

# An untold story of policy failure: the Total Sanitation Campaign in India

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## Abstract

The Total Sanitation Campaign (TSC) was a community-led, people-centred, demand-driven and incentive-based programme ideal to address India's rural sanitation crisis, or so it seemed. But policy failed to translate into practice and outcomes were remarkably poor. In the 2011 census data showed 31% sanitation coverage in 2011 (up from 22% in 2001), far from the 68% reported by the Government. The decade has witnessed progress slowing down and the number of rural households without latrines increasing by 8.3 million. This article draws on evidence from two coordinated studies in four Indian states. It aims to explore the dichotomy of TSC policy and practice, its causes, and the potential of the new sanitation campaign, the Nirmal Bharat Abhiyan (NBA). The study found that TSC implementation was unaligned with the programme's guiding principles. In reality the TSC was government-led, infrastructure-centred, subsidy-based and supply-led, leading to poor outcomes. The reasons behind the theory–practice gap include low political priority; flawed monitoring; distorting accountability and career incentives; technocratic and paternalistic inertia; and corruption. In the new NBA, despite promising changes such as a stronger demand creation focus, key issues hampering implementation remain ignored. It is thus doomed to fail, burdened by known past hurdles.

*Keywords:* Failure; Implementation; India; Policy; Political economy; Rural; Sanitation; Total Sanitation Campaign

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## 1. Introduction

### 1.1. Sanitation in India

The provision of sanitation is important for the prevention of many illnesses (UN-Water, 2008), as well as for dignity, education, livelihoods, and security. In India, home to one-third of the world's 2.5 billion people without access to improved sanitation (WHO & UNICEF, 2012), 450,000 people die yearly due to one of the many sanitation-related illnesses: diarrhoea (Government of India, 2011b).

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Inadequate sanitation reduced India's gross domestic product by 6.4% (US\$53.8 billion) in 2006 (Tyagi *et al.*, 2010). Not only are consequences of insanitation serious but also inequitable, affecting the most vulnerable groups more severely. Children account for 88% of the diarrhoea-related deaths due to water and sanitation. There is also an important gender dimension since women and girls suffer most, for instance risking sexual assault while open defecating away from the village in the dark. Further, the wealthiest 40% Indians are 10 times more likely than the poorest 40% to access improved sanitation (Narayanan *et al.*, 2011). The urban–rural divide is also significant; two-thirds of India's rural population defecate in the open (WHO & UNICEF, 2012). This has startling consequences, for instance, in nutrition: prevalence of malnutrition among Indian children is among the highest in the world, nearly doubling that of sub-Saharan Africa and affecting 50% of children (Shekar *et al.*, 2006).

### 1.2. Total Sanitation Campaign in India

In 1999, after 13 years of slow rural sanitation progress under the Central Rural Sanitation Programme (CRSP), the Government of India (GoI) created the Total Sanitation Campaign (TSC). The TSC Guideline appeared to present an ideal, cutting-edge policy to eliminate insanitation in rural India. The 2004 Guideline (Government of India, 2004: 6), which set the stage for India's rural sanitation policy up to 2011, sought to

*'... make the programme 'community led' and 'people-centred'. A 'demand driven approach' is to be adopted with increased emphasis on awareness creation and demand generation (...). Subsidy for individual household latrine units has been replaced by incentive to the poorest of the poor households.'*

Thus the TSC sought to be community-led, people-centred, demand-driven, and incentive-based (Peal *et al.*, 2010). The concept of total sanitation – the entire community becoming open defecation free (ODF) – was reinforced with the introduction of the Nirmal Gram Puraskar (NGP) in 2004. NGP is a clean village award scheme in which high-level authorities distributed cash to Gram Panchayats (GPs) for achieving total sanitation.

With such a well-crafted policy, laden with principles widely promoted in the global sanitation sector (Jenkins & Scott, 2007), India's TSC was expected to bring real sanitation progress. India's Department of Drinking Water and Sanitation (DDWS), which led the TSC, reported rural sanitation coverage of 68% in 2011, up from 22% in 2001 (Government of India, 2011b; Aiyar, 2012).

In reality, though, there was 'significant disconnect in terms of intent and action' (WaterAid, 2008: 7), that is, sound policy did not translate to good practice because interventions were poorly implemented. As a result, outcomes have been insufficient. Reported progress was exaggerated: actual rural sanitation coverage in India was 31% in 2011, as per India's last census (Government of India, 2012b). Thus, from 2001 to 2011 rural sanitation coverage increased by less than 10 percentage points, far from the 46 points jump DDWS reported, and less progress than in the previous decade under the CRSP. These numbers imply that only one in five latrines reportedly constructed since 2001 were in place in 2011. During the same period, population growth outpaced latrine coverage: rural households without a latrine increased by 8.3 million (approximately 37 million people), as the calculations in Table 1 show. This entails a daily increase of about 11,300 people defecating in the open in rural India.

The TSC's poor performance was officially confirmed in late 2011 when India's Minister of Drinking Water and Sanitation stated that the 'TSC has been a failure. It is neither total, nor sanitation nor a

Table 1. Calculation of rural households without latrine in India, 2001–2011.

	2001	2011
Number of households [N] <sup>a</sup>	138,271,559	167,826,730
Share of households with latrine [L] <sup>a</sup>	21.9%	30.7%
Households without latrine [W] <sup>b</sup>	107,990,088	116,303,924
Increase in households without latrine [I] <sup>c</sup>		8,313,836

<sup>a</sup>As per Census data (Government of India, 2012b).

