To,

The Principal Secretaries/ Secretaries/Commissioners
i/c Rural Sanitation
All States /UTs

August 22, 2014

Subject: **Note on Swachh Bharat Mission - Distribution to State Governments for further discussion on 25th August 2014 in Review meeting**

Dear Sir/Madam,

In the context of the declaration of the plan to achieve Swachh Bharat by 2019, the Ministry of Drinking Water and Sanitation has prepared a Note on the Swachh Bharat Mission.

The note is being enclosed for perusal at the state level. You are requested to examine the note urgently and give your comments and feedback to the proposal during the NBA Review meeting scheduled on 25th August 2014 at New Delhi.

Yours faithfully

-sd-
(Sujoy Mojumdar)
Director (NBA)

Copy to:

1) State Coordinators/ NBA/ All states/UTs
2) JS (Sani), MDWS
3) JS (Water)
4) JD (Stats)
5) PPS to Secretary, MDWS
6) Principal Secretary, DWS, all States
7) Director CCDU, All States
Swachh Bharat Mission

Draft of Note for Distribution to State Governments for discussion on 25th August 2014 in review meeting

Swachh Bharat, Swasthh Bharat

Action Plan

of the

Ministry of Drinking Water and Sanitation

Government of India
Swachh Bharat

The Concept

Mahatma Gandhi said “Sanitation is more important than independence”.

He made cleanliness and sanitation an integral part of the Gandhian way of living. His dream was total sanitation for all.

The concept of Swachh Bharat is to pave access for every person to:-

(a) Sanitation facilities including Toilets, Solid and Liquid Waste Disposal Systems, village cleanliness

and

(b) Safe and adequate drinking water supply.

We have to achieve this by 2019 as a befitting tribute to Father of the Nation Mahatma Gandhi on his 150th. Birth Anniversary.
Action Plan - Achieving a ‘Swachh Bharat’ by 2019 through Swatch Bharat Abhiyan (Rural Areas)

1. Introduction:

To accelerate the progress of sanitation in rural areas, Government of India is implementing from 1.4.2012, the ‘Nirmal Bharat Abhiyan (NBA)’, a Centrally Sponsored Scheme [earlier Total Sanitation Campaign (TSC)]. Similarly, to provide drinking water to rural population in adequate quantity, the Govt. of India is implementing a centrally sponsored Scheme called the National Rural Drinking Water Programme (NRDWP).

2. Swachh Bharat Abhiyan: The present goal under NBA is to achieve 100% access to sanitation for all rural households by 2022. Under Swachh Bharat Abhiyan (SBA), the Goal is now pre-poned to make India Open Defecation Free (ODF) India by 2019 by construction of individual, cluster & community toilets; and villages will be kept clean, including through solid and liquid waste management through Gram Panchayats. Water pipelines have to be laid to all villages enabling tap connection into households on demand by 2019. In this matter, co-operation and convergence of all Ministries, Central & State schemes, CSR & bilateral/multilateral assistance may become necessary as well as new & innovative ways of funding such interventions. In a federal set-up like ours, where sanitation and water are state subjects, it is all the more important that states take the initiative to complete all activities to achieve Swachh Bharat by 2019 by dove-tailing all schemes - Central or State.

3. The need for better Rural Sanitation:

3.1 India is a home to 1.21 billion people, about one-sixth of the world’s population. The rural sanitation coverage in the country was as low as 1% at the beginning of the 1980s. With the launch of Central Rural Sanitation Programme (CRSP) in the year 1986 and the introduction of the Total Sanitation Campaign in 1999, the coverage rose to 22% as per 2001 census. According to the Census 2011, about 72.2% of the Indian population in 16.78 crore households stay in around 638,000 villages. Out of this, only 5.48 crore households (32.7%) had
access to toilets which means that 67.3\% of the rural households in the country still did not have access to sanitation facilities. Later as per the Baseline Survey, 2012-2013, carried out by the Ministry through the States, 40.35\% rural households have been found to have access to toilets. This Ministry goes by Baseline Survey data as this survey covers 100\% rural population and also captures names of households with access and without access which Census 2011 does not share.

