Government of the Republic of the Union of Myanmar

RURAL SANITATION AND HYGIENE POLICY

2020 - 2030

November 2020

Table of Contents

ABBREVIATIONS AND ACRONYMS

BCC	Behavior Change Communication
CATS	Community Approaches to Total Sanitation
CLTS	Community Led Total Sanitation
CSO	Civil Society Organizations
CSR	Corporate Social Responsibility
DALY	Disability Adjusted Life Year
DHS	Demographic and Health Survey
EASAN	East Asia Sanitation Network / Conference
EMIS	Education Management Information System
FSM	Fecal Sludge Management
GDP	Gross Domestic Product
GPI	Gender Parity Index
HCF	Health Care Facility
HMIS	Health Management Information System
IA	Implementing Agency
IDP	Internally Displaced Persons
IPC	Inter-Personal Communication
JMP	Joint Monitoring Program
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MHM	Menstrual Hygiene Management
MICS	Multiple Indicator Cluster Survey
MIS	Management Information System
MoHS	Ministry of Health and Sports
MSDP	Myanmar Sustainable Development Plan
NA	Not Applicable
NGO	Non-Governmental Organization
O&M	Operation and Maintenance
ODF	Open Defecation Free
RHC	Rural Health Centre
S&H	Sanitation and Hygiene
SDG	Sustainable Development Goals
SHG	Self Help Group
SWA	Sanitation and Water for all
TWG	Technical Working Group
UNICEF	United Nations Children Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

DEFINITIONS

Sanitation	"Sanitation refers to the provision of facilities and services for the safe management of human excreta from the toilet to containment and storage and treatment onsite or conveyance, treatment and eventual safe end use or disposal. More broadly sanitation also included the safe management of solid waste and animal waste." (https://www.who.int/topics/sanitation/en/)
What is Sanitation?	Sanitation is the practice of eliminating all the factors that can interfere with a physical and mental well-being of human beings. Sanitation is an overall culture of cleanliness, hygiene and healthy habits within the society. It is more than having a toilet or using a toilet; these are just a means to an end. It is part of the overall development process. This overall culture should be evident at all places – at the household, school, institutions, in urban or rural areas, while travelling, etc.; in fact, improved sanitation and hygiene behavior should be such an ingrained habit that its absence would create discomfort within the individual and within societies.
Handwashing	Handwashing is the act of cleaning your hands with soap and water, when hands are visibly dirty or before/after certain behavior/actions such as before having meals/feeding, using the toilet, washing baby's bottom, and other actions which can potentially contaminate the hands.
Hygiene	Hygiene refers to the maintenance of a clean environment, both at personal and at the environment level. "Cleanliness that promotes health and well-being, especially of a personal nature". It mandates clean body, especially hands, covered food and water, and maintenance of a germ-free environment.
Improved Sanitation	Sanitation facility where the fecal-oral chain and water contamination has been blocked; practically, it means that flies cannot access the fecal waste and come back to human beings; also, ground and surface water is not contaminated by the sanitation facility.
Basic Sanitation Services	Terminology used by SDG for improved sanitation. Use of improved sanitation facilities which are not shared with other households. Sanitation facility where the fecal-oral chain and water contamination has been blocked; practically, it means that flies cannot access the fecal waste and come back to human beings; also, ground and surface water is not contaminated by the sanitation facility.
Safe Sanitation Services	Use of improved sanitation facilities which are not shared on premises with other households and where excreta is safely disposed in situ or transported and treated off-site or pit latrines

	that are sealed when they become full and new pits dug. Basic/improved sanitation where the fecal matter is stored, transported, treated and disposed in a safe manner. Looks at not just the toilet, but also the service chain until final disposal of the treated waste.
Joint Monitoring Program (JMP)	International monitoring system of the SDG, undertaken jointly by WHO and UNICEF. Source of data is typically country based data collection systems, DHS, MICS, etc. A best fit line is drawn for a country based on multiple data systems.
School Sanitation	Sanitation facility for the children, teachers and staff in a school. Needs to be gender-segregated, subscribe to safe sanitation standards, adequately in quantity (ratio of urinals/toilets to children and staff), have handwashing facilities, and menstrual hygiene management facilities
Health Care Facility Sanitation	Sanitation facilities in hospitals and health centers. As per size of the hospital – number of in- and out-patients, and health staff.
Menstrual Hygiene Management facilities	Typically, in schools, but also in community. Facilities in schools to meet menstrual needs of adolescent girls, including privacy and safe disposal facilities (e.g. incinerators)
Development Partners	Donors, development banks and multilateral development organisations
Open Defecation	Feces left openly exposed to the air, typically done in the 'fields or forests or behind the bushes' or into open bodies of water (e.g. river or stream), beaches and other open spaces directly; includes pit toilets with no covering where feces is open to flies or contaminates ground water.
Open Defecation Free (ODF)	Situation where there is no open defecation (see definition of Open Defecation) in the environment
At-scale Program	Program where the intervention is targeted at a larger unit, say a district or region/state
SDG Targets	Sustainable Development Goals of the United Nations adopted in 2015. Aims to achieve 100% coverage / access across 15 developmental goals. Goal 6 covers WASH, with Goal 6.2 covering Sanitation and Hygiene: "By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations"

ACKNOWLEDGEMENTS

The development of the Sanitation and Hygiene Policy for rural Myanmar was led by the Ministry of Health and Sports (MoHS), Government of Myanmar. The process was led by the Minister of Health and Sports, H.E. Dr Myint Htwe, Deputy Minister H.E. Dr Mya Lay Sein, Permanent Secretary Dr Thet Khaing Win and Director General of Department of Public Health, Dr Soe Oo. It was also coordinated by the Task Force created for the purpose, consisting of members from various Departments of the MoHS such as Department of Public Health and Department of Medical Service, various Ministries/ Departments of the Government of Myanmar such as Department of Basic Education, Department of Rural Development, Department of Planning, Department of Budget, Central Statistics Organization, General Administration Department, Environmental Conservation Department, Department of Disaster Management, Department of Building, Inland Water Transport, Department of Marine Administration, Myanmar Railways, Road Transport Administration Department, Directorate of Water Resources and Improvement of River Systems, University of Public Health (Yangon), University of Medicine (1) Yangon, University of Medicine (2) Yangon, University of Community Health (Magwe) and technical experts from WHO and UNICEF. Thanks to the TF members for their constant guidance and leadership during the process.

The representatives of the Task Force and sub-national governments, from the States/Regions and selected townships, participated in the consultative workshops at the preliminary stage as well as the draft stages, and contributed extensively to the development of ideas for the policy. All these representatives who participated in these meetings, as well as those in the background who contributed, are thanked for their contribution.

The MoHS was supported in the development of the policy by WHO and UNICEF, including the provision of support of consultants (Dr. Min Than Nyunt and Ajith Kumar). Additionally, other development partners and national and international NGOs also contributed to various drafts of the policy through physical and online feedback. This policy acknowledges the contribution that all these partners to the MoHS, made in the preparation of this policy.

FOREWARD

The Rural Sanitation and Hygiene Policy commits the Government of Myanmar to pursuing a set of principles and strategic approach that will enable all residents of rural Myanmar to enjoy their right to a high standard of sanitation, as well as a clean and healthy environment as guaranteed by the Constitution of Myanmar. The goal of this policy is to ensure better health, dignity, social well-being and quality of life for all the people of rural Myanmar. The policy aims to mobilize resources from public, private, community and household in pursuit of the national vision of transforming Myanmar into a developed country.

The policy articulates and clarifies the roles and responsibilities of many stakeholders and agencies involved in the sanitation sector, commits to increasing investment in sanitation and create an enabling environment.

The policy has been developed by the Ministry of Health and Sports through the Department of Public Health, in collaboration with other Government Ministries, Departments and Agencies, as well as other national and international stakeholders. In particular, I would like to express my deep appreciation to WHO and UNICEF for providing technical support to the Ministry of Health and Sports and making possible this Myanmar National Rural Sanitation and Hygiene Policy 2020-2030.

Finally, it is envisaged that this policy will provide a critical reference to all agencies, both public and private that are, or will be, actively working towards achieving our vision by ensuring that all Myanmar citizens enjoy their guaranteed constitutional right to improved sanitation and a clean and healthy environment. To ensure its effective implementation therefore, along with the policy, a costed Implementation Plan is also being prepared.

Union Minister for Health and Sports
Ministry of Health and Sports
Government of Myanmar

PREFACE

Myanmar Sustainable Development Plan (MSDP), 2018-30 is the national development vision of Myanmar, set within the global SDG agenda. It seeks to provide an overall framework for coordination and cooperation among all the stakeholders at national and sub-national levels. The MSDP has 3 pillars and 5 goals, out of which Goal 5: Natural Resources and the Environment for Prosperity of the Nation under Pillar 3: People and Planet is most relevant to WASH. The strategy 5.3 states: "Enable safe and equitable access to water and sanitation in ways that ensure environmental sustainability". The MSDP therefore sets the framework for achievement of sanitation and hygiene objectives, for which this policy assumes relevance.