<sup>b</sup>Calculated from the two previous data:  $W = (100\% - L) \cdot N$ .

<sup>c</sup>Difference of W between 2001 and 2011:  $I = W_{2011} - W_{2001}$ .

campaign' (Tandon, 2011). With the Government's recognition of a failed TSC a new policy was formed. In February 2012, the Ministry announced the Nirmal Bharat Abhiyan (NBA) to 'revamp' India's rural sanitation policy, again.

### 1.3. The research

This article primarily aims to explore the dichotomy of TSC policy on paper and its implementation on the ground.

We want to test our hypothesis that TSC implementation often did not follow its stated principles, negatively affecting the outcomes. We seek to identify elements and processes that help understand the theory–practice gap and briefly examine whether the changes introduced in the new NBA take into account previous lessons. By reflecting on the substandard past TSC, we hope to contribute to a well-implemented future Indian rural sanitation programme, which would improve quality of life for hundreds of millions of people in rural India.

The article is based on three primary research questions:

- To what extent does TSC implementation differ from its principles?
- Why is the policy–practice gap happening; what are the processes and barriers behind the gap?
- Does the revamped NBA take lessons from the past TSC into account?

### 1.4. Analytical framework

To assess the performance of a programme or policy, opening up the programme black box and examining implementation can provide insights into why programmes succeed or fail (Love, 2004). The lens shifts towards the bases and processes for decision-making that shape the policy process.

Following these ideas, implementation studies flourished in the past 30 years, with heated debates between top-down and bottom-up approaches. The first generation emphasizes the ability of decision-makers to produce policy objectives and control implementation, while the second investigates local leaders as central actors in policy delivery (Hill & Hupe, 2002). A recent third generation combines elements of both approaches. The Contextual Interaction Theory is a useful third generation approach that has been applied to various policy processes, including some related to health and river policy (Spratt, 2009; de Boer & Bressers, 2011).

The Contextual Interaction Theory is founded on the concept of policy implementation as a social interaction process based on actors' participation. The course and outcomes of the processes depend on actors' 'core characteristics': their objectives, information and power. Exogenous circumstances, such as availability of resources, have influence to the extent they affect the core characteristics of the actors involved (de Boer & Bressers, 2011).

In this study we use this theory as the analytical framework, although renaming the core characteristics of actors: motivations, cognitions, and power.

- Motivations are the drivers of actors' actions: internal and external goals, values and pressures. They are defined by how actors value a policy or programme and the degree to which implementation fulfils personal and institutional goals.
- Cognitions are actors' information and knowledge that inform interpretation of reality. They include knowledge of the policy, of the institutional architecture and of communication channels for monitoring, feedback and dissemination of guidelines and protocols.
- Power is the capacity actors have to use available resources to facilitate (or hamper) policy implementation. Power relates to regulatory dispositions, informal rules, hierarchies, resources and assets.

These interacting characteristics of motivations, cognitions, and power are central to policy implementation processes and research. Characteristics are not just intrinsic, but are also influenced by institutions and processes. External factors, such as policy guidelines, must also be considered in the analysis since they can alter interaction of core characteristics. For instance, increasing the power of a particular actor or shifting the balance of available information (O'Toole, 2004).

### 1.5. Methodology

To answer the research questions, the article draws on evidence from two coordinated studies conducted in India in 2011, in the frame of academic post-graduate research of the authors. The studies aimed to evaluate the TSC programme after more than a decade in place, analysing its processes and outcomes in four Indian states in order to understand the how and why of rural sanitation in India.

At the national level, 37 semi-structured interviews were held with key informants. Interviewees included decision-makers at the Government of India DDWS; sanitation specialists from the World Bank's Water and Sanitation Programme and UNICEF (the United Nations Children's Fund); and non-governmental organizations, senior researchers and consultants in the sanitation sector.

Key informant selection started with sanitation experts from government, academia and the private sector. Snowball sampling was used, reaching new informants through the networks of interviewees. The number of interviews conducted was determined by the saturation factor, that is, based on when new interviews did not shed further light on the topics analysed (Mason, 2010), always being aware of potential biases or actors excluded.

Four states with varying TSC strategies were studied: Himachal Pradesh, Haryana, Madhya Pradesh (MP), and Uttar Pradesh (UP). The TSC in Himachal Pradesh was said to have been implemented following a demand-driven, community-led, people-centred and no-subsidy-based mode. In Haryana, the case was similar, but only for certain districts or blocks. UP was considered to fully illustrate implementation failure. The same applies to MP, although there were small islands of successful implementation in MP (WaterAid, 2008).

The selection of states followed strategic sampling (Flyvbjerg, 2006); covering the different degrees of implementation coherence, a complete picture of the processes and relevant elements in the country could emerge.

In the four states altogether, more than 100 interviews were held with sanitation key informants such as government officers, researchers and civil society workers at the state, district and block levels. Snowball sampling was again used, as it was at the central level.

At the village level, more than 60 GPs were briefly visited during field research, in order to gain insights about the ground reality regarding the implementation of the TSC. Interviews, transect walks, focus group discussions, and observation were utilized. The selection of GPs aimed to include a multitude of situations, regarding sanitation implementation (subsidization and awareness methods), outcomes (good and bad situations) and relevant local characteristics (village size, settlement pattern, social fabric, etc.). The selection was based on secondary data (e.g. sanitation awards lists) and opinions from government officers (e.g. ranking the GPs with specific criteria). Several officers were consulted separately and some GPs were selected randomly in order to triangulate and counter potential bias towards 'good' GPs. The number of GPs included was determined by saturation.