3.2 Access to safe drinking water and adequate sanitation, and good hygiene behavior such as hand-washing, have a positive impact for the rural population, and lack of access to these services have adverse health, social and economic effects.

3.3 UNICEF reports indicate that it is the poorest quintile of the population which has the least access to sanitation. Inadequate access to water, sanitation and hygiene services keep children especially adolescent girls out of school, and keeps women in poor health and in poverty and destined to bear and raise children who are sick and nutritionally poor.

3.4 While having a toilet is important for everyone, access to safe, clean toilets brings particular benefits to women and girls. Freed from the need to defecate in the open, they no longer have to suffer the indignity, humiliation and often verbal and physical abuse when relieving themselves. Sexual harassment and rape are a risk for many women who without a household toilet have to wait until nightfall to seek the privacy of darkness outside to relieve themselves. Women and girls don’t need toilet facilities just for defecation; they also need privacy and dignity when menstruating. The symptoms of menstruation, pregnancy and the postnatal periods become more traumatic, if women have no space to deal with them. The need for sanitation facilities within homes and in public places, which meet women’s physical and psychological demands cannot be over-emphasized.

3.5 Separate toilets at school mean more girls are likely to attend, and stay on after puberty to complete their education. There is an immediate need to provide adequate number of toilets separately for boys and girls in all schools of the country.
3.6 As per Lancet 2, a key cause of child under-nutrition is a small intestine disorder known as tropical enteropathy. This is caused by faecal bacteria ingested in large quantities by young children living in poor sanitation and hygiene leads to stunting. The study finds that use of toilets and hand-washing after faecal contact could reduce tropical enteropathy and thereby stunting. This study has important policy implications for India, as accelerating provision of toilets and improved drinking water quality will prevent tropical enteropathy resulting in growth, in better health and survival, of a very large number of children across the country.

4. Current Data on Sanitation in Rural areas

4.1 Census Data

<table>
<thead>
<tr>
<th>Year</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1981</td>
<td>1</td>
</tr>
<tr>
<td>1991</td>
<td>9</td>
</tr>
<tr>
<td>2001</td>
<td>22</td>
</tr>
<tr>
<td>2011</td>
<td>32.70</td>
</tr>
</tbody>
</table>

4.2 NSSO Estimations

<table>
<thead>
<tr>
<th>Year</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>49th Round (1993-94)</td>
<td>14.20</td>
</tr>
<tr>
<td>58th Round (2002-03)</td>
<td>23.70</td>
</tr>
<tr>
<td>65th Round (2008-09)</td>
<td>34.80</td>
</tr>
<tr>
<td>69th Round (2012-13)</td>
<td>40.60</td>
</tr>
</tbody>
</table>

4.3 100% Base Line Survey 2012-13 (by MoDWS)

As per latest Base Line Survey 2012-13 done by State Sanitation Departments, 40.35% rural households have access to toilets. Census 2011 compared to the Baseline survey data is 2 years older and also does not share names with this Ministry, whereas baseline survey does.
4.4 Data of Individual household latrines (IHHL) coverage as fed by States on Ministry’s computerized Integrated Management Information System (IMIS) which came in existence in 2005.

Since 1999, reports from States as well as from the MIS indicate that over 9.65 crore rural households have been covered with toilets (IHHLs) up to 31.3.2014, out of the 17.13 rural households. This neither matches with Census 2011, NSSO estimation nor the Baseline Survey data 2011.
There is a however a strong possibility of over reporting of achievement by the states on the MIS inter-alia due to the following reasons:

(a) Eagerness by GPs to apply for Nirmal Gram Puraskar, which required 100% coverage in applicant GPs.
(b) APL were not eligible for Incentives for IHHLs before 1.4.2012. States could resort to over-reporting again for the Puraskar which cannot be checked with financial release data, as APLs were non eligible for funding before 2012 and even now non entitled APLs are not eligible.
(c) Progress was monitored at the GP level in numbers and not by names, making the situation open to over reporting for Puraskar. (Now the progress is monitored on the MIS/Base Line Survey by names)

