THE SANITATION SCANDAL

Identifying and responding to the barriers to improved sanitation and hygiene in developing countries

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Written by Laura Webster

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Acknowledgements

This report was written by Laura Webster. It draws on the work of Peter Newborne and Katharina Welle at the Overseas Development Institute (ODI). They have been working with Tearfund and our partners to carry out research into the barriers to delivering improved sanitation and hygiene. Our thanks to both of them. Thanks are also due to Deogratias Mwakamubaya Nasekwa and François Kiza Odjuku of PPSSP, and Nelson Paluku Syayipuma in the Democratic Republic of Congo; Robert Sanou, Marthe Bardo and Norbert Zerdo of Accedes in Burkina Faso; and Dr Alfred Ranaivoarisoa of the University of Antananarivo and Dr Francis Rabeantoandro of FFBBM/HVM in Madagascar – for all their work on the individual country case studies.

While their work has been an extremely important input to this report, the recommendations made are Tearfund's alone. Thanks are also due to Paul Cook, Seren Boyd, Charlotte Flint and Amy Levene for their useful comments and support.

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Contents

	Executive summary	3
	Key facts	4
1	Introduction	5
	1.1 Rationale	5
	1.2 The sanitation gap	5
	1.3 Defining sanitation	6
2	The barriers to sanitation	8
	2.1 Problem definition	8
	2.2 Agenda setting and policy formulation	8
	2.3 Policy implementation	18
3	Burkina Faso case study	13
	3.1 Context	13
	3.2 Findings	15
	3.3 Conclusions	20
4	Madagascar case study	22
	4.1 Context	22
	4.2 Findings	23
	4.3 Conclusions	29
5	Democratic Republic of Congo case study	30
	5.1 Context	30
	5.2 Findings	31
	5.3 Conclusions	37
6	Removing the barriers	38
	Bibliography	41
ANNEX	Methodology	44

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Executive summary

Lack of sanitation is one of the world's most urgent crises. Governments have promised to halve the number of people without access to sanitation by 2015[1] – yet, this target is now off-track in 74 countries worldwide, and not expected to be met in Sub-Saharan Africa until at least 2076.[2] Without improved sanitation and hygiene, progress on other targets relating to child health, access to education and gender equality will be severely undermined. It is a scandal that every year, 1.8 million children in developing countries die of diarrhoea – an illness which is so easily avoided or cured in the developed world.

Working with the Overseas Development Institute (ODI) and our partners in Madagascar, Democratic Republic of Congo (DRC) and Burkina Faso, Tearfund has been carrying out research to try to determine exactly why progress has been so slow. We reviewed existing literature and summarised what are perceived to be the main barriers to improved sanitation. We then carried out scoping studies in Burkina Faso, the Democratic Republic of Congo and Madagascar to establish which of these barriers are present in each country, as well as identifying positive indicators. We held a workshop in each country to bring together some of the people who had taken part in the research and other key stakeholders, and to discuss findings and future actions.

We found that all of the blockages identified in the literature review were indeed present, to a great or lesser extent, in each of the countries studied. In particular, sanitation and hygiene did not appear to be prioritised by local people, national governments or donors in each case. There was a huge under-investment in sanitation at all levels; a need for much better coordination between all players; and a massive lack of human and technical capacity amongst both state and non-state actors. We found that sanitation and hygiene needed to be much better incorporated into other development programmes, such as those relating to health and education, and the local studies revealed that changing behaviour is a complex process, and that cultural factors need to be carefully considered in all interventions.

In summary, the following actions are required.

DONORS SHOULD:

- **Increase the high-level political attention given to these issues** by agreeing a new Global Action Plan on Water and Sanitation. This plan must recognise the different dynamics of delivering sanitation and hygiene compared with water. It must set out a comprehensive strategy for ensuring progress internationally.
- **Mainstream sanitation and hygiene into other sectors** – so that health, education, urban, rural and other relevant strategies contain specific sanitation components and indicators. No donor-funded schools or health facilities should be built without adequate sanitation.
- **Ensure that all national plans for sanitation are fully funded**. This will be vital if human and technical capacity are to be increased. Resources should be specifically targeted at addressing the key barriers identified in this report and should not, therefore, be spent simply on subsidised latrine-building as a stand-alone activity.
- **Promote innovative and community-led approaches which are culturally sensitive**. This study has revealed different cultural and social barriers in each context, which demonstrates that a one-size-fits-all approach is unlikely to be effective. Local ownership will be key.

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1 MDG 7, Target 10: to halve, by 2015, the number of people without sustainable access to safe drinking water and basic sanitation.

2 UNDP Human Development Report 2006, page 57

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NATIONAL GOVERNMENTS SHOULD:

- **Give high-level political attention to the issues of sanitation and hygiene** – breaking the taboos which surround them.
- **Put a national plan and coordination mechanisms in place**. This means bringing all relevant departments together to devise and implement a sanitation and hygiene strategy.
- **Ensure that the sanitation and hygiene strategy is prioritised within the national budget**. This is likely to require specific sums set aside for sanitation within the budgets of several government departments, as well as within local government budgets.
- **Ensure all new schools and health facilities are built with adequate sanitation facilities**.
- **Improve data collection** to help monitor progress – or lack of it – in the sector.
- **Promote innovative and community-led approaches which are culturally sensitive**.
- **Invest in appropriate training and capacity-building for key players** within central government departments, local governments and also non-state actors.