During the village visits, 10 GPs were identified for further case study, in order to have a deeper understanding of the ground-level processes and of the consequences of varying intervention modalities in each area. Primary research tools in the case studies included semi-structured interviews, focus group discussions, household surveys, observation and village immersion.

Due to the scope of this paper, it draws mainly on the information from interviews across levels and observation in GPs.

The analysis of the information gathered was through codification, according to the location and topic. This allowed combining data by themes and/or areas in order to make further comparison and analysis.

Several primary research limitations should be noted. The states selected cover the range of TSC implementation types, but are geographically limited to north-central India, introducing a geographical bias. In addition, cultural and language gaps apply.

## **2. Principles and practices in India's TSC**

The TSC aimed to be a community-led, people-centred, demand-driven, incentive-based approach. In this section we compare these TSC principles to actual practices on the ground.

### *2.1. Community-led or government-led?*

The TSC advocated for communities to lead their own sanitation improvements, with strong involvement of GP leaders and community groups. Government officers from the districts and blocks were supposed to facilitate communities to make the TSC a bottom-up campaign. Most government officers leading TSC implementation, however, were over-worked and under-paid. They had minimal motivation for achieving true sanitation access and usage; only ever-increasing sanitation achievement on paper was pursued. Even where local officers were committed to sanitation, they were often under-trained in awareness-based and participatory development methods, many times being unable to provide adequate information or facilitate villages to adopt improved sanitation practices. But even if local

government officers championed the TSC effectively, motivated local leaders were a complementary condition for villages to achieve sanitation success.

Thus, rather than being a community-led campaign, the TSC became a government-led programme. A high-level officer at DDWS confirmed this point, suggesting the TSC had yet ‘to evolve to a community-centred campaign, but sensitization and capacity building are still needed to make a transition.’

Plentiful evidence of government-led implementations was found, especially in UP, where officers were spread thin and had to prioritize other programmes, causing haphazard top-down implementation. There were no full-time government sanitation employees at the districts or blocks in UP. As a result of low capacity, village leaders received little training on sanitation software and implementation remained construction-oriented. Community member participation was limited, if not absent. The consequence: DDWS reported in 2011 that over 90% of rural households in UP had latrines, but the census found only 22% coverage. The coverage increase during the TSC is minimal in percentage, and the absolute number of rural households defecating openly increased by 8.3 million ([Government of India, 2012b](#)).

In MP a similar top-down implementation was common, with parallel results: rural coverage rose from 87 to 91%, and 2.2 million more households defecated in the open in 2011 ([Government of India, 2012b](#)). There were a few islands of TSC success, but only in areas where community participation and involvement had been high due to uncommon, high-quality government facilitation and village leadership. For instance, after attending Community-Led Total Sanitation (CLTS) training, community leaders in Budni block implemented the TSC with focus on community participation and software. Ad hoc community sanitation committees led sanitation revolutions in many villages. The case of Manjarkui GP is illustrative, where the work of an enthusiastic committee brought the GP to ODF status in a matter of weeks. In just a few months, many GPs were ODF, and 11 of them received the NGP awards in 2011 (of 30 initially triggered).

In Haryana the state government had been promoting what they called a CLTS approach, although not fully aligned with CLTS principles. In areas where CLTS triggering had been adequately applied some villages had highly positive outcomes, such as Basara GP with a rise from 28% before to 95% sanitation coverage after TSC implementation. However, the state government continued to promote subsidy distribution, and so implementation remained supply-driven, making outcomes highly dependent on the motivation of the district and block officers and the village leaders. This is reflected in the 2011 census data on rural Haryana, showing coverage increasing from 29 to 56%. The jump is considerable, although far from DDWS’ figure of 100% coverage and uneven from one district to another. In Panipat District for instance, where CLTS facilitation was more intense, 30% of the GPs had received the NGP award by 2010 ([Water and Sanitation Program, 2011](#)) and the census found 67% rural sanitation coverage ([Government of India, 2012a](#)). In a neighbouring district, Jind, on the contrary, coverage was only 51%, with 14% of NGP-awarded GPs.

Himachal Pradesh was an exceptional case of community-led TSC, as a result of the state government’s strong political will and the endorsement of community-led principles (including zero-subsidy). Overall, sanitation outcomes and sustainability were high. In fact, Himachal Pradesh was the state with the highest coverage jump in the decade, from 28 to 67% ([Government of India, 2012b](#)). Nevertheless, the figure is far from the 100% coverage reported (exaggeration is below the Indian average, however) and performance varied by village, with outcomes being most significant where committed GP leaders and sanitation committees were involved.

Overall, India’s TSC was largely unsuccessful at facilitating the community-led campaign it aimed to achieve. A top-down, government-led implementation prevailed, especially in UP and MP. Where trained



officers and motivated village leaders worked towards a truly community-led campaign, as in Himachal Pradesh and Haryana, they could engage with the community and achieve meaningful sanitation progress.

### 2.2. *Incentive-based or subsidy-based?*

Due to the negative effects of subsidies on community mobilization (Kar & Pasteur, 2005), DDWS dropped the term ‘subsidy’ from the TSC Guideline in 2004. The intention was to use post-construction incentives for Below Poverty Line (BPL) households. The incentive was initially of Rs. 1,200 per latrine, increasing to Rs. 2,200 in 2007 (WaterAid, 2008), approximately 50 US dollars.