4.5 On the contrary, there can be cases of under reporting in the Census /NSSO Survey. The Census has the criteria of “access to toilets”. From 1999 to 2006, the Incentive for IHHL was Rs.500/- to Rs. 1200/- often resulting in non- durable toilets which became defunct/dysfunctional over the years, thus not getting captured in Census or NSSO or Baseline survey data. However they cannot be incentivized again and a certificate will be required from Gram Panchayats at the time of resolution asking for toilets that beneficiaries listed out in the resolution have never availed of any scheme for toilets through any Ministry in the past. Thus just relying on Census/NSSO data as having access to toilets and covering the balance population is not enough. Those who have received assistance before but now do not have access to toilets, would also need to be removed from list of future beneficiaries. Similarly those who may have suffered from over-reporting but never received assistance and do not still have a toilet but are entitled to one as
per guidelines, could now be considered under our scheme. The incentives would be based on ground truthing and a certificate of correctness from GP.

4.6 The above gives an idea of the difference between the Census/NSSO/Baseline data, and the achievement data on the MIS i.e. possibility of over-reporting by states for Puruskar etc and possible under-reporting in Census etc of dysfunctional toilets.

4.7 From reports from States plus MIS data: 27723 Community Sanitary Complexes (CSC) have been constructed in rural areas of the Country. Additionally 13.38 lakh school toilet units and 4.70 lakh Anganwadi toilets have been constructed upto 31.3.2014.

4.8 Year-wise achievements under TSC/ NBA in Eleventh Five Year Plan and Twelfth Five Year Plan so far is as under:

<table>
<thead>
<tr>
<th>Year</th>
<th>Household Latrines</th>
<th>Sanitary Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td>1,15,27,890</td>
<td>3006</td>
</tr>
<tr>
<td>2008-09</td>
<td>1,12,65,882</td>
<td>3245</td>
</tr>
<tr>
<td>2009-10</td>
<td>1,24,07,778</td>
<td>2230</td>
</tr>
<tr>
<td>2010-11</td>
<td>1,22,43,731</td>
<td>3377</td>
</tr>
<tr>
<td>2011-12</td>
<td>87,98,864</td>
<td>2547</td>
</tr>
<tr>
<td>2012-13</td>
<td>45,59,162*</td>
<td>1995</td>
</tr>
<tr>
<td>2013-14</td>
<td>49,63,382*</td>
<td>1516</td>
</tr>
</tbody>
</table>

*Slowing down of yearly achievements was due to convergence of NBA incentive of Rs 4600 with Rs. 5400 NREGA incentive, taking total incentive to Rs. 10,000. However, since toilets are not the highest priority under MNREGA, and toilet targets under MNREGA are less than toilet targets under NBA, rural households wait for full 10,000 with MNREGA, thereby dragging down the achievement under NBA.

4.9 The recent Base Line Survey 2013 has thrown up the following balance requirements of IHHLs, CSCs, School & Anganwadi toilets, which need to
inevitably be completed by 2014 by roping in and converging resources available with various Ministries in order to achieve a Swachh Bharat by 2019:

<table>
<thead>
<tr>
<th>No.</th>
<th>Component</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>IHHL</td>
<td>11.11 crore</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Out of which 8,84,39,786 * falls under the eligible category)</td>
</tr>
<tr>
<td>2.</td>
<td>School Toilets</td>
<td>56,928</td>
</tr>
<tr>
<td>3.</td>
<td>Anganwadi toilets</td>
<td>1,07,695</td>
</tr>
<tr>
<td>4.</td>
<td>Community Sanitary Complexes</td>
<td>1,14,315</td>
</tr>
</tbody>
</table>

5. **Financial Position**

In the XIIth. Five Year Plan (2012-17), an outlay of Rs. 37159 crore has been made for rural sanitation. Allocations and Releases under NBA during 12th Plan is as under:

<table>
<thead>
<tr>
<th>Year</th>
<th>BE</th>
<th>RE</th>
<th>Release</th>
<th>% of RE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012-13</td>
<td>4260</td>
<td>2500</td>
<td>2473.29</td>
<td>98.93</td>
</tr>
<tr>
<td>2013-14</td>
<td>4260</td>
<td>2300</td>
<td>2250.32</td>
<td>97.84</td>
</tr>
<tr>
<td>2014-15 (till 30.6.2014)</td>
<td>4260</td>
<td>4260</td>
<td>300.00</td>
<td>-</td>
</tr>
</tbody>
</table>

Thus Rs. (37159 - 4724)cr = Rs. 32,435 cr are available as Central share for the 3 years 2014-15, 2015-16 & 2016-17 of the 12th Plan.