"Sustainable Development Goals (SDGs), 2030": *The '2030 Agenda for Sustainable Development were adopted by the United Nations in 2015, "provides a shared blueprint for peace and prosperity for people and the planet, now and into the future*". It sets out 17 SDGs and out of which, Goal 6 is *"to ensure availability and sustainable management of water and sanitation for all"* [1]. *Goal 6.2 has the objective: "By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations"*

A. VISION FOR THE SECTOR

The Path to The Vision

1. The strategic objective of the vision includes:

> *"All residents of the rural areas in the country are living and practicing, by the year 2030, in a clean and safe environment as a social norm, as a way of life, leading to a brighter image of the country within and outside."*

- All residents people in the rural areas including the peri-urban areas of the country are living in ODF communities. Residents include all those who are living permanently, short- or long-term visitors, short- or long-term migrants, those who have come for work for a day or for longer duration.
- All people in rural areas have access to a basic sanitation service and handwashing station (with soap), always by the year 2030. This would be at home, at schools, at work, at public places, at disaster or emergency situations and the like, that are:

1 https://sustainabledevelopment.un.org/SDGs

- Safe, hygienic, socially and culturally acceptable, and affordable, provides privacy and ensures dignity.
- Are always easily accessible, day and night, and during health emergencies
- Protects health, are environmentally appropriate and climate resilient
- Handwashing stations are near to point of use (toilet, dining areas), along with soap, and are always easy to use.

- At least 70% of the toilets fall into the 'safely managed' category by 2030, with the remaining 30% being achieved by the year 2035.
- No one is left behind, with all the people, including marginalized of any kind, have equal access to an ODF environment and improved sanitation and hygiene facilities as anyone else.
- All feces, including infant feces, is disposed of in the toilet or other safe practices
- Other feces, like animal feces, are also disposed-off in a safe manner
- ODF and improved access becomes a society norm that sustainability of these behaviors are guaranteed in the future, without dangers of slip-backs.
- The vision of achieving an ODF rural Myanmar is a means to achieving ODF Myanmar by 2030.

B. Need for Improved Sanitation

2. A need for improved sanitation has been identified as a critical development need due to its impact on overall quality of life of the people and the development of the country. It is for this reason that it has been addressed as a priority by the Myanmar sustainable development plan and the sustainable development goals of the UN.

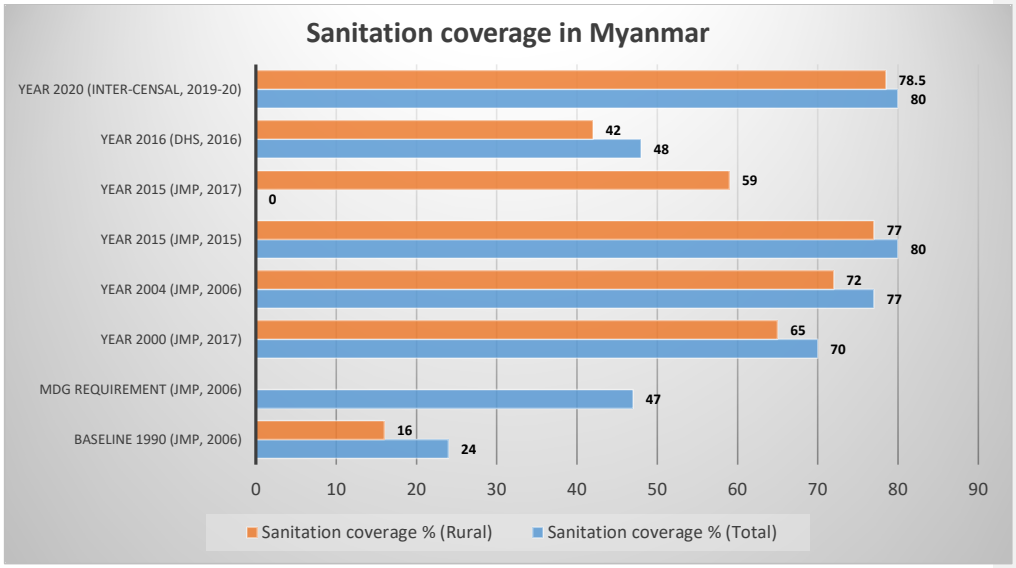
3. Improved sanitation sits at the intersection between water, health and the environment. It has a deep impact, directly or indirectly, on most developmental indicators including health, education, and poverty reduction. Beyond the physical morbidity and mortality that it causes, it has been known to have an impact on cognitive development of children. Additionally, it has been known to cause losses of the national GDP in several developing countries in Asia and Africa. These are impacts that a developing country like Myanmar cannot afford. The human capital of our country is one of Myanmar's greatest assets, which we must be protect for the country's long-term development.

4. Sanitation and hygiene is considered as 'public good' nature. A public good is one where the adoption or non-adoption of certain practices affect not just the individual concerned, but the wider society at large. Adoption/non adoption of sanitation and hygiene practices impacts all in the society – open defecation can impact the health of all people in the vicinity. This is the reason why improved sanitation and hygiene practices should be adopted by all in the society. And this element of public good is why public investments (by governments, by development organizations, etc.) are required for sanitation and hygiene.

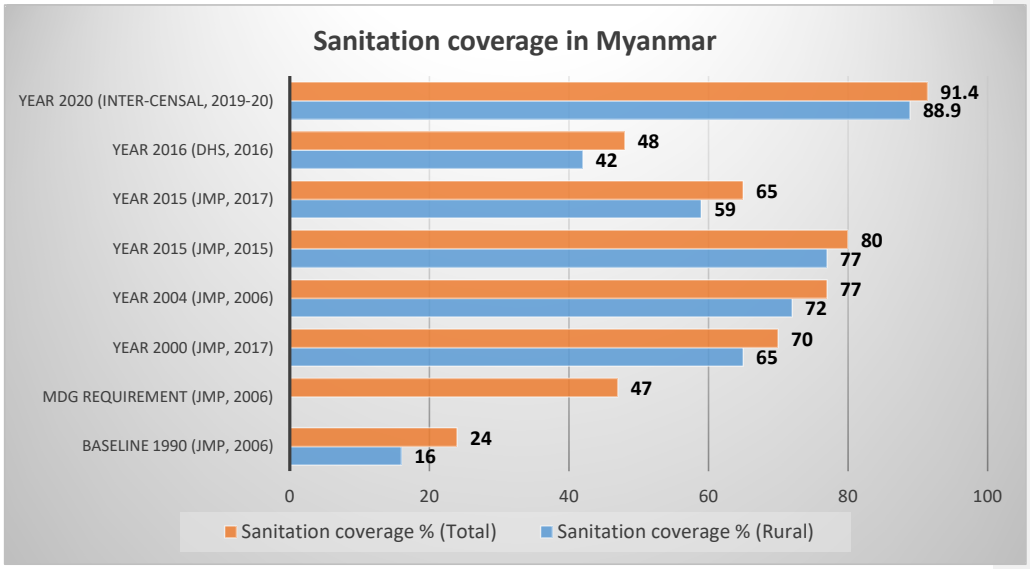
5. DHS, 2015-16 has noted no significant difference in diarrheal cases between those households with improved toilet facility (10.4%) than unimproved facility (10.7%). This could be because even those households with improved sanitation facilities are exposed to contamination in the environment which leads to diarrheal incidences. An open defecation free (ODF) environment in which all practice safe sanitation is therefore required for all the households to benefit from a sanitary environment.

C. Current Status

(Improved Sanitation Facilities – can be used if the main intercensal survey report is not launched)



(Basic sanitation services) (The official report is not launched yet and have to wait)



Access to toilets

6. The status of rural sanitation has kept changing due to various factors. The data from 1990 baseline of the JMP shows that Myanmar had a coverage of 24% in 1990 (rural 16%) and required 47% to reach the MDGs (JMP,2006[2]). The same report cites a sanitation coverage of 77% (rural 72%) in the year 2004. However, the overall coverage figures has kept fluctuating, most likely as a) the quality of data collection has improved, b) the definitions of an improved sanitation has changed, c) the population has increased and d) slippages in assets (number of toilets have reduced) or behavior (usage has come down/changed). The JMP 2015[3] lists 77% sanitation coverage for rural areas and 80% for the country. The JMP, 2017 report[4] gives a 65% basic sanitation coverage in rural areas for the year 2000, with 9% unimproved and 15% open defecation. The 2014 census report[5] showed that 67% of rural communities used improved toilet facilities, 33% of households used unimproved toilet facilities with 19% households practiced open defecation.

7. In 2015, the new SDG indicators were established with ambitious a new global benchmark and service ladder which includes safely managed sanitation services, basic sanitation service, limited sanitation service, unimproved sanitation facilities and open defecation. This has changed the sanitation coverage of Myanmar to 58.7% basic service, 10% limited service, 24.5% unimproved and 6.9% open defecation in 2015. The Myanmar DHS, 2015-16[6] provides a figure of 42% coverage of improved sanitation which were not shared in rural areas (total 48%) plus 9.2% which are shared, with 35% unimproved and 14% open defecation. The 2019 Inter-censal survey reported that 91.4% of households have access to an improved sanitation facility (88.9% of rural households). However, only 26.1% of households have a flush toilet linked to a sewer system or septic tank. 3.7% of households still use an unimproved sanitation facility (4.6% of rural households) (80% of households used at least basic sanitation services (an improved sanitation facility which is not shared on premises with other households) (78.5% in rural areas), 11.9% of households share toilet facilities with other households (limited services) (10.5% in rural areas), 3.6% of households use an unimproved sanitation facilities (4.4% in rural areas) and 4.9% of households practice open defecation (6.5% in rural areas).

Comment [A1]: This will be replaced with the previous sentence if the main intercensal report is lunched in Nov 2020.

Trends Among States/Regions

2 WHO and UNICEF, 2006, Meeting the MDG drinking water and sanitation targets: The Urban and Rural Challenge of the Decade,

3 https://washdata.org/sites/default/files/documents/reports/2017-06/JMP-2015-Report.pdf

4 Progress on drinking water, sanitation and hygiene: 2017 update and SDG baselines. Geneva: World Health Organization (WHO) and the United Nations Children's Fund (UNICEF), 2017. Licence: CC BY-NC-SA 3.0 IGO.