It is widely recognized, though, that incentives were disbursed upfront in most states, thus becoming a harmful pre-construction subsidy; a member of the GoI’s planning commission stated when interviewed: ‘The current subsidy approach (...) does not result in behaviour changes desired. Subsidy is an enormous waste of money. This money is literally being thrown down the loo.’

Evidence from MP and UP shows subsidies were distributed at varying amounts to BPL and non-BPL households as cash or materials, with disastrous results: many half-built, short-lived and unused latrines. In MP negative impacts of subsidization were reinforced through the use of the rural employment scheme for sanitation, which added coordination and operation problems. The case of Haryana is similar to MP, with exceptions such as Sirsa district where no subsidy was disbursed (WaterAid, 2008), resulting in 278 of its 324 GPs being awarded with the NGP by 2010 (Water and Sanitation Program, 2011) and in the highest coverage rate in rural Haryana: 87.5% (Government of India, 2012a).

In contrast to these three states, Himachal Pradesh followed a non-subsidy policy with impressive results, as described earlier. In Mandi, the district where this policy was pioneered, coverage jumped from 28% in 2005 (Vaidya, 2009) to 82% in 2011 (Government of India, 2012a), with impressive success stories in many GPs. In GP Chhaprahan, for instance, community theatre and door-to-door visits encouraged households to build toilets on their own without external support and toilet coverage rose from 32% to 100% in a few months of 2007, according to our survey.

Similar isolated experiences in the other states also demonstrate that non-subsidy approaches do not hinder, but rather enable sanitary revolutions. Obviously, households need to be motivated to fund, design and construct their own latrines. In areas where this motivation happened, people exhibited better ownership, using and maintaining latrines effectively over time.

Based on the evidence from the villages, truly incentive-based sanitation implementation has been rare in India’s TSC, with the exception of Himachal Pradesh. Instead, TSC implementation generally included upfront subsidies.

### 2.3. *People-centred or infrastructure-centred?*

The TSC aimed to be people-centred, that is, focused on what people think and want, as well as on what they can do to change the sanitary situation in their communities. This is important because ‘if the toilets’ construction is not as per the choice and need of the community, if it is done as a contracted out process, not just the technology but desirability, location, and several other factors leading to usage will be compromised’ (India Wash Forum, 2011: 3).

However, government officers and village leaders tended to focus on subsidized construction, neglecting the human dimensions of the campaign (motivation, awareness), and the TSC became hardware-oriented.

Clear evidence of hardware-orientation emerged in most GPs visited in UP, where leaders excluded households without BPL cards from any involvement (including awareness raising activities) because only BPL households were eligible for hardware subsidies. The non-eligible, non-BPL households were sometimes the poorest in the village, while better-off households sometimes had BPL cards. Mehrotra & Mander (2009) confirmed that poverty classification in India has many large-scale exclusion and inclusion errors, causing widespread discontent and injustice.

Exclusion based on subsidy also occurred due to politics, caste and clientelism. For example, in Killod GP in MP, support for toilet construction was biased towards households politically allied with the village leader. This resulted in exclusion of the most vulnerable sectors of the GP, such as widows, tribal groups and oustees (displaced communities from a nearby reservoir) that had settled in the village.

Where implementation was less subsidy-centric and more focused on the reasons for ending open defecation, inclusion and outcomes improved. For instance in Basara GP in Haryana, dignity of women was the main driver of the campaign. In Haryana and Himachal Pradesh, it was common that all households lacking latrines were included in house-to-house awareness raising, regardless of socio-economic condition. This is one of the main reasons explaining why these two states are among the three best states in India regarding TSC performance (Hueso, 2013). But, challenges remained even in some highly people-centred interventions. For instance, reversion to open defecation affected poor households which were not able to sustain improved sanitation practices since their latrines were of low-cost, temporary construction requiring later upgrading or ongoing maintenance.

The TSC was not a campaign about people but a target-driven programme about constructing latrines. As a result, its outcomes were often short-lived and exclusionary.

#### *2.4. Demand-driven or supply-led?*

The TSC aimed to be demand-driven, with community demand for sanitation pushing progress. Therefore, Information, Education and Communication (IEC) tools, aiming to increase awareness and generate demand, were emphasized. But, ‘the vision to have a demand-driven TSC has not been realizable.’ (interview with an officer responsible for TSC nationally).

Although some IEC was used, such as wall paintings, true demand-driven implementation was rare. Focus was normally on hardware implementation and subsidies instead of on awareness, participation and behaviour change.

For example, as a result of the UP Government’s supply-led approach, village leaders purchased materials and hired masons to construct dictated latrine designs en masse. There were limited signs of household motivation, participatory community sanitation meetings or household involvement in latrine construction and maintenance. Village sanitation committees were rarely formed. Village level research showed that, as a result of low quality interventions, latrine access following TSC implementation was only 25% in Mandora GP, 54% in Kaundada GP, and 27% in Simra GP. It was higher in Kaundada because the GP leader had constructed latrines for all BPL households in the village.