It may be mentioned that the absorption capacity in the States needs to pick up which is indicated by lower R.E.s in last 2 years based on actual utilisations. Since in our federal set-up, ultimately the States are implementing the sanitation schemes, it is necessary that States pick up pace and have a faster implementation in order to achieve Swachh Bharat by 2019.
6. **Present Components of NBA:**

(i) **Provision of Individual household latrines (IHHL) Incentives:**

(a) For BPL households and Identified Above Poverty Line (APL) households (In Rs.)

<table>
<thead>
<tr>
<th></th>
<th>NBA</th>
<th>NREGA* convergence support upto</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government of India</td>
<td>State Share</td>
<td>Beneficiary Contribution</td>
<td>Total</td>
</tr>
<tr>
<td>Share</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3200*</td>
<td>1400</td>
<td>900</td>
<td>5500</td>
</tr>
</tbody>
</table>

*(Additional Rs 500 for Hilly and difficult areas)*

(ii) **School Toilets and Anganwadi Toilets:** (Centre State 70:30)

School Toilets Assistance - Rs. 35000/- (Rs. 38500/- for Hilly/difficult areas)

Anganwadi Toilets Rs. 8000/- (Rs. 10000/- for Hilly/ difficult areas).

(iii) **Community Sanitary Complexes(CSC) (Centre State Beneficiary 60:30:10)**

Provision upto Rs. 2,00,000 for construction of CSC

(iv) **Solid and Liquid Waste Management (SLWM) in project mode for each Gram Panchayat (GP) with financial assistance upto Rs. 20 lakhs capped for a GP on number of household basis.**

7. **Key challenges & Way Forward**

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Way Forward</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mindset : About 590 Million persons in rural areas defecate in the open. The Mindset of a major portion of the</td>
<td>Changing mindset is very important. Since most of the IEC funds are with States, the State Govts will have to focus on Inter Personal</td>
</tr>
</tbody>
</table>
population habituated to open defecation needs to be changed. Many of them already have a toilet but prefer to defecate in the open. The biggest challenge therefore is triggering behaviour change in vast section of rural population regarding need to use toilets.

Communication (IPC) through students, ASHA workers, Anganwadi workers, Doctors, teachers, Block Coordinators etc., including house to house visits. Also, distribution of information through short film CDs, use of TV, Radio, Digital Cinema, pamphlets will be carried out. Local & National Sports/ Cinema icons are required to be engaged by States to prepare AV messages to spread the message of safe sanitation practices to change mindsets.

We have recently hosted on our Ministry’s website 11 short advertising spots of 30 secs duration for use by State Water and Sanitation Departments for display in rural areas. M/o DWS has also shared copies of these CDs with M/o Health, WCD, PR and HRD to distribute to their functionaries in the States. These short films are also being telecast regularly on all TV channels.

2. Problems of Convergence between MNREGA and NBA. The achievement has gone down drastically ever since introduction of convergence. The Matching Rs. 5400 from MNREGA is often not available to the extent required as toilets have not been a high priority under NREGA, thus targets under both at the local level do not match, targets under NBA being higher. This issue is being scrutinised.

3. Need for availability of water Conjoint approach through District
<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>for use of toilets.</td>
<td>Level conjoint DPRs for piped water supply and Household latrines will be done through bottoms-up planning to include both water and sanitation simultaneously, for approval by the State level Scheme Sanctioning Committees (SLSSC).</td>
</tr>
<tr>
<td>4.</td>
<td>How to deal with toilets already constructed which have become Defunct/dysfunctional.</td>
</tr>
<tr>
<td></td>
<td>Incentivising these HHs again is not advisable, and these cases should be covered by an intensive IEC campaign and peer pressure for voluntary re-construction. Such toilets can also be re-constructed, as also non-entitled APL toilets through microfinance and under priority sector lending window of banks.</td>
</tr>
<tr>
<td>5.</td>
<td>Inadequate dedicated staff at the Field Level for implementation of rural sanitation.</td>
</tr>
<tr>
<td></td>
<td>Strengthening of administrative infrastructure at state level is proposed through merging of drinking water supply and sanitation departments to avoid the unnecessary duplication and confusion at present.. Block Coordinators and Swachhata Doots are being now engaged on contractual basis. We will also explore Inter Personal Communication through NGOs, SHGs, School children, local women’s groups etc for dissemination of information and for motivation of the people.</td>
</tr>
</tbody>
</table>
8. Special Purpose Vehicle:

A SPV is proposed to be set up within the Mission as a Company under the Companies Act. It will source out Govt. and non-Govt funds, including CSR funds and interalia also implement CSR projects. It will also act as a specialised PMC for water & sanitation jobs entrusted to it by the Centre and States. Also it will process PPP cases having revenue streams, say community toilets, community water treatment plants etc. VGF for ensuring viability can be routed through the SPV who would then be in-charge for tendering etc on behalf of Central Govt. The PMC would also take on jobs if required by States for preparation of district DPRs, for water and sanitation and for multi-village pipeline projects covering several districts and will also undertake IEC/IPC activities as a PMC on payment basis by Centre/States.

10. Future targets for Swachh Bharat

It may be noted that since there is a gap of 2-3 years between the Census 2011 and the Baseline Survey of 2013-14, and the Baseline survey 2013 gives lower deprivations now as compared to Census 2011, and also gives actual names whereas the Census data gives numbers and not names, hence the proposal to use the Baseline Survey data. However it will have the rider that GPs will certify that the proposed individual beneficiaries have not availed benefit of a toilet from any government scheme before.

Thus the Base Line Survey 2013 figures are utilised in the estimations.

In the Baseline Survey 2013, States have reported that the following sanitation services shall be required to be provided in the country.

<table>
<thead>
<tr>
<th>No.</th>
<th>Component</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total Households in India</td>
<td>17.13 crore</td>
</tr>
<tr>
<td>1</td>
<td>IHHL</td>
<td>11.11 crore (Out of which only 8,84,39,786 fall under the eligible*)</td>
</tr>
</tbody>
</table>

13
### HHs Left for Coverage

<table>
<thead>
<tr>
<th>Total HHs shown as requiring toilets in Baseline Survey</th>
<th>11.11 cr</th>
</tr>
</thead>
<tbody>
<tr>
<td>(-) Non entitled APL</td>
<td>0.88 cr</td>
</tr>
<tr>
<td>(-) Defunct</td>
<td>1.39 cr</td>
</tr>
<tr>
<td>* Net Eligible BPLs and Eligible APLs</td>
<td>8.84 cr</td>
</tr>
</tbody>
</table>

10.1 Thus under the Swachh Bharat/NBA Yojana **8.84 crore HHs** have to be covered with individual toilets in next 5 years till 2019 @ 177 lakhs per year though Incentives. We are covering about 50 lakhs now, from earlier 125 lakhs, principally because of slowdown due issues with MNREGA convergence as explained earlier. The Present Growth in number of Toilets is 3% of the households which will be tripled to 10% to achieve Swachh Bharat by 2019. From present construction of 14000 toilets daily, this Action Plan proposes to increase the construction to 48000 toilets daily.

10.2 A further 2.27 crore toilets (falling in non-entitled APL plus defunct toilet categories) are to be covered by persuasion, peer pressure plus using trigger mechanism, Information, Education and Communication (IEC) and Inter Personal Communication(IPC) methods, as also with help of NABARD/SIDBI who could arrange loans, microfinance & priority sector lending to construct these toilets.

10.3 There is a Jan Bhagidari contribution of Rs. 900 per beneficiary, which will continue. The beneficiary can always contribute more than this to obtain a superior toilet.
11. **To Achieve Swachh Bharat by 2019 – ACTION PLAN**

11.1 **Delivery mechanism**

To strengthen the Delivery mechanism in sanitation in rural areas the following shall be carried out:

(a) There shall be a MoU with States, on water and sanitation in which states will commit to a Swachh Bharat by 2019, as also to creating by 2015 an unified structure at State level for implementation of both water and sanitation, with interchangeability of funds between water and sanitation so that idle funds do not lie in States and targets are not starved of funds in either of the two sectors.