5 The 2014 Myanmar Housing and Population Union Report

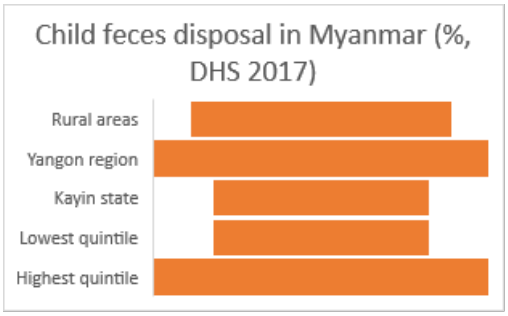
6 Ministry of Health and Sports (MoHS) and ICF. 2017. Myanmar Demographic and Health Survey 2015-16. Nay Pyi Taw, Myanmar, and Rockville, Maryland USA: Ministry of Health and Sports and ICF.

8. The national average covers the disparities between the States and Regions. The 2019 inter-censal survey found that the rural communities in Myanmar; a variation from 55% to 96% (average 88.9%) for access to improved sanitation facilities and households use unimproved sanitation facilities from 2.4% to 8% (average 4.6%) among the States and Regions (49% to 90% have access to at least basic sanitation facilities (average 78.5%) and households shared toilets with other households from 4% to 20% (average 10.5%) among the States and Regions. Unimproved sanitation facilities ranged from 1.4% to 9.6% (average 4.4%), while Open Defecation range from 1% to 37% (average 6.5%). This points to the differing challenges among different States/Regions. The policies, strategies and plans need to cater to these wide variations.

Comment [A2]: This will be replaced with the previous sentence if the main intercensal report is lunched in Nov 2020.

Disposal of Child feces

9. In rural Myanmar, about 59% of the households disposed of the children's feces safely (74% urban)[7]. Yangon Region had a high 76% safe disposal rate, while Kayin state had 49%. The lowest quintile had 49% safe disposal, with the highest quintile at 76%.



School Sanitation

10. The total number of schools in rural Myanmar is 50,066 (primary schools - 26,293, middle schools - 15,506, high schools - 5646; private schools - 1,091, monastic schools - 1,530). A UNICEF survey in 2010 found 65% of the toilets functional with 69 students to a toilet. The JMP 2018 report of WASH in schools contains only limited information for water supply service in 2016 and not sanitation and hygiene. https://washdata.org/sites/default/files/documents/reports/2018-11/JMP%20WASH%20in%20Schools-EN%20v5%20WEB%20Brochure.pdf

Health Care Facility Sanitation

7 Ministry of Health and Sports (MoHS) and ICF. 2017. Myanmar Demographic and Health Survey 2015-16. Nay Pyi Taw, Myanmar, and Rockville, Maryland USA: Ministry of Health and Sports and ICF.

11. The number of health care facilities in rural areas (up to township level) is 12,820 (2162 hospitals – (40) 100 bedded hospitals, (115) 50 bedded hospitals, (150) 25 bedded hospitals, (9) 16 bedded hospitals and (744) station hospitals; 10,658 health centers, (416) station health centers, (1,494) rural health centers and (8,748) sub rural health centers)[8]. The Ministry of Health and Sports' document of 2016 (reference in the Myanmar National WASH Strategy) found 98% of the RHC/UHC having a toilet, and 79% of the sub-RHC having a toilet facility.

Comment [A3]: Please kindly update with 2020 data from DPH including maternal child centers and urban health centers

Achievement of the MDGs

12. The WHO/UNICEF joint monitoring program (JMP) of 2015[9], assessing the status and the achievement of the MDGs, has categorized Myanmar into 'met MDG target'. In this report, the baseline data from 1990 is not mentioned (perhaps due to the change in the definitions or other reasons); however, going by the coverage of 16% coverage in rural areas in 1990, the MDG for rural sanitation in Myanmar was 58%. With a coverage of 77% in rural areas as mentioned in this report, the MDGs for rural areas were also met.

Equity – income, gender, disability, ethnicity

8 Ministry of Health and Sports (MoHS) July 2019.

9 https://washdata.org/sites/default/files/documents/reports/2017-06/JMP-2015-Report.pdf

13. There is a correlation between the income levels of households and their sanitation status. It is found that households at the lowest quintile have the poorest sanitation outcomes, and vice versa. DHS, 2015-16[10] found the practice of handwashing in 85% of the lowest quintile to 98% of the top-most quintile; however, of those washing hands, 67% from the lowest quintile had soap and water available vis-à-vis 98% in the highest quintile. 50% and 76% of the households in the lowest and highest quintiles disposed of the children's feces in a safe manner, respectively. These point to the influence that economic status of the household has on sanitation and handwashing.

14. The inequality between men and women may not be significant at the household level, as both use or do not use the same sanitation facility; in houses which don't have at toilet, the women may have to take more pains to go for od. Additionally, in houses which has a toilet, the women may have additional burden to fetching water for toilet use and keeping the toilet clean. The girl child may be disadvantaged at school, especially in secondary school stage, where menstrual facilities may be lacking; lack of privacy and changing facilities, and disposal of menstrual products may provide high levels of discomfort, leading to temporary absence from school or drop out. Currently, a gender parity index (GPI) of 1.07 (DHS, 2015-16) at secondary school level, is reassuring as this means that more girls than boys are attending secondary schools (however, Rakhine has a GPI of 0.82; lowest quintile has GPI of 0.96).

15. 2.1% of the population in rural areas have mobility issues (Census 2014), with some states/regions have a percentage above 3. Poorly constructed sanitation facilities, without sufficient access through ramps, appropriate height, handles, etc., creates obstacles for people with disability, especially those with mobility issues.

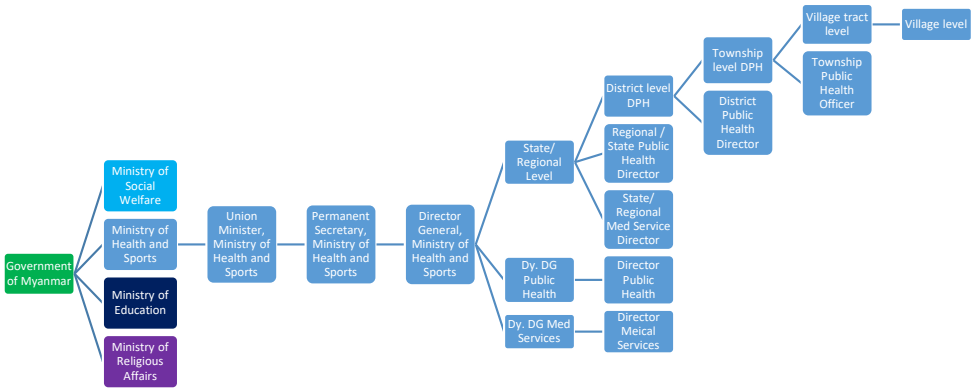
16. Myanmar is composed of different ethnic groups, all residing in harmony and with respect. People and communities of all ethnicities will be treated equally under this policy, and access to sanitation and hygiene facilities will be promoted equally among all of them.

Institutional responsibilities

17. Myanmar has a decentralized system under its constitution of 2008. The union government is complemented by governments at the seven states and seven regions plus Nay Pyi Taw; states and regions are divided into districts, further divided into townships – urban wards and village tracts (composed of a number of villages) make up the township. Constitutional governments are present at national and state/regional level, with elected legislatures and executives (led by chief minister at state/regional level).

[10] ibid

18. The Ministry of Health and Sports is the nodal ministry for sanitation and hygiene (Ministry of Agriculture, Livestock and Irrigation for water supply); the Ministry of Health and Sports has a structure from national level departments down to health centers at township, village tract and village level (see organogram)



Financing

19. The sanitation and hygiene sector requires funding for both software and hardware interventions. The source of these could be varied – households themselves, government budgets, donor support, private sector, etc. Households typically pay for their own toilets, while institutional sanitation (Schools, Health Care Facility) is paid out of respective government (ministry) budgets. Software across the sector is subsidized by public financing.

20. The WASH strategy in 2016 estimated that USD 80 million is required till 2030 to address the sanitation gap. As there is no consolidated information on the budgets spent on sanitation and hygiene till date in one place, this must be based on estimations.

Monitoring

21. The monitoring of sanitation and hygiene infrastructure and behavior is currently being monitored through the Health Management Information System (HMIS) for household sanitation and Education Management Information System (EMIS) for school sanitation.

Current rates of coverage

22. The current rate of progress in coverage means that the rural sanitation may not reach the SDGs, i.e. 100% by 2030 (including end open defecation and use of unimproved sanitation). To reach the SDGs by the year 2030, the rate of progress will have to be increased exponentially.

D. IMPACT

23. The direct impact of poor sanitation and hygiene practices are on health, the environment and the economy. Poor sanitation leads to the contamination of the environment, especially water, resulting in water- and air-borne diseases among human beings. DHS, 2015-16[11] records a 10% diarrheal incidence of children under 5 in Myanmar; Chin (24%) and Kachin (20%) led the States/Regions with diarrheal incidences. The lowest quintiles have around 12% diarrheal cases, while it is 7% in the highest quintile. Around the world, 480,000 number of children are victims of poor sanitation (https://data.UNICEF.org/topic/child-health/diarrhoeal-disease/); in Myanmar, it is anticipated that about 4,000 children die every year due to diarrheal incidences caused by poor sanitation.