Similarly, in MP IEC was mostly a secondary add-on to construction projects. Haryana showed a more awareness-focused record. Sanitation committees were formed in most GPs visited. Committee members visited house-to-house to encourage residents to build toilets for reasons of children’s health and women’s dignity, with the goal of achieving an ODF village. For instance, in the village of Dhindar, where latrine coverage was found to be 84% in 2011, a model latrine was built at the community centre and households were then normally responsible for building latrines without upfront



subsidy. Meanwhile, in Namuda GP in Haryana sanitation coverage had reached only 57% by 2011, resulting from low quality awareness raising and focus on upfront cash subsidy distribution.

In Himachal Pradesh, a socially progressive state, the story of sanitation is the most demand-driven one. Door-to-door campaigning and community theatre by sanitation committees of motivated GP members, Anganwadi workers or members of women's groups, proved to be powerful for awareness raising and yielded impressive results.

Closely related to the supply–demand tension was the NGP award scheme, which became a double-edged sword. On one hand, it boosted the interest in sanitation at all levels and impelled village leaders to motivate villagers to achieve ODF in the four states. On the other hand, it contributed to a rushed supply-led and unsustainable implementation of the TSC, as was observed in MP. In Khandwa District, for instance, GPs awarded NGP in 2008 showed average rates of open defecation of more than 50% in 2011 and the overall rural sanitation coverage only increased from 10% in 2001 to 17% in 2011 (Government of India, 2012a).

As a whole, the level to which TSC was demand-driven varied by state. In states such as UP and MP, an infrastructure focus without awareness raising was common. Even when conventional IEC tools were used, they were ineffective. In contrast, the less common awareness raising methods, such as participatory triggering and door-to-door campaigning, showed effectiveness in Haryana and Himachal Pradesh.

Village level research confirmed our hypothesis that the TSC was not implemented as a community-led, people-centred, incentive-based, and demand-driven programme. The fact that where implementation was more true to these principles, the outcomes were observably better, highlights the great opportunity that was lost.

### 3. The theory–practice gap explained

The TSC Guideline was not implemented following its core principles. Why was there such a gap between theory and practice? What core characteristics of the actors involved hindered a coherent implementation?

It is important first to identify the actors. We make an approximation of the institutional constellation through four main actors: top-level officers in the DDWS, mid-level government officers, GP leaders and rural communities. Actor groups and their roles are summarized in Table 2.

The core characteristics of the TSC actor groups are presented in Table 3, and subsequently discussed.

#### 3.1. Motivations

Motivations drive the behaviours and actions of actors. Four motivations contributed to the theory–practice gap: low priority for rural sanitation, misdirected accountability, competing personal interests and corruption.

*3.1.1. Low priority for rural sanitation.* Even though rural sanitation gained attention with the TSC and especially with the popularization of NGP awards, sanitation remained a low priority. Government officers and engineers, tasked with leading water and sanitation projects, neglected sanitation in favour of more stimulating and costly water projects. Even where officers were motivated to facilitate real sanitation change, lack of training in participatory development methods was an obstacle for implementing

Table 2. Actor groups in the TSC.

Top-level officers in the DDWS	Develop and coordinate the TSC. Update policies and inform states. Delegate responsibilities to states. Monitor progress. Distribute 80% of TSC funding to states.
Mid-level officers at state, district, block levels	<i>State level</i> Attend national trainings. Develop state policies based on TSC guidelines. Coordinate implementation with districts. Distribute the TSC funding to districts (contributing 20%). Report sanitation coverage to national level. <i>District level</i> Attend state trainings. Prepare and implement district projects. Distribute funding to blocks. Report sanitation coverage to state. <i>Block level</i> Attend district trainings. Support implementation. Provide trainings to GP leaders. Organize IEC or motivational activities in villages. Distribute funding to GPs. Report sanitation coverage to districts.
GP leaders	Attend district and block trainings. Lead implementation in villages. Motivate households to adopt improved sanitation. Distribute funds to households. Report sanitation coverage to blocks.
Rural communities	Attend village sanitation meetings and activities. Construct latrines independent of external support (BPL households with incentive). Adopt improved sanitation practices.

Table 3. TSC actor characteristics.

Motivations	Cognitions	Power
Low priority	Infrastructure-focused technocrats	Decentralized governing system
Misdirected accountability	Lack of training	Technocratic governing machinery
Competing personal interests	Flawed monitoring system	Paternalistic inertia
Corruption	Inaccurate poverty classification	

the TSC, which was meant to emphasize behaviour over infrastructure. Similarly, sanitation was seldom an expressed priority for village leaders and households, likely due to the taboo surrounding faeces and the neglect of the voice of those most affected: women, children, and disabled.

As a complex programme, the TSC would have required strong political will and leadership. The success stories found in our research – like Budni block in MP, Basara GP in Haryana and many areas of

Himachal Pradesh – have a common thread of committed sanitation champions at the district, block and village levels. Strong will across government levels to advance sanitation and committed villagers allowed the TSC to overcome obstacles and achieve the intended goals.

*3.1.2. Misdirected accountability.* Accountability in the administration was focused mainly on subsidy expenditure, to some extent on coverage achievement, and minimally on latrine usage. Government officers knew they would be evaluated based on funds distributed and toilet numbers accrued. Hence, they focused on spending and construction, which resulted in subsidy-driven, infrastructure-centred and supply-led implementation. For instance, the officer pioneering a no-subsidy implementation in Budni block in MP was questioned by superiors for not spending the funds allocated for sanitation infrastructure. Similarly, in Panipat District, Haryana, the state forced the release of subsidy funds or else face negative evaluation of district officers.

