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Swachh Bharat Mission: Awareness Strategies, Implementation and Issues

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SWACHH BHARAT MISSION: AWARENESS STRATEGIES, IMPLEMENTATION AND ISSUES

D Rajasekhar and R Manjula[1]

Abstract

Access to basic sanitation is fundamental to human development and central to the eradication of poverty and gender inequality. Sanitation as a comprehensive term means more than the construction of toilets. It includes measures to bring in behavioural change through Information, Education and Communication (IEC). Swachh Bharat Mission (SBM), a flagship programme implemented in India since 2014, placed considerable emphasis on behavioural change among people in rural areas to promote good sanitation practices. The Indian government, however, noted that despite the centrality of IEC in SBM adequate attention is not given to the behaviour change through IEC and that state governments did not perform well in the expenditure of allocated funds leading to a detrimental impact on quality and quantity of the programme.

This paper, therefore, reviews the implementation of IEC strategies for promoting sanitation activities in rural areas as part of SBM in Karnataka and provides policy suggestions that are required for sustainable sanitation practices. With the help of primary data collected from 30 Grama Panchayats, 60 villages (through focus group discussions) and 900 sample households in five representative districts of Karnataka, this paper concludes that the implementation of IEC activities varied across districts, GPs and villages, and the impact of IEC strategies at the household-level was mixed. Policy suggestions to improve the implementation of awareness of swachh bharat are made in the paper.

Introduction

Swachh Bharat Mission (SBM), a flagship programme implemented in India since 2014, placed considerable emphasis on behavioural change among people in rural areas to promote good sanitation practices. Information, Education and Communication (IEC) strategies have therefore become an integral component of SBM, and activities to promote awareness and bring about behavioural change were initiated from the beginning. In addition, planning and effective implementation of IEC activities become very crucial if Swachh Bharat is to become successful.

However, GoI (2017: 2) notes that "despite the centrality of IEC in Swachh Bharat Mission, states have not given adequate attention to the behaviour change through IEC". It has been found that states did not perform well in spending the IEC funds allotted. GoI (2017: 6) noted that, in Karnataka, the proportion of IEC funds utilised was only 16.7% of the total in 2016-17. GoI also noted that such a poor performance in fund utilisation leads to inadequate behavioural change and a detrimental impact on the quality and quantity of the programme.

Objectives and Methodology

It is in this context that this paper reviews the implementation of Information, Education and Communication (IEC) strategies by the decentralised government for promoting sanitation activities in rural areas as part of the Swachh Bharat Mission in Karnataka. The specific objectives are to: a) discuss the SBM guidelines on IEC; ii) analyse the implementation of IEC activities in rural Karnataka; and iii)

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assess the extent to which IEC activities influenced behavioural change that is required for sustainable sanitation practices.

Multi-stage sampling method was adopted to select the study localities and sample households. In the first stage, five representative districts of Karnataka (Belagavi, Chamarajanagara, Dakshina Kannada, Davanagere and Kalaburagi) were selected. In the second stage, two taluks were selected from each district based on the development status[2]. In the third stage, three Grama Panchayats (GPs) were randomly selected from each of the selected taluks. The total number of GPs covered in the study was thus 30. From each GP, two villages were selected based on the distance from the GP headquarter village – one is the farthest village and the second is the GP headquarter village. In all, 60 villages were selected from 30 GPs. In the final stage, 15 households from each village were randomly selected. The total number of households covered in the study was thus 900. A structured questionnaire was prepared to elicit information from the sample households, and a checklist for collecting secondary data and other information from sample GPs. The data were collected from May-June 2019.

After this introductory section, policies followed in India for promoting sanitation (with a special focus on SBM) and training provided to functionaries of sample GPs are discussed in Sections 2 and 3. In the third section, the SBM guidelines for IEC are discussed. After presenting the evidence on IEC Strategies implemented in the sample GPs and villages in the fourth section, the impact of IEC on behavioural change is assessed with the help of household-level data in the fifth section. Conclusions and policy suggestions are presented in the last section.

Policies on Rural Sanitation in India

Access to safe drinking water and basic sanitation is fundamental to the human development of a region or a country and is central to the eradication of poverty and gender inequality. World Health Organisation defines sanitation as the provision of facilities and services such as toilets, and safe management (containment, storage, treatment and disposal) of human excreta[3]. On the other hand, UNICEF views sanitation as a comprehensive term which means more than toilets and includes measures that reduce human exposure to diseases and bring in behavioural change through IEC[4]. In 2000, the United Nations General Assembly recognised sanitation as a human right. Sanitation through the use of latrines/toilets and solid and liquid waste management (especially human excreta) can have a strong positive effect on human health as it decreases the incidence of diseases, extends life expectancy, and promotes effective behavioural change. In the same year, the Millennium Development Goals (MDGs) were declared, and Goal 7 aimed at a target to halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.

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[2] With the help of District Human Development Reports (http://planning.kar.nic.in/hdr-karnataka.html), two taluks from each sample district were selected; accordingly, one most developed taluk (obtaining the highest rank) and the least developed taluk (obtaining the lowest rank in the district).

[3] For details, visit https://www.who.int/topics/sanitation/en/.

[4] https://www.unicef.org/wash/3942_43084.html

In the last two decades, considerable progress has been made in achieving the United Nations Millennium Development Goal to provide access to sanitation where 2.1 billion people have gained access to improved/ basic sanitation (WHO/UNICEF JMP, 2015). Despite these efforts, 946 million people still openly defecate (9 out of 10 live in rural areas), 2.4 billion people lack access to basic sanitation (7 out of 10 in rural areas), 663 million lack access to basic water sources, and diarrhoea is the second leading cause of death in children under five much of which is preventable by clean water and sanitation (WHO/UNICEF JMP, 2015; WHO, 2017). Sustainable Development Goal (SDG) 6, therefore, aims to achieve equitable access to safely-managed water and adequate sanitation for all and end open defecation by 2030. According to United Nations in 2015-16, 63.3% of rural households and 19.7% of urban households were not using improved sanitation facilities[5].