24. It has been reported by DHS, 2015-16 that diarrhea is the fourth largest cause of death among children under-5 in Myanmar. There is a difference in diarrheal incidence among those households with improved water source (9.9%) than unimproved source (12.6%); however, there is a very small difference between those households with improved toilet facility (10.4%) than unimproved facility (10.7%) – this may be due to the 'public good' nature of sanitation and hygiene, whereby all are victims of the contaminated environment, regardless of their nature of assets (or lack of).

25. Infant mortality is 40 deaths per 1,000 children, while under-5 mortality is 50 per 1,000 children[12]. However, as per the DHS, 2015-16, IMR is 80 per 1,000 in rural areas, twice the urban areas. There are differences between States/Regions and between income groups. Shan and Chin are the worst performing States/Regions for under 5 mortality; the under-5 mortality among the poorest is 99 per 1,000 children, while it is 26 per 1,000 children among the richest quintile. The girl child has a better chance at survival in the first 5 years (46 per 1,000 live births), than the boy child (55.40 per 1,000)[13].

Stunting

26. DHS, 2015-16 reports a severe stunting rate of 21% with 8% moderate stunting; this figure is 32% for rural areas (20% urban). Chin State has the highest stunting rate at 41%.

Morbidity, Disability-Adjusted Life Year (DALYs)

11 Ministry of Health and Sports (MoHS) and ICF. 2017. Myanmar Demographic and Health Survey 2015-16. Nay Pyi Taw, Myanmar, and Rockville, Maryland USA: Ministry of Health and Sports and ICF.

12 ibid

13 https://www.indexmundi.com/facts/Myanmar/mortality-rate

27. In Myanmar, women are expected to live till the age of 70, while men have a life expectancy of around 64 and both sexes are expected to live till the age of 67[14].

28. The three leading causes of loss of DALYs in Myanmar in 2010 included diarrheal diseases[15].

29. Additionally, there is an economic impact of poor sanitation and resultant morbidity; in many countries, it has estimated that 1.4 to 6.1% of the GDP is lost due to the impact of poor sanitation. Myanmar spent about USD 50 per person (2016), with the bulk of it coming from private spending (USD 42; Government spending USD 12; Development assistance USD 5)[16].

E. CHALLENGES

14 The 2014 Myanmar Housing and Population Union Report

15 https://www.healthdata.org/sites/default/files/files/country_profiles/GBD/ihme_gbd_country_report_Myanmar.pdf

16 http://www.healthdata.org/Myanmar

30. Addressing the poor status of Sanitation and Hygiene faces certain challenges. The availability (or lack of) of water is one of these challenges. It is increasingly felt that there is either a shortage of water or an abundance of water; these drought or flood like situations can have an impact on effective sanitation and hygiene. Lack of water impacts the effective cleansing of the body after sanitation acts (like washing hands after defecation or before eating) and maintaining the toilets in a clean condition, while floods enter the pits and carry the fecal matter back into the open, leading to contamination.

31. The increasing incidences of these droughts and floods due to climate change is a major challenge which has to be addressed in times to come. All these impact the health of the people, as increasing incidence of poor sanitation impacts health. As climate change mitigation may be beyond the control of the immediate population which it impacts, adaptation strategies will need to be put into place at broader community and district/township levels.

32. The lack of adequate human resources, which has the capacity to facilitate change among the communities as well as others at district/township levels who can plan, manage and monitor large scale campaigns is a challenge faced in many States/Regions, especially the remote ones.

33. The availability of subsidies for hardware in the past (and in some cases, still continuing), by various development partners, has raised expectations among the people for its continuation. In the absence of resources, lack of such support may dampen enthusiasm among the people.

34. The financial resources available to address sanitation and hygiene is another major challenge. Finance is required for promotion of sanitation and hygiene behavior, construction of toilet facilities, and continued O&M of these facilities. This may need to be sourced predominantly from households themselves, but also from government budgets, international and national development support agencies, and the private sector (Corporate Social Responsibility - CSR funds). The magnitude of the need may be beyond the capacity of these sources.

35. The availability of resources at the last mile in addition to the connectivity issues has an impact on service delivery. A Behavior Change approach requires frequent access to the communities, which is a challenge in remote areas with poor and/or costly transportation facilities. Facilitating the community therefore becomes a challenge.

F. Rationale for a Rural Sanitation and Hygiene Policy

36. Sanitation and hygiene has been a neglected sector for eternity. It was treated as the least priority in the development sector, which itself faces discrimination compared to other sectors; often it is clubbed with either health, water or environment and never given a free-standing status and importance that it deserves. It is expected that having an explicit policy for the Sanitation & Hygiene (S&H) sector will reverse this trend. This policy will therefore help the Sanitation and Hygiene sector by:

- **Setting Priorities**: The Policy will help set sanitation as a priority for intervention, at the national and State/Region levels. Currently, sanitation is considered as an adopted child, invisible within the overall development sector, and within it, subsumed within the WASH sector. Having a policy will enable it to be visible to policy makers at the highest levels, which would lead to adequate resources to be made available.
- **Enabling environment**: The Policy will help set an enabling environment for the sanitation and hygiene interventions to take place. The policy will set the stage for resources to be allocated to the sector – human resources to undertake the promotion, coordinate and undertake monitoring; financial resources to support the processes. Effective systems can be put in place to support the sector. The responsible entities will find comfort within the policy to back them in the above-mentioned initiatives.
- **Institutional clarity**: The policy will help define the various institutions and their responsibilities at policy, implementation, monitoring and regulatory levels. The national and sub-national entities responsible would be identified; they would have the backing of the policy to assume the authority to undertake their responsibilities. The principles of decentralization and subsidiarity will form the basis of this institutional definition. The policy will help further define the incentives (and disincentives) for achievement of output and outcomes.
- **Scaling up sustainable program**: Policy will help focus on planning for a sanitation program, help simulate local action, enables scaling up a sustainable sanitation program. The policy by setting the vision and the direction for the sector will help in giving the overall road map to the stakeholders to carry the sector forward to its conclusion.
- **Equity**: The policy will help address equity in access to sanitation and hygiene. The policy will set the universality of outputs and outcomes as one of its principles and approaches; a 'leaving no one behind' approach will ensure that every section of the society is facilitated to achieve the desired outputs and outcomes.
- **Monitoring and accountability**: The policy will define monitoring frameworks and helps in ensuring accountability of institutions and the processes. The vision and the outcomes set by the policy in reaching a rural ODF Myanmar (leading to an ODF

Myanmar), along with intermediate outcomes, will assist in setting up the monitoring system and thereafter, demand accountability from the responsible stakeholders.

G. Policy Context

37. The rural sanitation and hygiene policy is framed within the context of the Constitution of Myanmar and other policies.

- Constitution of the Republic of the Union of Myanmar, 2008

  The Constitution of Myanmar sets the foundation for justice, liberty and equality in the nation. The constitution has provided the right to health care for its people. The constitution has set up a decentralization framework with State and Regional governments, which enables a decentralized delivery of services; new institutions, actors and responsibilities were made available at the sub-national level. The constitution set up the two schedules, 1 and 2, which defined the roles of the national and sub-national governments; the latter has defined revenue resources and can form a civil service organization, including appointment of personnel, which enables service delivery.

- Sanitation and Water for all (SWA)

  The SWA is a global partnership of governments, development partners, private sector, media and other stakeholders, created in 2010, to advance the global agenda on water and sanitation. The partnership focusses on increasing political prioritization for WASH, increasing financing and improving its effective utilization, and building an enabling environment towards increasing access to sanitation and water.

- National Health Policy and National Health Plan

  The National Health Policy was developed in the year 1993, and seeks to reach a Health for all goal, using primary health as the means; it talks of environmental health activities and prevention of pollution of air and water. The Myanmar National Health Plan, 2017-21 is part of a three-phase plan extending up to 2031, seeking basic, intermediate and comprehensive health care respectively.

- National Water Policy, 2014

The national water policy seeks to achieve the right to water and sanitation, as declared by the UN in 2010. It focuses on allocation of the water resources in the country along certain principles, with provision of drinking water and access to basic sanitation being one of the objectives. It directs attention on the need to address issues in WASH, especially sanitation, due to climate change factors. Investment in WASH capacity, monitoring, learning are some of the areas that the policy focuses on.

- National Environmental Policy, 2019, and Myanmar Climate Change Policy, 2019

  The National Environment Policy, which was brought out by the Government of Myanmar in 2019 builds on the 1994 policy and builds on others including the 2018 MSDP and the 2015 Paris Agreement. It seeks to adapt and mitigate the impacts of the global climate change, industrialization and urbanization on the environment and natural resources. Mainstreaming the environment into the development planning and implementation and seeks a balance between the needs of development and environment. It envisions a "clean environment, with healthy and functioning ecosystems, that ensures inclusive development and wellbeing for all people in Myanmar". The policy recognizes the right of every citizen of Myanmar to a clean and health environment, and recognizes its tangible and intangible value, including spiritual values.

  The Government of Myanmar has understood the impact of climate change on the country's development, which is why a specific Climate Change Policy was brought out in 2019, along with the National Environmental Policy. The policy seeks to adapt and mitigate the anticipated increasing impact of climate change like frequent droughts, floods, tropical cyclones, sea level rise, saline intrusion, etc. The policy envisions all sectoral investments and developmental plans to acknowledge and address challenges posed by changing climate. It sets out a vision of climate-resilient, low-carbon society which is inclusive and sustainable. Sustainable development, prevention, precaution, environmental integrity, shared responsibility and cooperation, inclusiveness, good governance, climate justice and equity, gender equality and women's empowerment are set as its principles.