*3.1.3. Competing personal interests.* District and block level officers had personal incentives that deterred sanitation progress. With frequent post transfers, officers preferred to invest efforts in programmes they knew could be successful. Sanitation, a challenging area to confront that takes a long time to show progress, might not be conducive to career success. Alternatively, in order to benefit professionally, some officers haphazardly implemented the TSC and then over-reported coverage progress. Also, the dynamics in the administration left them little time to stop and learn from early results. The NGP award scheme intensified these problems, especially during the early years when verification was lax.

Also, due to career incentives, they tend to privilege programmes with larger budgets. This, coupled with interests of politicians, resulted in a pressure on the GoI to increase subsidies.

*3.1.4. Corruption.* The sophistication and pervasiveness of corrupt behaviour in South Asian water and sanitation programmes are widely recognized (Davis, 2004), and the TSC is not an exception. An anonymous DDWS employee stated ‘corruption leads money to stay with people who have power. Funds sent from the centre are first skimmed by the states, then districts and blocks and finally by village leaders’. In UP, an anonymous Rural Development Ministry employee stated ‘20 to 30% of funds allotted by the state for rural development leaks out before reaching the beneficiaries. Leakage of rural development funds may be up to 50% in some of the most underdeveloped areas’. Self-guided distribution of hardware subsidies and lack of oversight during project procurement and construction promoted misuse of subsidy funds. Consequently, community distrust of leaders and officers grew, hindering future efforts. Apart from the capture of the funds by elites, some local leaders also diverted materials or cash to caste and political affiliates, excluding members of other village groups from government programmes.

## 3.2. Cognitions

Cognitions are the information and knowledge that inform actors’ interpretation of a situation. Four cognition components contributed to the implementation gap: infrastructure-focused bureaucracy, lack of personnel and abilities, flawed monitoring system, and inaccurate poverty classification.

**3.2.1. Infrastructure-focused technocrats.** TSC officers from the central to local levels viewed rural sanitation as a dilemma of technology and poverty, not as a social and institutional issue requiring focus on the people. According to India WASH Forum ‘the district and state level coordination (...) is geared towards construction and hardware, since these are the strengths of the implementing agency. Hence at the institutional level there is a structural gap in planning and delivery effective BCC [Behaviour Change Communication] for sanitation’ (2011: 5). Although technology and subsidies had proven problematic, a technocratic perspective continued, causing the TSC to be supply-led and target-driven.

**3.2.2. Lack of officer training.** Local government officers tasked with leading the TSC were generally under-trained. They were also simultaneously responsible for many other rural programmes. Districts and blocks did not rely on social workers or community development experts to implement the campaign, but on engineers. Without experience and adequate training, many local government officers lacked the skills needed for a community-led campaign.

**3.2.3. Flawed monitoring system.** As proven by the 2011 census, the TSC monitoring system was highly inaccurate. Examples abound at the local level, too. Dhindar GP in Haryana reported 100% latrine coverage in 2011, but our research showed that 15% of households lacked latrines and 30% defecated openly. In Killod GP in MP, another reportedly ODF GP, many toilets had collapsed since the NGP award received in 2008 and our survey found only 60% coverage in 2011.

Inaccurate coverage data in the TSC were mainly due to haphazard reporting. In some states, like Haryana, GPs self-reported sanitation coverage. Others, such as UP, calculated coverage based on subsidy funds released from blocks, not on physical verification. As a result, many GPs showed 100% coverage when in reality they were far from total sanitation. Figure 1 illustrates that this might apply nationally: sanitation coverage reported by DDWS rose hand in hand with funds released, while actual sanitation

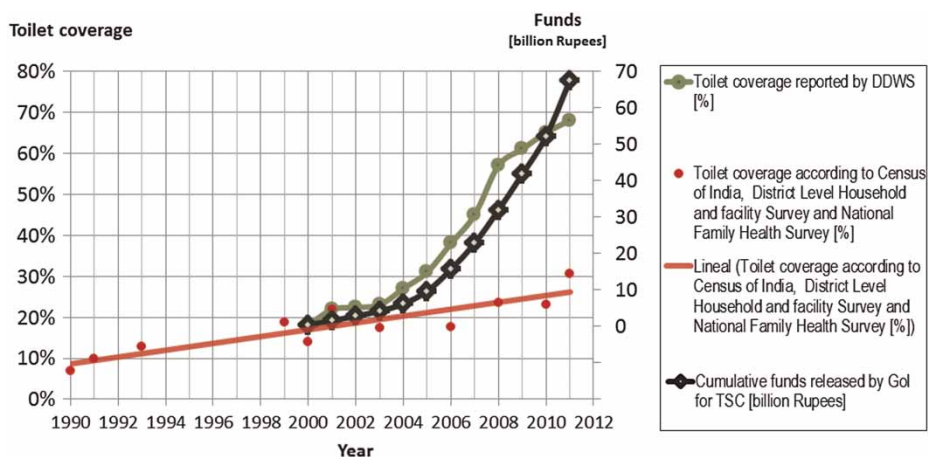


Fig. 1. Reported and surveyed rural sanitation coverage compared to funds released. In the graph, the light curve represents rural sanitation coverage as reported by the Government of India until 2011. The unconnected dots – and the corresponding trend-line – represent the same information, but according to the Census (Government of India, 2012b) and different survey-based sources (International Institute for Population Sciences, 2007, 2010; WHO & UNICEF, 2012). The dark curve represents the funds released for sanitation by the Government (Government of India, 2012c).

coverage – from surveys – continued on the same slow path since the 1990s. Clearly, TSC monitoring had more to do with subsidies than with real coverage. The millions of missing latrines were either never constructed or partially constructed and abandoned.