Indian government started to give priority to improving sanitation with effect from the Sixth Five Year Plan (1980-85)[6]. In this Plan, the main aim was to initiate pilot projects in all the Indian states. An important objective of these pilot projects was to assess the community attitudes in the rural areas to the type of latrines to be provided and the nature of sanitation facilities needed. At the end of the Sixth Five Year Plan, only less than one per cent of the rural population was covered with sanitation facilities and this was considered to be low. It was also found that the funds allocated to rural sanitation were inadequate.

The first nationwide programme of rural sanitation was Central Rural Sanitation Programme (CRSP)[7] introduced in 1986. This programme, implemented for over a decade during the period 1986 to 1998, assigned priority to the development of infrastructure through the construction of household toilets. A single technology model (double pit pour-flush toilets) was promoted by providing subsidies to generate demand from needy households. The programme was supply-driven, highly subsidy-oriented and infrastructure-oriented for improving the quality of life of the rural people and providing privacy and dignity to women. Despite considerable importance given to rural sanitation in the 1990s through CRSP, the progress in rural sanitation was found to be slow. The Census of 2001 found that only 22% of rural households had access to toilets. The major problem was that this programme could not motivate rural households to construct individual toilets, and also effect behavioural change to end open defecation.

Total Sanitation Campaign (TSC) was the next programme introduced to end open defecation. Introduced in 1999, this was a demand-driven, community-led approach to total sanitation. It mainly focused on targeting communities, villages, and local governments and the use of Information, Education and Communication (IEC) to mobilise and motivate communities towards safe sanitation. Under TSC, the funding for Individual Household Latrine (IHHL) was confined to BPL households. The amount of assistance started at Rs. 1,500 and then increased to Rs. 2,500 and then to Rs. 3,000. Subsequently, the scheme was extended to both BPL and APL families with the financial assistance of

[5] http://in.one.un.org/page/sustainable-development-goals/sdg-6/

[6] http://planningcommission.nic.in/plans/planrel/fiveyr/6th/6planch23.html

[7] https://mdws.gov.in/sites/default/files/TSCGuideline2007_0.pdf

Rs. 3,700 per latrine and assistance was also provided to rural institutions[8]. The cost-sharing ratio between the Centre and States was 70:30 respectively.

Nirmal Gram Puraskar (NGP) was introduced as a component of, and to give a fillip to, TSC in 2003. The main objective of NGP was to achieve open defecation-free (ODF) rural India by 2022. NGP incentivised the achievement of collective outcomes in terms of 100% achievement of total sanitation by a Gram Panchayat (GP). It gave fiscal incentives in the form of a cash prize to local governments that achieve 100% sanitation (100% ODF). TSC, that was existing from 1999 to 2012, contributed to some improvement in rural sanitation. According to the Census data, sanitation coverage increased from 22% in 2001 to 31% in 2011. Ghosh and Cairncross (2013) analysed the progress of sanitation across different states and districts in India with the help of Census data of 2001 and 2011. Their study revealed wide disparities between states, and between urban and rural areas. UNICEF found that 72% of the rural population did not have access to toilets in 2006. The study on TSC by Hueso and Bell (2013), undertaken in Himachal Pradesh, Haryana, Madhya Pradesh and Uttar Pradesh, found that the implementation of the programme was not very well aligned with the guiding principles of the programme. They argued that, as against the guiding principles of demand-led, community-based and spearheading of information on the importance of sanitation, TSC turned out to be government-led, infrastructure-centred, subsidy-based and supply-led. This is further supplemented by Ghosh and Cairncross (2013) who found a close association between district sanitation coverage and female literacy, suggesting an important role for education.

Realising that a generation of stronger demand from the public is necessary, Nirmal Bharat Abhiyan (NBA) was introduced in February 2012. NBA prioritised the creation of stronger demand through the emphasis on Information, Education and Communication (IEC) to achieve the Millennium Development Goals. It aimed to achieve sustainable behavioural change with the provision of sanitary facilities in all communities in a phased, saturation mode with 'Nirmal Grams' or clean villages as outcomes. It was found that there was an increase in the number of toilets constructed; but, the programme could not lead to a decline in open defecation in a sustainable manner, mainly due to the following reasons: first, the absence of large-scale IEC (information, education and communication) campaigns to bring about behavioural change, and secondly, poor quality, incomplete, and non-maintenance of toilets and related infrastructure.

Swachh Bharat Mission

The latest one in the long list of initiatives to improve sanitation in rural areas is Swachh Bharat Mission (SBM), and an attempt has been made to address the weaknesses of the earlier sanitation programmes and widen the scope by including solid and liquid waste management. This is a national-level sanitation programme to achieve the vision of a "clean India" (open defecation free) by 2nd October 2019. However, some states voluntarily committed to achieving ODF status by 2nd October 2018, which is one year ahead of the national deadline.

[8] The grant fixed for other institutions for toilet construction were as follows: Anganwadi Rs.5,000, School Rs.20,000, Community Complex Rs.3.5 lakh, Production Centres (PC) and Rural Sanitary Mart (RSM) a maximum of Rs.3.5 lakh.