- Sanitation is a Human right

The United Nations General Assembly has, in the year 2010, recognized the human right to water and sanitation, as these are essential to realize human rights[17]. Under this, people are right-bearers and the state are duty-bearers of providing water and sanitation[18]. The former can claim while the latter must guarantee.

- Asia Pacific Water Forum (APWF) declaration

  The APWF, an independent and non-profit network organization, brought out the Yangon declaration at its third summit held in Yangon in 2017. Among other call to action, it urged all parties to end open defecation by 2025 and promote hygiene education for behavior change.

- East Asia Sanitation and Network (EASAN) declarations

  At the first every EASAN conference in 2007, the delegates "vowed to increase the level of investment in sanitation and hygiene promotion to benefit, in particular, the poor and marginalized who face the worst conditions and the most limited access to adequate facilities". (https://www.wsp.org/FeaturesEvents/Calendar/easan-2007-november-30-december-1-2007)

- National Education Strategic Plan (NESP), 2016-21

  The NESP envisages the provision of education infrastructure in all schools, including WASH facilities, to further the educational outcomes required to build up the human resource capacity of the country.

H. Scope of the Policy

38. The policy will have the following scope:
    - Geographical delineation: The policy will be focused on the **rural areas**, including the peri-urban rural areas of the country. Peri-urban areas typically refer to only those which are situated in rural-administered areas, but which have urban characteristics[19].

17 https://www.un.org/waterforlifedecade/human_right_to_water.shtml

18 https://www.unwater.org/water-facts/human-rights/

19

Administrative → / Characteristics ↓	Urban	Rural
Urban	✖ scope of this policy	Rural administered areas, having urban characteristics
Rural	Urban administered areas, having rural characteristics	✓ Scope of this policy

- The policy will cover **liquid sanitation and hygiene**[20] – this will include all liquid forms of sanitation including fecal waste from humans (babies included), from animals; management of black water from toilets and grey water from kitchen, bathroom and other sources; hygiene would include handwashing at all critical times (e.g. after using toilet, before preparation and/or consuming food, before feeding babies), cleanliness of toilets and the general environment, safe storage and handling of drinking water, food safety, water quality including treatment etc.
- The policy would cover sanitation and hygiene at **all households in the rural areas**, all primary, middle and high **schools**, whether owned by public (including monastic schools) or private, up to the township level, all **Health Care Facilities** from Township hospitals and below, sanitation at **public places** (markets, bus stops, highways, etc.), water quality, liquid waste treatment facilities and promotion of improved sanitation behaviors.
- The policy would focus on all components of the **enabling environment** (e.g. institutional delineation, supply chains and markets, monitoring and evaluation, regulation) to enable effective service delivery and sustainability of the outcomes.
- This Sanitation and Hygiene Policy would be operational in **all rural areas in Myanmar** except under the management of municipalities of Yangon, Mandalay and Nay Pyi Taw; all persons and institutions, whether government or otherwise, are advised to follow the principles and approaches contained in this policy, in their implementation processes. Any departure from this should be restricted and should be informed and discussed with the government and other stakeholders, before putting into operations. This is due to the perverse incentives that some approaches (for e.g. having a hardware subsidy approach) could have on overall promotion of the sanitation and hygiene program.

20 Solid waste would be coordinated by other ministries/departments; a solid waste policy and strategy, Myanmar National Waste Management Strategy and Plan (2018-2030) has been developed for managing solid waste.

I. Targets

39. The enabling environment and physical outcomes for rural sanitation and hygiene will include:

- A clear legal framework for the sanitation and hygiene sector to operate in, will be developed / strengthened (if needed), by the national/sub-national Governments subsequent to this policy. This will include guidelines on the minimum standards for an improved toilet and handwashing stations, environmental laws and standards for storage of human feces, emptying of pits, transportation of human waste, treatment and disposal, water quality standards, and penalties for defecating and urinating in the open. (By 2021)
- Clear understanding of the roles and responsibilities of various institutions at national and sub-national levels, up to the household. (By 2021)
- The rural sanitation and hygiene sector will achieve full coverage, i.e. access to improved sanitation and hygiene for all people in the rural areas except under the management of municipalities of Yangon, Mandalay and Nay Pyi Taw in all situations, by the year 2030. This will be undertaken in phases and will involve the following interim targets:

	Baseline (2019)	2022	2025	2030
Open Defecation Free communities	2%[21]	20%	60%	100%
Access to basic sanitation services	78.5%[22]	85%	95%	100%
Access to safe sanitation services	N/A	20%	40%	70%[23]
Access to handwashing facilities	71%[24]	80%	90%	100%
Schools - Sanitation facilities	N/A	70%	90%	100%
School - Handwashing facilities	N/A	70%	90%	100%
Health care facility - Sanitation facilities	N/A	75%	85%	100%
Health care facility – Handwashing facilities	N/A	75%	85%	100%
Public Places – Sanitation facilities	N/A	60%	80%	100%
Public Places – Handwashing facilities	N/A	60%	80%	100%

Comment [A4]: The targets in Nat WASH strategy are
Both Toilets and Handwashing of HCF, 2020 – 70% and 2025 - 85%. Therefore, Put targets - 2022 – 75% and 2025 – 85%

- The scope of the objectives and targets will cover ALL the people in ALL rural areas of the country, including peri-urban rural areas. The definition of 'rural areas' shall be as per the Rural Development Law of the Government of Myanmar. This shall include, but not limited to, Households, Health Care Facilities, Schools, Institutions,

[21] UNICEF internal and partners report 2019
[22] 2019 Intercensal survey, Department of Populations, Ministry of Labour, Immigration and Population, the Government of Myanmar
[23] This envisages a 70% coverage of toilets to be either improved direct pit or leach pit toilets, which are considered in-situ safe sanitation facility. The remaining 30% would be septic tanks or others, which requires off-site treatment, so will require few more years for completion
[24] 2019 Intercensal survey, Department of Populations, Ministry of Labour, Immigration and Population, the Government of Myanmar

Public areas (Markets, Bus stops) and any other area where people of the rural areas interface; also included will be rural roads, which connects villages and villages to urban centers.

- There shall be equitable (same or similar) access to sanitation and hygiene facilities for the poor, disabled and other marginalized. Gender equality will be given attention to, while ensuring access.
- The minimum levels of service (minimum level definition – achieve access to adequate and equitable sanitation and hygiene for all, and end open defecation) under this policy, which may be entitled to support from public resources, shall be as defined by the standards set by the Sustainable Development Goals (SDG) and as monitored by the Joint Monitoring Program (JMP).
- Support from the Government's annual budget for sanitation and hygiene software and (limited) hardware activities.

J. Principles

40. The sanitation and hygiene policy shall be guided by these principles – they are the core beliefs and attitudes by which the framework for taking the sector forward is defined. The principles include:

- **Public Health.** Public Health is the rationale for intervention in improved sanitation and hygiene. The rationale behind the intervention is that public health is impacted by the lack of poor sanitation and hygiene.
- **Sanitation and hygiene**. Sanitation is essentially a 'public good' – using or not using an improved sanitation or hygiene facility by any single person has an impact on the wider society; the health of everyone within a particular community is impacted by individual person/household behavior. This is the rationale for public interest in addressing the lack of improved sanitation and hygiene behavior (use of unimproved toilets, open defecation, no handwashing facilities, etc.). The rationale of using public resources, from government budgets, public grants (donors, NGOs, development agencies) is thus justified; public resources shall only be used to the extent that it benefits the public good and not be used for private benefit. This public good element necessitates a total community-wide outcome in the form of an Open Defecation Free (ODF) environment where everyone has access to improved sanitation and handwashing facilities, and where there is no OD visible in the environment and thereby, effectively containing the fecal-oral transmission routes.
- **Environment.** Environmental considerations shall guide the interventions**.** In addition to health, pollution of the environment would also be one of the considerations while undertaking the policy and its implementation. The pollution of the environment ultimately impacts the health of the society and its people. All actions shall be subjected to Environmental Impact Assessments (whether formally or informally) to ensure that the benefits outweigh the costs; appropriate mitigation efforts shall be undertaken if the

equation is in the negative. The concept of 'Polluter Pays' shall be one of the key principles that this policy promotes; all such mitigation efforts shall be paid for by the polluter, with due considerations to equity. The principle of reuse and recycle of the human waste products will also be promoted throughout the intervention process. Using ecological approaches of 'closing the loop', where waste products can be reused for natural uses, human and other waste once safely treated will be used in various agricultural and non-agricultural uses.

- **Equitable approach, with opportunity for access available to all.** The promotion towards an improved sanitation and hygiene community will have equity and justice as its underlying principle. The approach will focus on enabling access to resources (and not necessarily providing resources) to ensure everyone has the opportunity to access the basic minimum standards of sanitation and hygiene access. This will be through software (information, demand creation) and support to facilitating the market for efficient supply chain and affordable products, softer credit availability, etc. Focused and special approaches will be adopted to ensure that the intervention is gender-sensitive and reaches the poor, people with disability, and other marginalized in the community; focus will also be given to lagging districts / zones within the country. An approach of 'leaving no one behind' shall be applied; in addition to financing for poorer households, if required, other national and international best practices of smart financing will be explored to adapt to the Myanmar situation. Monitoring systems will give special emphasis on tracking equity and differences between geographical, social and other equity identities.
- '**Some for all than all for some' – resource allocation**. As the public resources are scarce, it is important that it benefits the maximum number of people. There are multiple ways to ensure that all residents have access to safe and improved sanitation and hygiene facilities. The public resources used (financial, human, others) will be used in the most effective way, to facilitate the residents adopt the basic minimum required to ensure community wide health benefits. This standard will be aimed at the definition of improved and safely managed toilet and handwashing, by the SDG and others (see graphic from the SDGs). The higher levels of toilets, which go beyond these basic standards, will be undertaken through non-public funds (private funds, loans instead of grants, etc.).
- **Decentralization and subsidiarity shall guide the institutional framework**. The institutional framework to achieve the sanitation and hygiene vision shall be based on the principles of decentralization and subsidiarity. Decentralization ensures that the intervention is undertaken at the most efficient way, is responsive to the needs of the population and increases both downward and upward accountability. Subsidiarity ensures that a higher level is not undertaking tasks which can easily be done at a lower level; implementation will therefore be decentralized to the lowest level possible while higher levels will provide facilitating, guiding and enabling roles.