(b) Releases to States with ‘Just in time’ concept be adopted by Centre to avoid extra cost of funds to GOI.

(c) It would be better to release not as per present formula giving entitlement of States, but on projectised basis, on basis of FR/DPR of a district as a whole both for Water and Sanitation. The releases to be done not as advance but for projects on reimbursement basis. However this requires discussion, keeping in mind various States’ capabilities to make District wise DPRs/FRs. For large pipeline projects, DPRs are essential, and not many states are making new DPRs for large pipeline projects, after identifying dams/reservoirs that are available or from future creation of sources. The proposed SPV under the Mission (see para ‘f’ below) can also make DPRs when asked.

(d) MoU with States should include all the above.
(e) At the Central level an SPV, (to be set up) acting as a PMC will route CSR funds and also do PPP projects e.g. Community toilets, Water purification etc This SPV would also handle donations under Section 35 AC Income Tax Act and or works allotted by States as a PMC or allotted by Ministry in consultation with States through a MoU. This will be in line with other SPVs/PMCs working in other Ministries for specified works. It is clarified that normal work can continue through State Governments and when SPV is set up by 2015, works allotted to it on PMC charge basis will be decided in consultation on case to case basis with State Govts. and may include making of DPRs/FRs including for Multi-village Pipeline projects. The SPV will also effectively carry out IEC/IPC activities.

(f) Enable a system of small loans through agencies like NABARD, SIDBI (or Banks through priority sector lending without co-lateral) to those households for the construction of toilets which are either not eligible for Incentives or need funds to construct better toilets maybe with bathing space.

(g) Developing a Block Level cadre of Sanitation Coordinators who shall be the main support to GPs in disseminating information and strengthening capacity in sanitation activities.

(h) Identifying a Swachhata Doot for each GP in the country, equipping him with skills on sanitation and giving him Performance linked incentives.

(i) Intensive Monitoring at the HH level shall be taken up through the MIS of the Ministry, as already name of each household has been collected by MoDWS through baseline
data recently. Besides senior officers of Centre & State should directly talk to the Sarpanches on telephone to get feedback.

(j) Annual Sanitation Survey will be taken up with focus on capturing data on actual usage of built toilets.

(k) The Nirmal Gram Puraskar will be discontinued and a Swachh Bharat Puraskar launched with widened focus of awarding PRIs (GPs, BPs and ZPs) and also to Institutions, Individuals, officials, best practices, NGOs etc.

11.2 Convergence with Other Ministries, and within Ministry with Schemes

The main convergences proposed are

11.2.1 Convergences will be explored with MNREGA, IAY for construction of IHHLs, with BRGF for construction of CSCs and with MHRD and MWCD programmes for school and Anganwadi toilet construction.

11.2.2 Convergence with NRDWP will be carried out to ensure simultaneous Water Supply for IHHLs, Schools and Anganwadi Toilets and Community Sanitary Complexes (CSCs). Interchangeability of funds and functionaries in the two sectors will be implemented if need be.

11.2.3 Convergence with MoPR will be carried out through the Rajiv Gandhi Panchayat Shashaktikaran Yojana to prioritize sanitation in their project activities, which would be high priority for the GP.

11.2.4 Tapping MPLADS/MLALADS funds for Gap Funding for construction of sanitary facilities especially in Schools, Anganwadis and for CSCs and SLWM projects as well as for water supply schemes.
11.2.5 This Ministry will increase convergence with CSR funds from Central PSUs as well as other Companies. Further the State Water and Sanitation Mission (SWSM) at the State level and DWSM at district level will be encouraged to tap CSR funds.

11.2.6 Convergence with M/o WCD for creation of Integrated Womens Sanitation Complexes. Further the M/o WCD shall be responsible to provide toilets and drinking water facilities in all Anganwadis.