The Mission aimed to improve the levels of cleanliness in rural areas through solid and liquid waste management activities and making Gram Panchayats Open Defecation Free (ODF), clean and sanitised through components like construction of individual household toilets, community and public toilets and waste management. The main objectives of the Mission are to:

- Bring about an improvement in the general quality of life in rural areas by promoting cleanliness, hygiene and eliminating open defecation;
- Accelerate sanitation coverage in rural areas to achieve the vision of Swachh Bharat by 2nd October 2019; and,
- Motivate Communities and Panchayati Raj Institutions to adopt sustainable sanitation practices and facilities through awareness creation and health education.

The Mission has two sub-missions, the Swachh Bharat Mission (Gramin) and the Swachh Bharat Mission (Urban), to achieve Swachh Bharat by 2019. The Ministry of Urban Development (MOUD) is in charge of the Swachh Bharat Mission (Urban) and the Ministry of Drinking Water and Sanitation (MDWS) is in charge of the Swachh Bharat Mission (Gramin) and the overall mission is coordinated by MDWS. SBM (Gramin) focuses on the construction of Individual Household Latrines (IHHL), Community Sanitary Complex (CSC), Institutional Toilets such as school toilets and Anganwadi toilets, Solid and Liquid Waste Management (SLWM) and Information, Education and Communication (IEC Activities).

The state of Karnataka is known for decentralised reforms in India and has been one of those states where Panchayat Raj Institutions (PRIs) have done concerted efforts to make all villages open defecation-free (ODF) and achieve high sanitation levels. The Swatch Bharat Mission in the state of Karnataka has undertaken several activities to promote sanitation in the state; of them, an important one is to provide financial assistance for the construction of individual toilets at the rate of Rs 15,000 to SC/ST households and Rs. 12,000 for other households.

According to the SBM portal, 27 out of India's 36 states and Union territories are now open defecation-free (ODF) with 98.6% of Indian households having access to toilets[9]. In Karnataka, rural areas have been declared as 100% open defecation-free, Urban Karnataka still has a long way ahead as it has achieved coverage of only 50.84% from 30% in 2014[10]. The progress of SBM is therefore impressive, as per the administrative data.

Evaluation reports and studies also argue that the focus of this programme should be more on people using the toilets rather than just the number of toilets constructed. The 51st Standing Committee on Rural Development[11] report terms the actual progress of SBM as lethargic and stresses that much more needs to be done to change the behaviour of the rural population. The report states: "*Even a village with 100 per cent household toilets cannot be declared open defecation-free till all the inhabitants start using them*". Similarly, the report raises several questions about the low spending of

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[9] http://sbm.gov.in/sbmReport/Home.aspx (Assessed on 2/8/2019).

[10] https://swachhindia.ndtv.com/karnataka-is-open-defecation-free-says-chief-minister-h-d-kumaraswamy-28104/, and https://health.economictimes.indiatimes.com/news/policy/karnataka-achieves-open-defecation-free-status-in-rural-areas/66690125

[11] 51st Standing Committee on Rural Development (2017-18), Ministry of Drinking Water and Sanitation, Delhi. Available at: http://www.indiaenvironmentportal.org.in/files/file/Rural_Development.pdf

funds earmarked for this Mission, especially the funds for carrying out "Information, Education and Communication" activities. With this background, let us now examine the awareness activities undertaken in Karnataka.

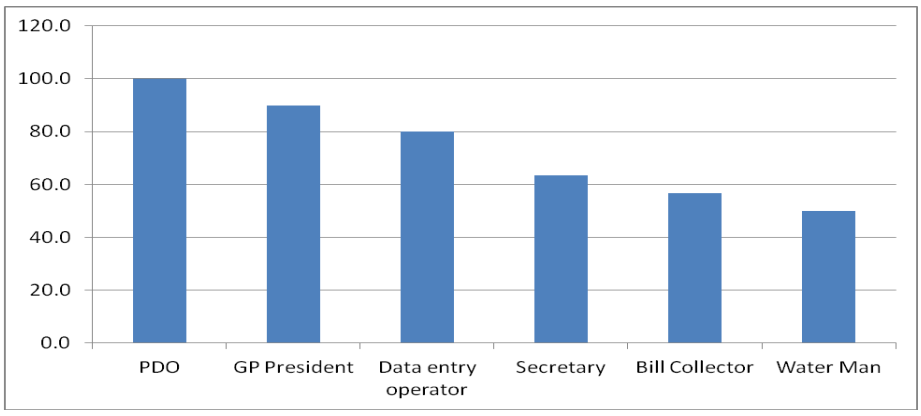
Training on Swachh Bharat

SBM guidelines note that behavioural change among people is possible when proper knowledge is imparted to all stakeholders at various levels including at the village/GP level. The guidelines stipulate that training workshops to this effect need to be undertaken at the state, district and block levels. In so far as the block-level training workshops are concerned, the following are suggested in the guidelines: i) Training of village motivators on community-led total sanitation approaches; ii) Training of PRIs to familiarize them with the programme; and, iii) Training of Teachers on Water, Sanitation and Hygiene (WASH) issues.

Figure 1 shows that all the Panchayat Development Officers (PDOs) and GP presidents from about 85% of the sample GPs attended SBM training.

Interestingly, Data Entry Operators (DEOs) from 80% of the sample GPs attended the training on SBM. Such a high proportion of DEOs attending the training is mainly because of the introduction of the Electronic Fund Monitoring System (EFMS) in 2016-17. As per this system, the incentive fund to households for constructing individual toilets will be deposited to the beneficiary bank account. EFMS account was created in the State Bank of India by the State government. The incentive grant is credited into the accounts of beneficiaries. DEOs were trained because they had a specific role in the EFMS system. Every GP has to check the completion of the construction of the toilet (foundation and final structure) and a photograph of the completed toilet along with a certificate has to be uploaded to the website/account for the release of the grant. As DEOs were expected to undertake this task, they were trained on what documents to be collected from beneficiaries and how to upload them onto the website. This has to be done at three points in time; when the place for the construction of the toilet is identified, a pit is dug and when a toilet is fully constructed. Hence, training was given to a large proportion of them.

