1998, they sold over 35,000 latrines sets. Under the traditional subsidy system, this would have cost the Government $17.5 million. Under the new system, it only costs $60,000 of external support plus managerial support for one-and-a-half years.

Source: UNICEF, Vision 21: Water supply & Sanitation collaborative Council.

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