11.3 ÍEC Plan

11.3.1 Since the major issue is need for Behaviour Change, this Ministry will unleash a National Reach Out Campaign, and initiate a continuous Door-Door contact with every rural HH in the country, so that they can be made aware of the importance of using a toilet and the consequences of not doing so. This will be similar to the Pulse Polio campaign. Immediately a week Long national sanitation campaign is proposed from 26th Sept 2014 and culminating on 2nd October 2014 in the nationwide Gram Sabha to be held in all GPs. In this endeavor, involvement of Social organizations like Rotary, Sulabh, Ramakrishna Mission, Red Cross etc., would be taken. These national organizations can also reach out through students of schools and colleges, which will be initiated. The proposed SPV when set up by 2015 will also handle the Ministry’s requirements of IEC/IPC. NABARD has also shown initiatives in IEC/IPC.

11.3.2 A Communication Strategy is already in place which focuses on Inter Personal Communication, and currently 15% of NBA funds to states are available for IEC/IPC.

11.3.3 Launching of a National Level/State Level Media campaign covering audio visual, mobile telephony and local outreach programmes to communicate the message. Involvement of Social, Local, Sports or Movie Icons in Sanitation messaging will be increased with new visuals for electronic / print media.
11.3.4 Involvement of School Children as messengers of Change on WASH – Water, Sanitation and Hygiene. Inclusion of WASH inputs in School curriculum till Class X.

11.3.5 Setting up of One Model Community Sanitary Complex (CSC) immediately to begin with in each of the 6000 Blocks in the country as an IEC tool.

11.3.6 Training of Masons in the construction of sanitary toilets will be taken up across the country in a focused manner.

11.3.7 Key Resource Centres to be strengthened both at the Central level as well as State levels to carry out capacity building of stakeholders. They shall also be given the task of IEC/IPC activities at the GP level.

11.3.8 Inter-alia, IEC activities will also be taken up through the following Media

(a) Mass Media

(i) Broadcasting of audio Spots through FM channels
(ii) Telecast of video spots through TV channels
(iii) Digital cinema campaign
(iv) Advertisements in newspaper including messages from icons.
(v) Messages in the train tea cups, tray mats
(vi) Rural outdoor publicity (e.g. advertisements on buses, trains, roadside, walls, hoardings etc)

(b) Community Mobilization-

(i) Inter personal Communication at household (HH) level using ASHA workers, Self Help Groups/NGOS.
(ii) Use of School children as a medium to influence families.
(iii) Involving Doctors. Teachers. Local Political and Religious leaders in Sanitation Communication

(c) Outdoor Media
(i) Use of Trucks fitted with Publicity material on sanitation and drinking water supply; including a large TV screen and video for showing short films on Sanitation as well as best practices. The trucks shall also carry models of twin pit latrines; rural sanitary pans with p-traps and models for water supply schemes.

(ii) Wall Paintings

(iii) Shows during weekly haats/market/ school/ chopals through Self Help Groups (SHGs).

(d) Folk Media

(i) Field publicity through workshop, nukkad natak, puppet show.

(e) Entertainment Education

(i) Involving the school students in rallies, walk/run for sanitation to spread the message.

(ii) Seminars, painting competition & other activities in Schools to disseminate the sanitation message.

(iii) Celebrating World Toilet day, World Handwashing day, at centre, states, Colleges and schools.

(f) Involvement of the following organizations in the Mass Communication plan amongst others may be done:

   i. UNICEF
   ii. WSP
   iii. WATERAID
   iv. WHO
   v. ADB
   vi. Rotary India/Sulabh
   vii. NGO networks
   viii. Universities
   ix. Schools
   x. Corporate houses
The assistance of some of these institutions have successfully been utilized in the Pulse polio campaign.

11.4  Financial Estimates and Timelines

11.4.1.1 Financial requirement

Financial Details are under Preparation.

11.4.2 Timelines


Year wise timelines

- It is proposed to achieve the target of Coverage of IHHLs, Schools, Anganwadis, CSCs and SLWM facilities as per the timelines resulting in ODF India by 2019.
- Details are being finalised.

11.5 Other Modifications proposed in the NBA Sanitation Programme to address the problems being faced in implementation.

(i) To support the above effort, it shall be essential to monitor sanitation status of every HH in the country by name on a continuous basis.