Figure 1: GP functionaries (%) attending SBM training from sample GPs



Source: Data collected from sample Grama Panchayats

In contrast, the Secretary from only about 60% of the sample GPs attended training because this functionary was not posted in all of them. Since watermen were appointed as Swachhaagrahis [persuaders (or enforcers) of cleanliness] in the SBM to undertake house visits and motivate households to go for individual toilets, training was also provided to them. On the whole, training was imparted to almost all GP functionaries based on their availability and needs.

The training provided was overlapping the functionaries in sample GPs. In general, the training focused on the following: a) how to motivate the community to construct and use toilets, and end open defecation through awareness provision, household visits and continuous follow-up; b) Advantages of having a toilet; c) Solid and liquid waste management, and d) preparation of work orders for toilet construction. While the first three were common to all the functionaries, financial aspects were emphasised in the training provided to DEOs.

When did GP functionaries obtain training? It can be seen from Table 1 that most of the GP functionaries obtained training during the period 2016-17 to 2018-19. The proportion of functionaries obtaining training during this period was nearly 87% in the case of PDOs, 78% in the case of GP presidents, nearly 48% in the case of secretaries and about 70% in the case of DEOs. This suggests that the SBM activities in the sample GPs have picked up from 2016-17 although SBM was introduced in the state in 2014.

Table 1: Distribution (%) of GP functionaries by the year of training

GP functionaries	2012-13	2014-15	2015-16	2016-17	2017-18	2018-19	No training
PDO	6.6	6.7	10.0	26.7	26.7	23.4	0.0
Secretary	0.0	6.7	10.0	0.0	30.0	16.7	36.7
GP President	0.0	6.7	3.2	16.7	36.7	26.7	10.0
Bill Collector	0.0	6.7	0.0	20.0	20.0	10.0	43.3
Data entry operator	0.0	6.7	3.3	26.7	36.7	6.7	20.0
Waterman	0.0	3.3	0.0	16.7	16.7	13.3	50.0

Source: Data collected from sample Grama Panchayats

This is corroborated by the evidence provided by sample GPs on the year of starting of SBM activities in their jurisdiction (Table 2). SBM activities in Davanagere and Kalaburagi districts were started in 2016-17, while those in Chamarajanagara and Belagavi started earlier. Thus, Davanagere and Kalaburagi can be termed as the late starters, while Belagavi and Chamarajanagara can be termed as early starters.

Table 2: Distribution of sample GPs (%) by the year of starting of SBM activities

Name of the district	2014-15	2015-16	2016-17	2017-18	2018-19
Belagavi	33.3	50.0	16.7	0.0	0.0
Chamarajanagara	83.3	16.7	0.0	0.0	0.0
Dakshina Kannada	0.0	50.0	33.3	16.7	0.0
Davanagere	16.7	0.0	66.7	16.7	0.0
Kalaburagi	0.0	0.0	66.7	16.7	16.7
All districts	26.7	23.3	36.7	10.0	3.3

Source: Data collected from sample Grama Panchayats

IEC activities under Swachh Bharat Mission

SBM guidelines (GoI 2017) stipulate the following activities can be taken up by States and districts. They can also devise the activities best suiting to their requirements.

CAS Training of Swachhaagrahis

The SBM guidelines note that the most important IEC activity is the training of grassroots motivators or Swachhaagrahis to be undertaken on priority in all the districts. As a part of this, Key Resource Centres (KRCs) were empanelled by the Ministry of Drinking Water and Sanitation to conduct CAS training at pre-approved rates. As per the information provided by the sample GPs, Swachhaagrahis comprising mainly watermen, ASHA workers, and Anganwadi teachers were provided training at the Taluk level and also by PDOs at the GP level.

Triggering and Nigrani

After training, Swachhaagrahis will be asked to visit villages to undertake two important IEC activities, viz., 'triggering' and 'nigrani'. A 'triggering' exercise typically includes the use of a Participatory Rural Appraisal technique to take stock of the situation of sanitation in the village or locality. This will be followed by a discussion with the community on the status of sanitation, problems and the way forward. 'Nigrani' (pro-active watch), which includes an early morning visit to common OD spots in a village, is a follow-up activity to triggering. The main purpose of Nigrani is to reinforce the message or conclusions emerging from triggering. According to the guidelines, Triggering and Nigrani are to be conducted by Swachhaagrahis trained in CAS.

Interpersonal communication

SBM visualised that the human resources required for undertaking IEC activities must come from the localities where sanitation activities are being taken up. The Mission believed that dedicated insiders can often facilitate interpersonal discussions better. As per IEC guidelines (GoI 2017), a cadre of Swachhaagrahis will be selected and well-trained in CAS and other modes of communication for behaviour change. The number of Swachhgrahis, which should be at least one per village, may vary depending on the volume of work. A mechanism to pay monetary incentives to Swachhaagrahis may be laid down, as per the SBMG Guidelines, using IEC funds. Swachhaagrahis are also engaged voluntarily and without any pay, if they show willingness for the same. IEC materials such as flipbooks, pamphlets, posters, etc., need to be provided to Swachhaagrahis to equip them to communicate better.

Song & drama activities

Local artists, singers, *naatakamandalis and* performers from the third gender may be engaged in song, dance and drama performances to encourage people to build and use toilets.

Wall Writing/Painting

SBM believes that once the community has been triggered through community approaches to sanitation, wall writing and paintings can be effective tools for reinforcing the message of Swachh

Bharat constantly to achieve the objective of open defecation-free villages. It is aimed to ensure that messages 'stick' and have an impact on the viewer or listener. Messages to include elements of surprise, humour, emotive appeals, positive reinforcements through celebrating Swachhata champions within the community and narrative formats so that the likelihood of retention of the message is increased.