- **Community led approach shall lead to empowerment and sustainability**. A participatory approach, which adopts the principles of Community Led Total Sanitation/ Community Approaches to Total Sanitation (CLTS/CATS), shall be adopted where the community, including women and the marginalized, would in the lead in taking decisions, which would result in empowering the community and help in reach community-level outcomes. The community shall be facilitated by internal and external stakeholders to facilitate a process of analysis, take decisions made based on these analyses, implement these decisions, monitor and sustain the implementation. These would empower the community in the long term for not only sustaining the sanitation outcomes, but also undertaking other developmental interventions. The participation of women and other social groups shall help in identifying local needs and local solutions, enhancing the chances of sustainability, long after the program is over. A participatory approach will lead to development of diverse ideas, leading to a sense of ownership.
- **Partnerships shall add synergy and strengthen the intervention.** The needs to make rural Myanmar ODF is significant, and the available resources are limited. It would be beyond the capacity of any one institution, even the government, to undertake this on its own. A forging of partnerships between programs and stakeholders is essential to achieve the boarder sector goal. There are various government programs and schemes in water, health, nutrition, etc., which could potentially be leveraged to support the rural sanitation and hygiene sector; additionally, there are many stakeholders beyond the national and sub-national governments such as the private sector, NGOs, media, the community, etc. A partnership between these programs and stakeholders will build synergy to lead to effective achievement of the goals.
- **User Pays, based on Affordability principles**. The users will pay for all private products (e.g. construction of toilet hardware), as well as for all services (public and private, e.g. use of urinal while traveling, emptying pits when full), from among the various affordable options available to them. This is to ensure ownership among the people and pay for the long-term management and sustainability of the services. Private infrastructure, such as household toilets, would be constructed out of private funds; public hardware subsidies will be available only in extremely rare cases, where the user cannot afford to pay fully or partly, and it is sufficiently justified that such external support is in the interest of the user and the wider community to which the user belongs. Support from external sources shall be given against objective, transparent criteria, and be structured in the form of incentives against achievement of outputs and outcomes. Public infrastructure, such as public-school toilets, public toilets shall be borne by public funds. All services (such as toilets in marketplaces) would be managed against a user fee, which would pay for upkeep and replacement costs. Post construction O&M of all private assets (routine maintenance, pit emptying, etc.) shall be borne by the owners themselves.

- **Sustainability of assets and behavior shall drive policy and practice**. Public funds are scarce and should reap the benefits of investments, without having to reinvest in the same again in the future. Any intervention shall, therefore, be undertaken with the sustainability of the assets and more importantly, the behavior, as the key outcome. Sustainability has to be considered as an important component from the beginning of the intervention (and not as an afterthought) and should permeate all intervention strategies and plans. Strategies and models will be assessed to ensure that they are sustainable in the long term; the local markets will be developed, as an example, so that maintenance and upgrading of the facilities shall be possible in the future by the users themselves, without programmatic support.
- **Monitoring shall create efficiency and drive accountability**. The expected returns on investment of resources will accrue only when the processes adopted to turn inputs into outputs and outcomes are timely and efficient. This can only be undertaken in the presence of a sound monitoring system, which tracks all the inputs and processes at various levels in (near) real time, to understand the efficiency of these systems. In addition to identifying gaps and bottlenecks, monitoring will also identify the causes behind the bottlenecks, including accountability of the institutions. Robust monitoring of the sector with credible verified data shall guide policy, and implementation, and ensure accountability of institutions, processes and outcomes.
- **Regulation of the sector shall drive standards and a fair system**. Regulation shall provide a level playing field for all stakeholders, ensure objective criteria for decisions and provide overall transparency. An independent regulator shall regulate the sector based on agreed principles and standards, which shall be common for all. Equity, fair play and efficiency would guide the regulatory principle.

K. Policy Elements

41. The various elements of the policy environment include:

Policy, Laws, Guidelines:

- The sanitation and hygiene sector shall function under the policies, laws and guidelines of the country. This shall include the existing frameworks, but also new laws, regulations, guidelines which may be needed to be put in place. Some of these shall be undertaken by other departments / ministries (e.g. Solid Waste Management guidelines by the Ministry of Environmental Conservation and Forestry) or the State/Region or at sub-State/Region levels, while some shall be the responsibility of the Department of Public Health, Ministry of Health and Sports. The existing and required policies, laws and guidelines along with their responsible stakeholder shall be identified, and broad timelines fixed in the costed Implementation Plan.

- A minimum set of standards shall be established for sanitation and hygiene facilities. This shall be done as part of the legal and regulatory framework for application at household, school, HCF and other situations.
- A poor intervention is worse than no intervention. Sanitation and hygiene facilities, if created without adhering to minimum standards, can pollute the environment, aid in the spread of diseases and drive people away from improved sanitation. It is therefore important that every sanitation facility created is not only constructed, but also operated and maintained, as per the minimum standards.
- The standards set shall be equivalent to the MSDP or the Joint Monitoring Program (JMP) standards. These shall be the minimum standards set for sanitation and hygiene, under which public financing shall be spent on, for promotion and/or in rare cases, infrastructure. Higher standards than the basic minimum shall be financed from private sources.
- Environmental assessments shall be part of any decision-making process. Any intervention shall adopt a holistic approach, including conducting an Environmental Impact Assessment – the complexity of the assessment shall be determined by the complexity of the intervention. All interventions shall be assessed against alternatives through a systematic evaluation. The final selection of the intervention shall consider the environmental impact as one of the decision-making factors, through a cost-benefit analysis (including quantitative and qualitative elements). Environmental impacts of any intervention, if any, shall be managed and minimized to the extent possible. Reduce and recycle approach shall be promoted. Instead of creating pollution and then treating it, the approach shall be preventing it through encouragement of reducing use and then recycling. Legislation shall complement awareness raising and advocacy to promote environmental concerns.

Institutional framework

- The institutions responsible for various aspects at policy, implementation, monitoring and regulation level is identified:
- The rural sanitation and hygiene sector shall be led and coordinated by the Ministry of Health and Sports at the national level. It shall set the standards for the sector and issue guidelines, enable the legal and regulatory frameworks, guide the regions and states in the promotion of sanitation and hygiene, coordinate the disparate stakeholders active at all levels and functions in the sector, provide finance for the construction of public facilities and monitor the progress and trends in the sector.
- The promotion and implementation of the sanitation and hygiene campaign shall be undertaken by the State/Region level Ministry/Department. It shall oversee and guide the process to ensure that the messages reach the stakeholders down to the community and

household levels, the supply chain and markets are facilitated, and outputs and outcomes monitored. Sub- State/Region level institutions at the township and Rural Health Centers (RHCs) shall undertake the actual implementation and monitoring.

- The development partners / donors shall contribute to the sector by way of providing of financial and technical assistance for promotion, establishing systems including supply chains and monitoring systems, financing approaches, etc. It shall support to document and disseminate best practices in the sector from within and outside the country.
- Financial institutions such as banks, credit cooperatives, micro-credit institutions shall be facilitated by the appropriate lead organization at national and sub-national levels to provide soft loans / credit to households and vendors on softer terms to avail or offer sanitation products and services.
- NGOs and CSOs shall be facilitated to partner with the implementing agencies to support the implementation process, build the capacity of the institutions involved in the sector, facilitate the monitoring and accountability of outputs and outcomes, and provide support to document and disseminate best practices.
- The private sector shall be facilitated to offer resources to set up self-sustaining supply chain and markets to offer sanitation and hygiene products and services, both to construct the infrastructure as well as their maintenance over the long term. Private sector may be facilitated to set up pit emptying businesses, as well as transportation, and operating Fecal Sludge Management (FSM) plants.
- The households shall be responsible for the construction and maintenance of their own household toilets and handwashing stations, as per the minimum standards set up the government, and adopt the improved sanitation and hygiene behaviors.
- Technical Working Groups on various themes would be set up at the national and sub-national levels, which would meet periodically to discuss on the issues, share experiences, and find solutions.

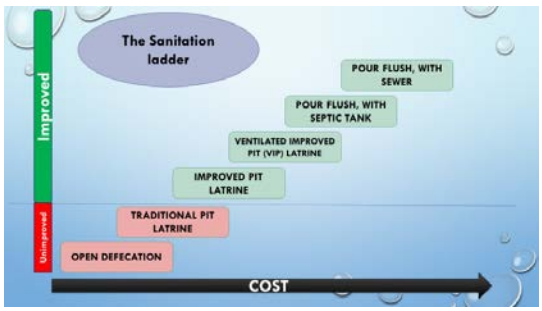
Advocacy and Demand creation

- A participatory approach shall be used to promote sanitation and hygiene. The promotion of sanitation and hygiene among households shall be undertaken using a participatory approach, along the CLTS/CATS approach, with the community playing a lead role. The promotion shall understand the current beliefs, practices and attitudes to understand the reasoning behind the same. The messaging to the community shall be based on this understanding; health should be one of the major components of messaging, to enable a full understanding among the people of the link between poor Sanitation &Hygiene (S&H) and health. Other factors such as shame, dignity, privacy, status, convenience shall be supplemented, as per the situation. Peer pressure to adopt improved sanitation and hygiene practices would be adopted to motivate the sustained change in behavior.