For this a Household level database, covering every Rural Household in the Country, in terms of coverage of sanitation (based on Baseline Survey 2013), is being created in the MDWS IMIS (likely to be completed by 31st December 2014). In future, monthly achievements are sought to be reported by name, photographs of beneficiary next to toilet, and if possible by LAT/LONG coordinates using hand held devices on spot. This will be updated retrospectively on IMIS from 1.4.2014. Details are being worked out.
(ii) In the absence of Government Employees working on sanitation, creation of an army of Sanitation workers at the Block and GP level is direly needed.

(iii) Increase in Unit costs to bring them closer to actual costs – Under Consideration.

(iv) Delinking of NBA from MNREGA. Under Consideration.

(v) To give flexibility to States (and thereby to GPs in a bottoms-up planning approach) to implement the Sanitation programme as per local situation and if states feel that would give faster results.

- Permit States as an option to provide Incentives not to Individuals but to Communities/ GPs with Communities/GPs tasked to motivate individuals to achieve NBA targets through society and peer pressure.

- Under this flexibility, one possibility:

  - Community Led Total Sanitation (CLTS) – Community-led Total Sanitation (CLTS) is an innovative methodology for mobilising communities to completely eliminate open defecation (OD). Communities are facilitated to conduct their own appraisal and analysis of open defecation (OD) and take their own action to become open defecation free (ODF).
    
    At the heart of CLTS lies the recognition that merely providing toilets does not guarantee their use, nor result in improved sanitation and hygiene. CLTS focuses on the behavioural change needed to ensure real and sustainable improvements – investing in
community mobilisation instead of hardware, and shifting the focus from toilet construction for individual households to the creation of “open defecation-free” villages. By raising awareness that as long as even a minority continues to defecate in the open everyone is at risk of disease, CLTS triggers the community’s desire for change, propels them into action and encourages innovation, mutual support and appropriate local solutions, thus leading to greater ownership and sustainability. This approach may not require Individual incentives, and would require greater discussion with States. However some initial block grant could be considered for the Gram Panchayat, as also a Puraskar once the whole village becomes open defecation free.

- NGO based approach creating awareness followed by handholding and actual training at site for Construction etc.

- Assembly line approach through National level NGOs having reputation.

(vi) As maintenance of IHHIs, CSCs are often difficult for the GPs, creation of smaller common Sanitary Units for 5-10 HHs, giving the maintenance to these 5-10 HHs, with access through keys to each participating HH. This model has worked well in some states. The unit cost of any such small common sanitary unit would be the sum of financial entitlements of the participatory households. This way they can have a better toilet even with a bathing space.
(vii) Use of Revolving Funds in construction linked-instalments to provide advance to poor HHs who cannot afford initial construction cost or to GPs in construction linked instalments to be finally recouped against incentives released on completion of the toilets.

(viii) Strengthening of Supply Side— Creation of Rural Sanitary Marts/Production Centres in every Block in the country.

(ix) Possibility of CSR completing the supply side of material supply like cement, pan, bricks etc through supply of exchangeable coupons, with labour contribution by beneficiaries.

(x) Ensure availability of sanitary hardware suitable for rural areas in adequate quantity and in reasonable prices. Availability of Deeper angle Rural pans with water seal p-traps which consume lesser water shall be ensured.

(xi) Large Scale Involvement of leading NGOs involved in sanitation, ITIs/ Polytechnics who will create an Army of trained Masons specializing in sanitation construction.

(xii) Increased Finance Commission transfers for this purpose may be considered to ensure maintenance of School, Anganwadis and Community Sanitation Complexes, which is very poor due to paucity of O&M funds.

(xiii) Linkage of funds released to GPs under all programmes, may be linked with coverage and usage of toilets in the GP, to use it as a leverage to ensure Swachh Bharat by 2019.
(xiv) To ensure the interest of the District, Sub-district and Block Level Government officers beginning from District Magistrates in sanitation, the achievements of their areas under sanitation, may be included in their APRs.

(xv) Involvement of Corporates to assist in covering the GPs in their Catchment areas for sanitation especially Community Sanitary Complexes, either directly or through CSR funding. The corporate may also look after O&M for a couple of years.