Hoardings and banners

Outdoor publicity creates a buzz around the Swachh Bharat Mission implementation underway in the district, and can be used to celebrate milestones, and to keep the spirit of *Swachhata* alive in the populace as well as officials.

Digital media

As is well-known, mobiles are being widely used in rural India. It was planned to develop mobisodes (short AV clips) and share the same over mobile phones. Social Media Campaigns may also be explored at the State Level.

Swachhata Rath

These are mobile exhibition vans which can be developed per district and can act like a travelling exhibition. They would contain all information about sanitation practices, toilet technology, printed, digital and audio-visual communication material to impress upon the urgent need for behaviour change regarding sanitation and hygiene.

Implementation of IEC Strategies

The database to ascertain the implementation status of IEC strategies in the jurisdiction of sample areas is the information collected from functionaries of 30 GPs and interviews held with key informants from 60 villages. Thus, the number of observations in the case of sample GPs is 30, while it is 60 in the case of sample villages.

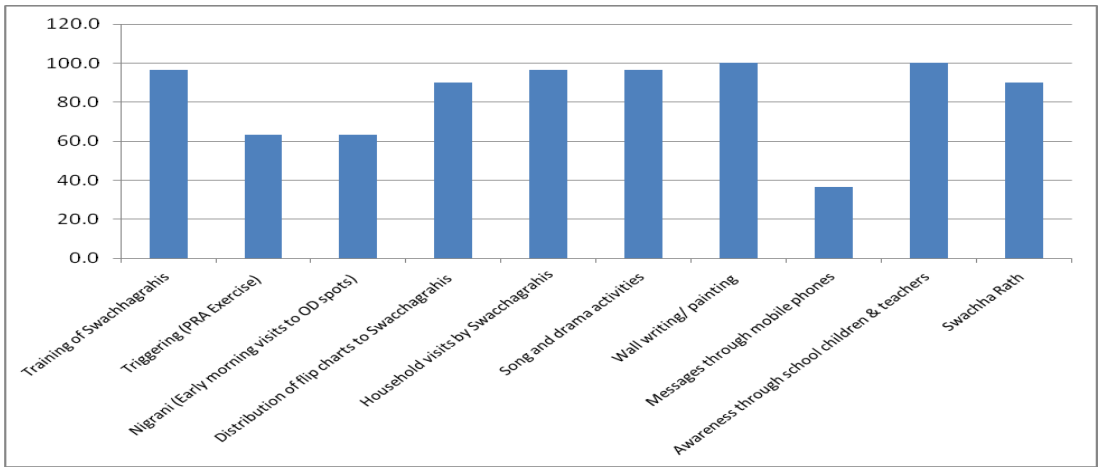
Figure 2 shows that, according to the sample GPs, seven out of 10 IEC strategies were implemented in the jurisdiction of over 80% of the sample GPs. These strategies are: training of Swachhaagrahis, household visits by Swachhaagrahis, song and drama activities, wall writing/ painting, awareness through school children and teachers and swachh rath. Triggering has the potential to bring a significant behavioural change in the community. PDOs informed that street or village-wise PRA exercises were undertaken to identify houses with and without a toilet, and generate a discussion on why some households do not have toilets and how they can build one. Despite the potential, this activity was implemented only in two-thirds of sample GPs.

Officials from GP (and at times from ZP and TP) visited villages early in the morning for undertaking nigrani activities and preventing villagers from practising open defecation. In this, ASHA and Anganwadi workers and watermen have also joined. The methods followed to shame villagers were "loud clapping", "whistling", "focusing torch lights", "threats that CCTV is fixed" and so on. In one of the villages, it was informed that when villagers were prevented they threw water that they were carrying for wash and returned home. In some other villages, villagers picked up quarrels with officials saying

how could they stop so suddenly and that they did not have space and/or money to construct a toilet. The proportion of GPs stating that they have implemented this activity was only around 60%.

Although considerable importance was given to messages through mobile phones as one of the newer forms of information dissemination, this was implemented in less than 40% of sample GPs (Figure 2).

Figure 2: IEC Strategies Implemented by Sample Grama Panchayats (%)



Source: Data collected from sample Grama Panchayats

Interestingly, the district-wise pattern in the implementation of IEC strategies (Table 3) shows that most of the GPs in Belagavi, Chamarajanagara and Davanagere districts have implemented IEC strategies. It is Dakshina Kannada district which seems to be pulling down the overall average figures for the strategies of triggering and nigrani. In this district, these two strategies were not implemented in any of the sample GPs mainly because of two reasons. First, by the time the SBM programme was initiated, the proportion of households without toilets in the sample GPs from this district was just 2.7%! This was very low compared to 81% in Chamarajanagara and 64.9% in the Davanagere district. Given the small number of toilets to be constructed in each GP and widespread levels of literacy and awareness, IEC strategies that aim to motivate the public (triggering) and shaming people (nigrani) were not considered to be essential. Second, the scattered settlement pattern of households also makes it difficult to implement the IEC strategies of triggering and nigrani. It should be, however, noted that more than two-thirds of the sample GPs in the district stated that they have relayed messages through mobile phones – an advanced form of information dissemination.