- A variety of methods shall be used to advocate and raise demand for sanitation and hygiene. The primary approach shall be interpersonal group communications, where 'triggering' events with the collective are undertaken to help the community analyze the status and then take decisions on the directions forward. This shall be supplemented by messaging from mass media, traditional media such as folk theatre, as well as the newly emerging social media (Facebook, WhatsApp messaging, etc.).
    - The messaging shall be developed based on the prevalent understanding and practices and the need to change them; it is ideal that information includes the need for sanitation as well as the various (technical, financial) options to reach there. Technical solutions offered should be location specific, able to meet the challenges of that areas – e.g. floor prone, water shortage areas. Affordability to various socio-economic status of people should be a factor while offering options.
    - The community should take the lead role in the planning, implementation, monitoring and maintenance of the sanitation and hygiene infrastructure as well as the behavior.
    - The intervention process would have the goal of sustained usage of improved sanitation and hygiene being a societal norm. The process should lead to a situation where using improved sanitation and hygiene facilities is a way of life, a behavior ingrained into the societal life.
- Various events and fora shall be used to promote the messages of improved sanitation and hygiene. Various opportunities like World Water Day, World Toilet Day, Global Handwashing Day, National Sanitation Week, etc. shall be used for this. Periodic meetings, conferences, and other events where stakeholders can convene to experience and share, shall be held, as this would help reinforcing the messages.
- Environmental education shall be promoted to lead to an environmental ethic among the population. Awareness campaigns at schools, within the community, through local art, mass and social media shall be conducted to raise the level of sensitivity to environmental issues among the populace.
- Climate change adaptation and mitigation. The interventions shall have climate change adaptation and mitigation as part of its central focus.

Technology options

- Principles of sanitation technology shall be informed to all. The basic principles, such as separation of the feces from vectors such as flies, water reaching the feces, distance of pits from water sources,



etc. should be informed to all the people. Detailed technical information including the designs of toilets can be informed to the masons, engineers and the like.

- Multiple options of technologies shall be offered at various price points. The technologies offered shall conform to the minimum standards set, but beyond this, various options at every rung of the sanitation ladder with different price-points shall be informed to the households. The selection of a particular technology which meets the health, functional and environmental standards shall be undertaken based on the affordability levels of the household. After the minimum standard sanitation and hygiene facilities have been adopted, further movement up the sanitation ladder can be undertaken by the household as their affordability increases; this shall be met out of private financing. Focus shall be on the sub-structure and the platform, and not on the super-structure.
- A technology hierarchy shall be provided for easy decision making. Convenience of use, use of water for flushing and cleaning, and costs shall be some of the criteria for creating this hierarchy.
- Technology propagated shall be tried and tested. The technological options proposed should have been tested and found appropriate from a socio-cultural, topographical, technical and financial point of view. It should be easy to use, meet the technical standards set and be affordable to the people. No pilot projects or testing of new technology without practical application should be propagated among the people. The technologies shall be reliable and less complex to construct and operate. It should be in line with the local situations, including meeting any specific challenges there exists (e.g. high-water table, coastal areas, tide line areas, rocky soils, mountain conditions, IDP camps, etc.).
- Local technology, conditions, material and skills shall be used. As far as possible these should be localized; strong justification should be available to use these imported from elsewhere. In addition to being in tune with the environment, they shall also be more sustainable in the long term (due to availability of products and services) and be cheaper. Additionally, this shall also encourage the local industry. Soil conditions, water availability (or lack of), water percolation rates, flood conditions shall be some of the other factors taken into account while deciding on the technology options.
- Technology shall promote equity and be disabled friendly. The availability of technology should not exacerbate differences between households; minimum standards of technology should be available at affordable rates even for the poorest and marginal families. Technology options should be friendly to the user, especially women, children and the disabled.
- Technology shall conserve resources. Technologies promoted shall conserve resources, especially water, through the advocacy of waterless or water-conserving toilet facilities, use of treated waste for agricultural and other natural uses.

Supply chain and markets

- A market-based approach shall underly the supply chain system. The private sector for products and services shall be promoted. This shall be decentralized to the extent possible with local masons, local retail shops, local service providers (for Operation and Maintenance -O&M) available to supply products and services for infrastructure installation and long-term O&M.
- Facilitation of private sector shall be undertaken. The public agencies shall restrict itself to its strong role of facilitating the private sector to understand the market, preferences of consumers, access to market-based credit and the like. Public sector institutions shall not be involved in supply of products and services, except in the rarest of circumstances with strong justification.
- Level playing field is important to enable efficiency. A policy and regulatory environment which provides an enabling environment for private and public sectors, without hidden subsides, is essential for private markets to emerge, which is critical for long term sustainability of the sector.

Financial Resources and Financing

- Efficient utilization of resources shall be key. The financial and other resources shall be utilized with the utmost care and efficiency to ensure that public resources give the maximum benefits. Public resources (monies from Government, Donors, NGOs, etc.) should be utilized only for promotion and investment of whatever is the minimum that is required to meet the health, environmental, social and economic goals. Subsidies shall be directed towards public expenditure (e.g. promotion, public school toilets) and not private assets (like household toilets).
- Output and outcomes-based funding approaches. The input funding should be commensurate to the outputs and outcomes generated. Planning to meet the most of outputs and outcomes against each unit of funds, tracking to ensure that the plans work as proposed, shall be part of the process.
- Life cycle costs approach shall be adopted. The total costs, which includes the capital expenditure and operational expenditure (recurrent cost) together shall be considered, while evaluating the cost-benefit analysis of any intervention. Even if individual (capital, operational) costs are high or low, they should not be basis for comparison, but the overall life-cycle costs should be. However, when there is a need to meet the costs of a particular intervention, if it is needed the public part of the financing shall be considered in addition to private resources.

- Long term costing of the intervention shall be prepared. The total quantum of costs required for the sanitation and hygiene sector to meet its goals by 2030 shall be computed, with break-down of component costs. The costs shall include the capital costs for households and institutions, the O&M costs over a period, promotion costs, monitoring costs, etc. The broad sources of funding such as Government budget support, donor funding, private sector funding, household funding, etc. shall also be used to understand the sources of financing.
- Public funding of private needs shall be based on transparent, objective criteria. In rare cases, public funds may need to fund private needs, such as a household toilet. This may be a full or partial subsidy of the capital or operational costs, and should be justified based on transparent and objective criteria which applies to all who meet these criteria; a major criteria would be the financial marginalization of the household, besides women-headed households, single-parent household, physical/mentally challenged. It is best offered as an incentive against achievement of specific outputs or outcomes, i.e. on completion of construction of toilets, its consistent usage, sustainability, etc.
- Financing shall be provided to units for promotion based on formulae. The amount of financial resources available to specific units, say region or state or community, shall be based on a formula, calculated based on normative and performance-based criteria. The former may include population, poverty rates, sanitation gaps, while the latter may include overall performance, efficiency in meeting outcomes, etc.

Monitoring and Accountability

- The monitoring system shall track indicators based on 'need to know'. The indicators for monitoring shall be based on a 'need to know' and not a 'nice to know' basis. The need to know may be different as per the different levels, from the community to the national and international levels. Some may be for day-to-day project management purposes, while others may be to track the trends in the sector over a longer period.
- All monitoring systems shall collect data based on statistically valid methods and be subject to in-built verification. The monitoring systems shall collect data on a census or on a sample basis; all the latter forms of data collection shall be undertaken based on statistically valid samples (validity for the unit for which the data is gathered) with high level of confidence. In-built verification modules shall be part of the system to ensure that data collected is of the highest reliability.
- Project management monitoring shall be supplemented by third-party objective monitoring. Project monitoring shall collect data critical to understand the day to day issues, as well as the status of the sector, on a periodic basis. These shall form the basis for the changes in direction, if need be, in project implementation. In addition, third party objective processes for collection of data would supplement, to ensure triangulation of the data. Third

parties shall include consulting firms, academic institutions, federations (of civil society, for e.g.) – anyone who are not part of the implementation process.

- Monitoring system shall evolve a set of indicators along with consistent definitions for the indicators. Monitoring systems shall develop relevant indicators from the rural areas to the national and international levels, as relevant, for both project management and long-term analysis. Multiple organizations shall conduct both project monitoring as well as third party (as above) monitoring programs, for which consistent and comparable set of indicators and methodologies shall be developed.
- Monitoring shall prioritize on output and outcome monitoring, in addition to focusing on inputs and process. The indicators for monitoring shall include output indicators like number of toilets built, efficiency of the process, outcome indicators like water quality status, Open Defecation Free community, etc. Other project management indicators related to inputs and processes such as the financial inputs, promotional approaches, etc. shall also be included.
- Routine monitoring done by the service providers shall be triangulated using third-party objective monitoring done through third parties. The sector monitoring system shall collect routine monitoring data on critical indicators at periodic intervals (daily/weekly/monthly/annual), which shall be used for project management and reporting. Objective monitoring led by third-party agencies shall also collect information at more infrequent intervals (annual to five years) to triangulate the routine monitoring.
- Monitoring system shall provide disaggregated data. The monitoring system shall provide data which is disaggregated on geographical (region, state, etc.), spatial (urban /rural), gender, economic class (quintiles), disability and other indicators.
- Modular approach shall be adopted with modules for different sets of monitoring data, with integration of data at higher levels. School sanitation shall be through the EMIS monitoring system, while HCF monitoring shall be undertaken by the HMIS monitoring systems. Household monitoring, water quality monitoring, etc. shall all have individual modular systems for monitoring. An integration of these modules shall be undertaken at the sectoral level for consolidation and analysis; in addition, S&H monitoring system shall 'dialogue' with water monitoring and other sector monitoring to compare and analyze.
- The monitoring system will adopt a participatory approach, with the involvement of all the concerned stakeholders. At the community level, it would be involved in monitoring its own performance and sustainability. A peer monitoring system will be adopted where each unit will be monitored by its peers – e.g. a community by another / combination of communities, township by another township(s), state by another state(s), and so on.