Further causes of the flawed monitoring system were that it was blind to sanitation slippage, immigration and population growth. An additional problem is that it focuses on coverage, neglecting usage. In Bareilly District in UP, where school sanitation coverage was reported to be universal, latrines in all seven schools in the three GPs studied were overflowing and unusable.

The flawed monitoring system reflects and reinforces the infrastructure-centred and target-driven implementation of the TSC. The pressure to spend and show coverage progress led officers to quickly arrange toilet construction and report positive results without verifying ground-level reality. An anonymous government employee acknowledged: ‘sanitation coverage is officially shown and signed for, but in reality there is no transparency, little organization, little capacity and much corruption, leading to over-reporting’.

In turn, the flawed monitoring also weakened the capacity to target the population properly and to identify what works where.

*3.2.4. Inaccurate poverty classification.* Because of an unreliable poverty classification system, hardware subsidies provided to households with BPL cards failed to promote inclusion of the poorest. The Indian BPL lists are often inaccurate, outdated or even manipulated due to village politics. For example, in Mandora GP in UP, 70 poor lower-caste Kashyup households – the most marginalized section of the village – did not have BPL cards because of their caste and status as perceived by the ruling community group. As a result, they had been largely excluded from government programmes, including sanitation: not one of these 70 households were included in the TSC project nor received a latrine subsidy. The unreliable poverty classification system misdirected the available resources, rewarding those with power and generating exclusion and segregation.

### *3.3. Power*

Power refers to an actor’s capacity to implement a policy. It includes the regulatory or formal dispositions, along with relevant informal rules or hierarchies. The three determining aspects of power in the TSC included the decentralized system, technocratic governing machinery and paternalistic inertia.

*3.3.1. Decentralized system.* The Indian governing system is widely decentralized, involving many actors across different levels. This is especially true for rural programmes like the TSC. Coherently, the central government issued guidelines and the states developed policies and delegated campaign implementation to districts, which in turn facilitated blocks and villages to take responsibilities over the campaign. Decentralized systems are considered to be positive for encouraging innovation and customizing programmes to the local situations. In the TSC, though, it made it difficult to achieve skilled facilitation or to make policy changes happen locally.

*3.3.2. Technocratic governing machinery.* India has a hierarchical and technocratic bureaucracy that is well suited to send down technical designs and subsidies for physical infrastructure projects. As a consequence, the TSC focused on subsidized hardware, instead of on facilitating behaviour change and sustainable latrine usage. Sanitation interventions continued to happen without the involvement of community members. As a result, the TSC was implemented in a supply-led mode despite guidelines that described a demand-driven, participatory programme.

**3.3.3. Paternalistic inertia.** For many decades the Indian government has been attempting to meet the basic needs of its most vulnerable citizens through various welfare schemes. A paternalistic inertia resulted; omnipresent welfare programmes and subsidies generated a strong expectation of a nanny state among rural programme beneficiaries. As a consequence, many rural communities expected to be passive recipients of the TSC. The paternalistic inertia thus challenged the foundations of the incentive-based and community-led TSC policy.

#### 4. Have we learned from the past?

After describing the TSC theory–practice gap and analysing the reasons behind it, the question arises whether we have learned from failure, that is, whether things are improving.

In theory, political priority of rural sanitation has risen on India's agenda with creation of the Ministry of Drinking Water and Sanitation in 2011. The advocacy in the media by the Minister, Jairam Ramesh, has boosted knowledge of national sanitation gaps. However, he has recently been stripped of the post and it is not clear whether the new Minister will keep the same level of commitment to the cause. Along with the new ministry has come a restructuring of the TSC into the NBA. We analyse here briefly some elements of the new NBA (Government of India, 2011a, b, 2012d), discussing their potential consequences in relation to the problems of the TSC and to the core characteristics of the actors involved.

The Minister's advocacy for sanitation has focused on enhancing the budget for incentives, seemingly omitting subsidy lessons of the past. The failure of the GoI to adopt a more software-oriented campaign underpins the technocratic, infrastructure-focused perspective programme administrators maintain. To enhance sanitation progress the GoI has increased this year's budget for rural sanitation from Rs. 15 billion to Rs. 35 billion (India Sanitation Portal, 2012), over US\$600. The majority of this budget bump will go to a threefold increase in the 'incentives'; the cash incentive climbs to Rs. 4,600 (US\$84) – from Rs. 2,200 until mid 2011 – and an extra Rs. 4,500 will be provided in materials or labour through convergence with the MGNREGA employment scheme (India WASH Forum, 2012). Taking into account a TSC history of upfront 'incentive' distribution and its consequences, increasing the cash distributed per household may lead to an even more supply-led, construction-oriented programme. The convergence with MGNREGA will emphasize construction and infrastructure, reinforcing both the subsidy-driven and supply-led character of campaign implementation. The renewed emphasis on hardware will likely work against the NBA by enhancing the corruption, paternalistic inertia and misdirected accountability that are known to have hindered achievement of a demand-driven and community-led TSC.

Another proposed change is a stronger focus on awareness and communication in the NBA. The revamped sanitation programme will devote more resources to IEC than before; IEC should continue even after ODF is achieved. Although conventional approaches to IEC are not clearly questioned in the new policy, the NBA does recognize importance of peer influence, calling for prioritization of inter-personal contact and motivation. For communication, the NBA will incorporate a national dimension, including an Indian sanitation week and involving Bollywood stars. These positive changes in the NBA will likely reinforce the demand-driven character of the policy.