Table 3: District-wise Pattern in the Implementation of IEC Strategies in Sample GPs

Strategies	Belagavi	Chamaraja-nagara	Dakshina Kannada	Davana-gere	Kala-buragi
Training of Swachhaagrahis	100.0	100.0	100.0	83.3	100.0
Triggering (PRA Exercise)	83.3	83.3	0.0	83.3	66.7
Nigrani (Early morning visits to OD spots)	83.3	66.7	0.0	83.3	83.3
Distribution of flip charts to Swachhaagrahis	83.3	100.0	66.7	100.0	100.0
Household visits by Swachhaagrahis	100.0	100.0	83.3	100.0	100.0
Song and drama activities	100.0	100.0	83.3	100.0	100.0
Wall writing/ painting	100.0	100.0	100.0	100.0	100.0
Messages through mobile phones	33.3	50.0	66.7	16.7	16.7
Awareness through school children & teachers	100.0	100.0	100.0	100.0	100.0
Swachha Rath	83.3	100.0	100.0	83.3	83.3

Source: Data collected from sample Grama Panchayats

We have also collected evidence on the spatial pattern in the provision of awareness in the jurisdiction of sample GPs. This information becomes important because IEC activities may have been implemented in all villages in the jurisdiction of GP, or a few villages or only in GP headquarter village. Table 4 shows that household visits by Swachhaagrahis, awareness through school children and teachers and swachha rath are likely to be implemented in all villages. On the other hand, the activities of triggering, nigrani, wall writing/ painting and messages through mobile phones are likely to be implemented only in a few villages. This is only to be understood given that the resources (money, time and effort) required for the implementation of triggering, nigrani and wall writing/ painting are high. This implies that the sample GPs have prioritised those IEC strategies which are easy to implement as compared to those which need more money and time. The policy implication is that more resources are to be allocated if the policymakers are keen on IEC strategies of triggering, nigrani and wall writing/ painting.

Table 4: Spatial Pattern of Awareness Provision in Sample GPs

Strategies	All Villages	A few villages	Only GP HQ village
Triggering (PRA Exercise)	5.3	84.2	10.5
Nigrani (Early morning visits to OD spots)	15.8	73.7	10.5
Distribution of flip charts to Swachhaagrahis	14.8	85.2	0.0
Household visits by Swachhaagrahis	93.1	6.9	0.0
Song and drama activities	41.4	44.8	13.8
Wall writing/ painting	16.7	76.7	6.7
Messages through mobile phones	18.2	81.8	0.0
Awareness through school children & teachers	76.7	20.0	3.3
Swachha Rath	60.0	23.3	6.7

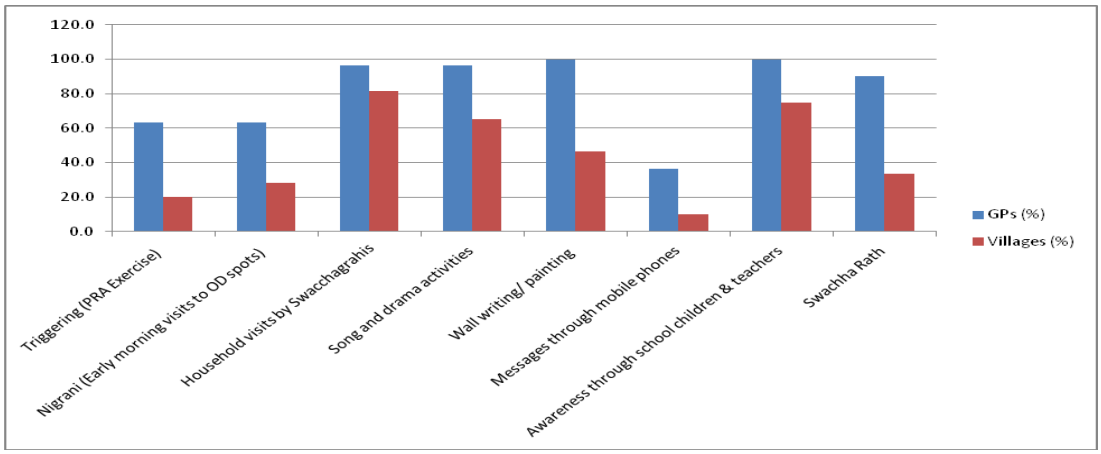
Source: Data collected from sample Grama Panchayats

An attempt is made to ascertain the implementation of IEC activities at the village level. For this purpose, discussions were held with key informants in a group. From Figure 3, it can be seen that there is a variation between claims made by officials of sample GPs and the status of implementation as per the information provided by key informants (KIs) in sample villages. There is not much gap between claims of GPs and KIs in the case of household visits by Swachhgrahis and awareness through school children and teachers implying that these two strategies are widely implemented. The gap is moderate in the case of songs and drama activities. However, the gap is very wide in the case of triggering, nigrani, messages through mobile phones and Swachh Rath indicating that these strategies are widely implemented.

KIs confirmed the implementation of triggering in a few villages. According to them, GP functionaries, GP president, Anganwadi worker and Asha worker visited the villages for conducting PRA exercises. In these PRA meetings, villagers were asked to go for toilet construction; otherwise, they were threatened that the ration card will be cancelled.

There was resistance to nigrani activities and villagers disapproved of the shaming activities because they could not suddenly stop open defecation. They believed that toilets could not be constructed because of lack of space and money. In one of the villages, the PDO snatched the mug from a person going for open defecation and threw the water down. Enraged, the villager retaliated and attempted to manhandle the PDO. He was upset that such shaming activities are not proper given that households could not go for toilets on account of space and monetary constraints.

Figure 3: IEC Strategies Implemented by Sample GPs and Villages



Source: Data collected from Key Informants from sample villages

Table 5, which provides information on the implementation of IEC activities in sample villages by district, shows that IEC activities were implemented well in Chamarajanagara, Davanagere, Kalaburagi, and Belagavi districts, in that order. On the other hand, these activities were not very well implemented in Dakshina Kannada. The reason for this is, as noted earlier, that the proportion of households without a toilet was very less in most of the sample GPs in the district when SBM was started in 2014. Understandably, therefore, the preference given to the implementation of IEC activities aimed at toilet construction was less.