Equity

- Sanitation is a human right. Sanitation has been declared as a right for all humans by the United Nations, in 2010, and which has been adopted by most countries. A special focus on the marginalized populations is necessary to enable them to escape the vicious cycle of poverty and marginalization. This necessitates that all human beings in the country have equal opportunities to gain access to a basic minimum standard (as defined by national guidelines) of sanitation and hygiene. This does not mean a provision of assets to all through the public resources, but creation of an enabling environment which benefits the access to all.
- Equity issues shall be focused on at intervention and monitoring stages. There would be needed to have special focus on the barriers in front of marginalized populations, which prevent their access to improved sanitation and hygiene. This would include addressing disparities and lack of differential opportunities between geographical regions (between States/Regions), between urban and rural, between gender, between the rich and poor, and the abled / disabled. Focused monitoring of access at constant intervals between these groups is extremely important for course correction to take place, throughout implementation and thereafter.

Regulation

- Regulation of the sector would be done based on the standards and the legal frameworks. The regulation of the sector would focus on the standards, like whether toilets are being constructed as per the improved toilets standards, and/or the relevant laws, like whether the effluents are disposed of into the environment as per the environmental laws.
- A regulatory framework shall be created. This shall define the regulatory system, the indicators to regulate, the institutional structure, the periodicity, the pre- and post-regulatory actions to be undertaken.
- A regulatory body shall be identified. If not already existing, a regulatory body, which may be part of the overall regulatory system in the country (clubbed with other related sectors) shall be identified and tasked with regulating the sector, as per the framework.

L. Sub-Sector Strategies

42. The broad strategies that each of the sub-sector would adopt to meet its goals:

Household Sanitation

- A community-wide approach, based on the CLTS/CATS approach, would be adopted to create awareness among the households for a behavior towards using improved sanitation and hygiene facilities. Community level 'triggering' events would be supplemented with advocacy and awareness through media (mass media, social media, folk

media). An advocacy and awareness package would be developed to facilitate this process. The 'triggers' used will include impacts on health but also identified based on the specific situations.

- The households will pay for their own sanitation and hygiene facilities based on their affordability. It is ideal that the toilets they build is close in appearance and uses material similar to their house; this will ensure that toilets are considered as part of the house and ensure long term sustainability.
- The toilets should subscribe to the minimum standards prescribed by the sector, and effectively break the fecal-oral chain by containing the access by flies and prevent water contamination. The technology adopted and material used are immaterial, so long as the principles of an improved toilet is met and is as per the above-mentioned standards.
- The maintenance of toilets and handwashing facilities will also be the responsibility of the household; it should be kept clean to the standards that has been set up by the sector. This is important as an unclean toilet and handwashing station is equally dangerous to human health.
- Post-usage of toilets, the long-term management of the toilet should also be addressed. If a leach pit/septic tank, once it is full, arrangements should be made to engage with operators (either in the public or private sector) to empty the pits, transport them to treatment facilities and have them treated to set standards, before disposing them into the environment.

Sanitation and Hygiene in Schools

- The school sanitation facility would include gender-separated facilities, have urinals and toilet facilities for both boys and girls, and have facilities for Menstrual Hygiene Management for girls.
- The toilets shall be child friendly and correspond to the age of the children in the school. There may be a need for differential standards in a large school with children across a wide variety of ages. The toilets and handwashing stations shall be of the right height, have proper lighting and ventilation to ease concerns of small children, and have emergency assistance.
- The Basic Education Department shall coordinate with the Department of Rural Development (DRD) to ensure availability of water for use in toilets, for proper O&M and cleaning.
- The toilets and handwashing facilities should also be friendly to the children with disability (difficulties seeing, hearing, walking or climbing stairs, remembering or concentrating, self-care, and communication (expressive and receptive)), as per the international and national standards for such facilities.
- The number of urinals and toilets shall be decided on the basis of the number of children studying in the school, in addition to the teachers and other staff. The urinal and

toilet habits of both boys and girls, including the time taken for usage, shall form the basis for this planning. National level standards and guidelines, which shall have taken these into account, can be followed here.

- The schools shall have facilities for Menstrual Hygiene Management. This shall include special rooms for privacy of the girl during changing, disposal units such as incinerators for used items, etc.
- The school sanitation, handwashing and MHM facilities shall be funded fully out of public funds, with priority given to those schools which have a cost sharing approach (partially from their own funds or through PTA, etc.). Post-construction, the maintenance and management of the facilities shall be facilitated by the school itself.
- Hygiene education in schools should be a core part of the intervention process. Rationale and importance of using improved sanitation and hygiene should be part of the curriculum to be taught in all schools. Health clubs should be established in all schools, to enable a children-led approach to improved sanitation and hygiene.

Sanitation and Hygiene in Health Care Facilities

- The Sanitation in HCFs shall be applicable for all hospitals from township level and below, whether owned/operated by Government or private entities. The owner of the HCFs shall be responsible for construction of the facility, while the operator shall undertake the O&M.
- The number of toilets and handwashing stations in HCFs shall depend on the number of out- and in-patients (and their attendants) and staff (doctors, nurses, support staff). As the patients may be temporarily or permanently disabled, special considerations for toilets for them will be addressed in all HCFs.
- As cleanliness is the lifeline of any HCF, they shall, in addition, also provide and maintain facilities for bathing, laundry. Additional focus shall be given to medical waste management (separate policy to be evolved for this) and Infection Prevention Control. All HCFs shall follow the “Hospital infection control guidelines” and “Health care waste management guidelines”, in letter and spirit.
- Financing of HCF sanitation shall be sourced from the Ministry of Health and Sports or other similar sources. It shall be integrated into the capital expenditure of the whole HCF.
- Maintenance of the HCF sanitation and hygiene facilities shall be integrated into the maintenance protocol of the HCF.

Sanitation and Hygiene in Public Areas

- The type of facility at markets, bus stops, festivals, other public areas shall be decided based on the need – the number of visitors (footfall) at the particular location on a periodic basis (time of the day, day of the week, certain times of the years). These shall be temporary or permanent as per the need.

- The toilets shall include gender-segregated urinals and toilets, washing facilities, facilities for babies and toddlers, arrangements for MHM and the disposal of diapers and menstrual waste. Toilets which are disabled friendly (mobility, hearing, seeing) would compulsorily be included. The toilets shall be situated in areas which are accessible to all, be in a secure area especially for women and children, be in a brightly lit area, have privacy and protect dignity.
- The capital expenditure of these facilities shall be sourced from Government / parastatals / organization in charge of the facility, either as a grant or credit. A viability analysis shall be undertaken at the beginning of the process to understand the self-sustenance of these facilities; life-cycle cost approach shall be adopted in this.
- The operation and management of these facilities shall be done by specific organizations, preferably in the private sector or community groups. The owners of the facilities, typically a public body, shall enter into O&M contracts selected out of competitive bidding.
- The facilities shall adopt a 'Pay and use' model for O&M and capital-management expenditure; the payment for usage shall be decided based on the need and the profile of the users.

Sanitation and Hygiene in Disasters and Emergencies

- Sanitation and Hygiene in disaster and emergency prone areas would be under the overall leadership and coordination of the Disaster Management Committees, set up at the national and sub-national levels, especially the township level committee.
- A management plan to deal with disasters and emergencies, along with Standard Operating Procedures (SOPs) shall be prepared by the township and disseminated to all stakeholders. The plan shall include emergency rescue locations, identify human resources to support the situation, material to be made available, and the financial needs.
- Awareness sessions shall be conducted in various institutions and among the general public on actions to be taken during these events.
- Supply chains for disasters and emergencies, which includes pre-cast material for quick set-up (mobile toilets/handwashing stations), emergency kits, etc., shall be set up at township level, to enable quick response during such situations.
- A township level emergency fund shall be made available to be exclusively used for emergencies, which shall enable rapid response in times of emergencies.
- A monitoring system which responds to emergency situations and captures the status in real-time shall be designed and tested, ready to be put into operations as the situation emerges.

M. Taking the Policy Forward

- A systematic dissemination of the Sanitation and Hygiene Policy would be undertaken across the country. The vision, objectives and principles of the policy should not only reach the sector stakeholders, but also the common man across the country, so that the social norm of adopting and practicing clean habits is achieved and sustained into eternity.
- A systematic implementation strategy, plan and costing will be put in place to undertake the challenging task of translating policy into action on ground.
- The creation of an enabling environment at national and sub-national levels will be undertaken to facilitate the scale-up of the intervention and achievement of outcomes. Political will, legislative framework, budgetary support,
- The strategy and plan will be completed at national and state/regional levels. Participation of all stakeholders, details and outline activities, institutional arrangements, funding requirements, monitoring
- Review of policy to be done at every five years. The policy would be reviewed for its practicality and relevance and adapted as per the situation once every five years or sooner, if required.