It has been said, that in the NBA the aim will shift from household access to community usage, adopting a saturation approach. This would be reflected in the monitoring system becoming less 'built-latrines' centred. It will also monitor performance, helping re-direct the accountability focus towards the elements relevant for solving the sanitation challenge. However, questions remain on how these improvements in



the monitoring will become operational. Since over-reporting has not been clearly acknowledged as a problem of the past TSC, there are doubts about how reporting accuracy will be guaranteed.

In addition, there is provision for biannual mandatory independent evaluations of the NBA in all states. These evaluations, if exhaustive, rigorous and independent, have potential to disincentivise over-reporting and re-align personal interests with adequate implementation.

Finally, the criteria for receiving the incentive have changed, introducing a more complex identification of weaker community groups needing assistance. Along with BPL, Above Poverty Line households are also eligible for the incentive if they belong to Scheduled Castes or Scheduled Tribes, or are small and marginal farmers, landless labourers with homestead, physically handicapped or women-headed households. The acknowledgement of the limitations of the current APL–BPL distinction and introduction of a finer ‘identification’ of those who need help is a positive step. However, the challenge of motivating collective behaviour changes will remain.

It could be said that the new policy reinforces the principles of the TSC both on a theoretical and practical level. The people-centred principle could be reinforced through the shift to monitoring ODF villages. The demand-driven principle is reflected in the stronger focus and efforts on awareness and communication. The community-led principle is supported by a stronger role of the GPs in the NBA. The incentive-based principle is endorsed, but no specific provisions are in place to ensure it is not used as a subsidy.

Still, the implementation process will determine the extent to which desired principles come true. In this regard, it must be noted that only some of the motivations, cognitions, and powers that negatively affected TSC implementation are tackled, namely the low priority for rural sanitation and, partially, the inaccurate poverty classification. There are some changes that could address the obstacles of misdirected accountability, flawed monitoring system and competing personal interests, but strong doubts remain for whether these will become true. Other characteristics remain ignored, such as lacking abilities of mid-level officers, decentralized system and the technocratic governing machinery, while three are reinforced: corruption, infrastructure-focused technocracy and paternalistic inertia.

## 5. Conclusions

India learned the shortcomings of a construction-oriented, subsidy-focused rural sanitation programme during the CRSP in the 1990s. The TSC was installed in 1999 as an improved community-led, people-centred, incentive-based, demand-driven programme that would set India on a new course towards achieving total sanitation. However, rural sanitation coverage has grown at a slower pace in the TSC, achieving just 31% coverage in 2011 and leaving millions of missing toilets, along with 8,300,000 more households defecating in the open than in 2001.

The poor outcomes of the TSC are related to the fact that the principles upon which the policy was based were not translated to practice, as our research confirmed.

Several elements and processes around the TSC, related to the characteristics of the actors involved in the implementation process, shed light on this theory–practice gap. These characteristics, defined by actors’ motivations, cognitions, and power, all interacted with and affected more than one TSC principle. A few of the relationships between TSC principles and actor characteristics are summarized below.

The community-led principle was hindered by the inability of mid-level government officers and an inaccurate poverty classification system. The people-centred principle was impeded by a flawed monitoring system coupled with misdirected accountability that made officers focus on budget expenditure

and the number of latrines built. The incentive-based principle was hampered by a paternalistic inertia in India and high levels of corruption in rural development programmes, including sanitation. The demand-driven principle was jeopardized by the technocratic governing machinery and the infrastructure-focused bureaucracy, as well as by the competing personal interests of officers due to career incentives.

The decentralized governing system and low political priority of sanitation affected the overall implementation process, reducing chances of all four TSC principles from occurring at ground level. As a result of the low political priority of sanitation, little effort was made to adequately implement the TSC or to overcome the interests and dynamics that countered it.

The recently revamped TSC, the NBA, is drawing the lines of the new sanitation policy in India. However, the changes in the new NBA are not taking into account past lessons. It does adhere to and reinforce the principles of the TSC, but the failing implementation processes are not sufficiently addressed.

In terms of motivations, the political priority of sanitation has risen with the advocacy of the first Minister of the newly created Ministry of Drinking Water and Sanitation. Mandatory independent evaluations might contribute to realigning the accountability focus and personal interests of the officers with sanitation progress. However, the tripling of the incentive and the lack of effective measures that prevent upfront incentive disbursement will run against programme realignment. It may even contribute to increasing the level of corruption, as well as to reinforcing the paternalistic inertia (related to power). At the cognition level, it is positive that the inaccurate poverty classification is being addressed. The shift from household toilet coverage to community-wide usage of toilets in monitoring is also promising. In addition to the challenges of operationalizing these changes, the over-reporting problems in the monitoring system are not tackled. Apart from that, the main focus of the Ministry on increasing the budget might reinforce the infrastructure focus of the bureaucracy.

In the end, the NBA has not adequately incorporated most of the lessons from 13 years of failed implementation of the TSC. Despite some positive changes, it seems that the key elements hampering implementation remain ignored or are reinforced. A strategy based on resetting unrealistic sanitation data and making policy changes without examining, understanding and tackling the roots of the implementation problems is doomed to relapse into past hurdles, fail to effectively improve the sanitary situation of rural India and end in another new ‘revamp’ after another decade.

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