Table 5: Implementation of IEC Activities in Sample Villages by Districts

IEC activities	Belagavi	Chamaraj -nagara	Dakshina Kannada	Davana-gere	Kalaburagi
Triggering (PRA Exercise)	16.7	33.3	8.3	33.3	8.3
Nigrani (Early morning visits to OD spots)	41.7	83.3	0.0	16.7	0.0
Household visits by Swachhaagrahis	75.0	83.3	75.0	91.7	83.3
Song and drama activities	66.7	83.3	25.0	75.0	75.0
Wall writing/ painting	41.7	83.3	25.0	33.3	50.0
Distribution of handbills	25.0	0.0	8.3	58.3	25.0
Messages through mobile phones	8.3	0.0	8.3	16.7	16.7
Awareness through school children & teachers	66.7	100.0	41.7	83.3	83.3
Swachha Rath	50.0	91.7	25.0	66.7	41.7

Source: Data collected from Key Informants from sample villages

Influence of IEC Activities on Behavioural Change

Did sample households notice IEC activities relating to sanitation in the last four years? This question was asked to all the 900 sample households. The responses of sample households, which are presented in Table 6, show that the proportion of households noticing some or the other IEC activity relating to sanitation was 26%. The factors contributing to as many as 74% of the sample households not noticing awareness activities are the following. First, the implementation of triggering was taken up only in 60% of villages leading to not many people participating in the identification of problems of poor sanitation, and offering solutions. Second, the problem of lack of individual sanitation was not uniform at the time of implementation of the SBM, and this contributed to uneven interest in the awareness activities. Third, the scattered settlement pattern made it difficult to implement awareness promotion activities. Fourth, only certain components were implemented in all the villages in the jurisdiction of Grama Panchayat.

The proportion of households stating that they have noticed IEC activities relating to sanitation was comparatively high in Chamarajanagara and Davanagere districts, while it was low in Dakshina Kannada and Kalaburagi. Table 6 thus, confirms the earlier observation that IEC activities were better implemented in Chamarajanagara and Davanagere districts. On the other hand, IEC activities were not very well implemented in Kalaburagi district. There is, therefore, a need to step up efforts to implement IEC activities in backward districts in North Karnataka such as Kalaburagi. In the case of Dakshina Kannada, IEC should focus more on SBM plus activities.

Table 6: Did Sample Households Notice IEC Activities Relating to Sanitation in the Last 4 Years?

	Belagavi	Chamarajanagara	Dakshina Kannada	Davanagere	Kalaburagi	Total
Yes	21.1	38.9	16.1	36.1	20.0	26.4
No	78.9	61.1	83.9	63.9	80.0	73.6
Total	180	180	180	180	180	900

Source: Data collected from sample households

From the policy point of view, it will be of interest to know which SBM activities were noticed by sample households. A larger proportion of households noticed street play and Jatha as compared to other forms of IEC activities (Table 7). There is, therefore, a need to focus more on these two IEC activities in future efforts relating to motivating households to go for toilet construction and use the same.

Table 7: What IEC Activities were Noticed by Sample Households?

Activities	Belagavi	Chamaraja-nagara	Dakshina Kannada	Davanagere	Kalaburagi	Total
Street play	29.8	34.4	17.1	32.4	46.0	32.9
Jatha	26.3	32.5	12.2	33.3	28.0	29.2
Cultural activities	19.3	17.9	12.2	10.2	12.0	14.7
Meetings to promote swachhbharath	10.5	13.2	36.6	14.8	4.0	14.5
House visits by Swachhaagrahis	12.3	1.3	17.1	6.5	10.0	6.9
Others	1.8	0.7	4.9	2.8	0.0	1.7
Total	57	151	41	108	50	407

Source: Data collected from sample households

Given that there is a variation in the implementation of IEC activities and the limited impact of IEC strategies at the household level, there is a need to find what contributed to behavioural change. The literature on SBM shows that threats were used to influence the households to go for toilets. We also find that threats were used by GPs for effecting behaviour change in the community. About 90% of sample GPs stated that they have adopted the threat of "discontinuation of ration card" and "non-sanctioning of future government benefits" if the household does not construct a toilet (Table 8). Key informants have also confirmed this. Key informants from nearly 72% of villages confirmed that Swachhgrahis in their house visits threatened the households that government benefits will be either withdrawn or not sanctioned if they do not construct toilets under SBM. Key informants also stated that these threats were effective. The proportion of sample GPs stating that they have adopted the threat of imposing fines and penalties if anyone resorts to open defecation was less at 37%. Key informants also stated that this threat was not extensively used and that people did not bother about this. At the time of data collection, it was observed in the sample villages that open defecation was practised even in localities where there was a notice board cautioning the public that a fine of Rs. 500 will be imposed on those resorting to open defecation.

Table 8: Extent to Which Threats were Used to Effect Behavioural Change

Behavioural change strategies	GPs (%) stating that this was followed	Villages (%) where it was followed	Key informants stating that this was effective
Discontinuation of ration cards	93.3	71.7	71.67
Non-sanctioning of future government benefits	90.0	71.7	71.67
Threatening to impose fines/ penalties	36.7	11.7	11.67

Source: Data collected from Key Informants from sample villages

We wanted to ascertain from the sample households what motivated them to construct toilets under the SBM scheme. Table 9 shows that over one-third of the sample households were convinced to have their own toilets. In other words, threats did not play a major role in deciding to go for toilets. About 34% of the sample household stated that the decision to go for the toilet under SBM was mainly influenced by threats made by GPs. About 29% stated that house visits by Swachhgrahis played an important role in their decision to go for a toilet.

Table 9: What Motivated Sample Households to go for SBM-Supported Toilets?

	Belagavi	Chamaraja-nagara	Dakshina Kannada	Davanagere	Kalaburagi	Total
IEC	27.9	34.6	100.0	34.4	39.0	35.1
IEC together with house visits	37.7	27.1	0.0	25.8	31.7	28.9
Ration card block	34.4	34.6	0.0	38.7	29.3	34.4
Others	0.0	3.7	0.0	1.1	0.0	1.6

Source: Data collected from sample households

The limited success of awareness strategies has contributed to the limited success of SBM in the sample villages. As far as access to individual toilets was concerned over 71% of sample households were found to be having access to individual toilets (Rajasekhar and Manjula 2019). A comparison of the access between 2014 and 2019 shows that an overwhelmingly large majority of the sample households constructed individual toilets, especially in Chamarajanagara and Davanagere, with the help of funding support provided by SBM. However, the situation continued to be grim in Gulbarga where a majority of the households were without toilets. Two important factors affecting access to individual toilets are high construction costs and space constraints. This shows that the factors constraining poor households to go for toilet construction are not entirely due to lack of awareness and that awareness will address the problem of poor sanitation to some extent, but not to the fullest extent.

Are the toilets constructed used? This question is important because households are expected to value toilets by way of regular use. It was found that as many as 92% of sample households having access to individual toilets were using them (Rajasekhar and Manjula 2019). This proportion was 100% in the developed district of Dakshina Kannada and the least in the backward district of Kalaburagi (68%).

Of the households having access to individual toilets, 88% stated that they do not practice open defecation, while 12% responded affirmatively. The proportion of households practising open defecation even while owning an individual toilet was higher than the state average in Kalaburagi (40%), Davanagere (16%) and Chamarajanagar (13%). The reasons attributed for the continued open defecation were lack of toilet-use culture and water shortage (especially in north Karnataka), high cost of toilet construction and lack of space.

Conclusions

Considerable emphasis is given to the implementation of awareness activities in the SBM. This paper examined the awareness strategies implemented in Karnataka and assessed their impact on bringing behavioural change among rural households. The following are key conclusions.

For proper planning and effective implementation of awareness activities, training was provided to GP functionaries (elected and non-elected) on SBM. However, training to most of the functionaries was given from 2016-17 onwards although SBM was introduced in 2014.

SBM guidelines suggest several IEC activities for implementation by the local government. However, activities such as house visits by Swachhaagrahis, song and drama activities, Jatha by school children and Swachh Rath are the ones which are likely to be widely implemented. On the other hand, activities such as triggering (PRA exercise to identify households without toilets to motivate them to go for toilet construction), nigrani (early morning visits to open defecation spots for undertaking activities of shaming villagers, and stopping the practice of open defecation), messages through mobile phones and wall painting/ writing are less likely to be implemented. GPs from the developed district of Dakshina Kannada did not see the need to implement triggering and nigrani activities as most of the households in their jurisdiction owned toilets and gave up open defecation by the time SBM was introduced in the state in 2014. Further, GPs found that undertaking the activities of triggering and wall writing/ painting not only takes more time but is also costly. Hence, they gave less preference to these activities.

A question was asked to the sample households on what IEC activities relating to sanitation were noticed by them. Although GPs claimed several IEC activities were implemented in villages in their jurisdiction, many sample households stated that they have noticed street play and Jatha more as compared to other IEC activities.

The implementers at the GP level used threats that existing benefits (such as ration cards) will be discontinued and new benefits of the government will not be sanctioned if households do not construct toilets. Such threats contributed to the construction of toilets in several cases. At the same time, they adversely affected the quality of toilets constructed and their use (Rajasekhar and Manjula 2019).

Policy Suggestions

From the foregoing analysis, it is clear that the 'one-size-fits-all' approach will not work in the implementation of IEC strategies. The strategies of triggering and nigrani were not found to be useful in the developed district of Dakshina Kannada. Hence, IEC strategies need to be situation specific. It is suggested that IEC activities relating to SBM plus (solid and liquid waste management) should be implemented in developed districts such as Dakshina Kannada, while IEC should focus on sustainable use of toilets in districts such as Chamarajanagara and Davanagere where there is considerable success in the achievement of construction targets. On the other hand, IEC activities should promote basic knowledge and awareness of the importance of sanitation in backward districts such as Kalaburagi.

As far as the individual components of IEC are concerned, there is a need to combine cultural activities such as mythological plays with messages on sanitation as these are more likely to be noticed

by the rural people. The focus should also be on street plays, Jathas and other cultural activities as these have been mostly noticed by the public.

Swachhaagrahis played an important role in spreading knowledge and awareness on sanitation and motivating rural dwellers to go for individual sanitation. This should be continued in the future.

There is a need to provide incentives to Swachhaagrahis as suggested in IEC guidelines issued by the central government. In the field, it was found that these actors were not paid incentives although initially promised due to administrative constraints and other reasons. This needs to be corrected.

IEC activities targeting school-going children should be continued as it was found that children have started to talk about sanitation and cleanliness at homes to the parents, and thus, implying that these activities will have a considerable positive impact on future citizens. Hence, these activities should continue and focus on SBM plus, sustainable use of toilets and basic sanitation.

To conclude, the programme of SBM focused mainly on the construction of individual toilets. While the programme was successful in some of the districts which hitherto did not have much success in the access and use of individual toilets, it needs to be noted that all the other aspects of Swacchata, such as solid and liquid waste management, were neglected in the sample villages. Given the open defecation continuing in several villages (especially in aspirational districts such as Kalaburagi) and the limited importance given to solid and liquid waste management, there is a need for the SBM to go well beyond the mere construction of individual toilets to embrace the true meaning of Swacch Bharat.

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