KEY FACTS

More than 40 per cent of the world's population do not have access even to a simple latrine.[3]

Improving sanitation and hygiene is vital for improving child health:

- 1.8 million children die of diarrhoea every year; almost five times as many as die from AIDS.[4]
- A baby born in sub-Saharan Africa is 500 times more likely to die from diarrhoeal disease than one born in the developed world.[5]
- Children in households with no toilet are twice as likely to get diarrhoea as those with a toilet.[6]
- Children who get intestinal worms are much more likely to have asthma and stunted growth, and to perform worse at school.[7]

Improving sanitation and hygiene is particularly important for women:

- Women forced to wait until dark to defecate, in order to avoid bringing shame on their family can suffer severe stomach problems as a result.[8]
- It is usually women who have to care for sick children, reducing their economic productivity.

Poor sanitation and hygiene is bad for economic growth:

- The WHO estimates that 443 million school days are lost annually worldwide due to diarrhoeal disease.[9]

Simple interventions can be really effective:

- Hygiene education and the promotion of hand-washing have been shown to reduce cases of diarrhoea by 45 per cent.[10]

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3 Figure is 42 per cent according to UN Water.

4 According to UNICEF, 380,000 children died of AIDS in 2006.

5 Figure is 520 according to UN Water.

6 From WELL Briefing Note on the MDG on child heath

7 UNICEF (2000)

8 Ibid

9 As quoted in the UNDP Human Development Report 2006.

10 Evans (2005) page 7

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1 Introduction

1.1 Rationale

In recent years, sanitation and hygiene have begun to rise up the international policy agenda. In 2002, sanitation was included in the Millennium Development Goals (MDGs), within Goal 7, Target 10, which sets the aim of halving '*by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation*'. Yet, in most developing countries, hygiene and sanitation do not receive much attention, despite the fact that this has the potential to undermine progress towards many of the other MDG targets. The aim of this report is to explore the underlying reasons for this apparent paradox. It identifies factors which hinder or support:

- the development of policies on sanitation and hygiene at national level; and
- the effective implementation of sanitation and hygiene programmes at community level.

In essence, it focuses on the difference that governments could be making as governments play the most important role in terms of creating an enabling environment in which all actors, including non-state providers, can operate. We have used rapid research methodologies with a strong capacity building element, to allow Tearfund's local partners to participate in the study.

1.2 The sanitation gap

'*Sanitation is more important than independence,*' Mahatma Gandhi once said.[11] According to the WHO and UNICEF, around 2.6 billion people, more than one third of the world's population, lack access to basic sanitation. But what does this actually mean, and how does this impact upon their daily lives?

It is difficult for people in the developed world to imagine what life would be like if there were no toilets in their houses and public buildings. Literally billions of people every day are forced to seek out a quiet spot, sometimes waiting for the cover of darkness, so that they can relieve themselves in the open. In rural areas, this may mean a walk out of the village into fields or a riverbed, or behind some vegetation. As the village grows, the walk may get longer and the elderly or sick will find this harder. Women and children are at risk of attack, and there is a danger of being bitten by a snake or encountering other creatures and insects. In urban areas such as Kinshasa, the situation can be even more difficult, with people resorting to the use of 'flying toilets' – defecating into plastic bags which are then thrown on to the street, waste land, or anywhere else people can find.

It is also difficult for us to imagine having to take water from a source which has been contaminated by human waste, not having a hygienic place to store clean water, or being a woman who has insufficient water or soap to keep herself clean during menstruation.

All of these consequences of poor sanitation and hygiene have a huge impact on people's lives. They can result in smelly and unpleasant living environments and a loss of dignity, security and self-respect. Poor sanitation is also one of the most widespread causes of bad health. When human waste is not managed properly or adequate hygiene is not practised, germs can be transmitted back to people via fingers, food, fluids or flies. These germs can cause a wide range of illnesses including diarrhoea, cholera, trachoma, intestinal worms and schistosomiasis. Evidence is also growing that improved hygiene is a factor in reducing acute respiratory infections such as tuberculosis or influenza (Cairncross 2003). In January 2007, readers of

11 As quoted on the UNICEF website: www.unicef.org/wes/index_healthandeducation.html

the *British Medical Journal* voted improved sanitation to be the most important medical advance globally since 1840.[12] It is a travesty that so many of our fellow human beings have so far been unable to share in this advance.

Many writers have noted that the effects of poor sanitation and hygiene will have a big impact on many of the other Millennium Development Goals, other than just Goal 7, as demonstrated in Table 1 below.[13]

TABLE 1 Sanitation and hygiene-related targets under the MDGs

MDGs	Targets
1 To eradicate extreme poverty and hunger	A large share of household income may end up being spent on healthcare for sanitation-related diseases, rather than food and other basic needs. Illness may also decrease an individual's capacity to work.
2 To achieve universal primary education	443 million school days are estimated to be lost every year due to diarrhoea.[14] Intestinal worms can negatively impact on children's performance at school.
3 To promote gender equality and empower women	It is most often women and girls who bear the responsibility for caring for sick family members, reducing their ability to work or attend school. Having separate sanitation facilities for girls increases their attendance at school, particularly after puberty.
4 To reduce child mortality	Illnesses such as diarrhoea and TB are some of the biggest killers of children.
5 To improve maternal health	Good sanitation and hygiene during and after birth can reduce the chance of infection and illness. Improved health is particularly important during pregnancy.
6 To combat HIV/AIDS, malaria and other diseases	The diseases linked to poor sanitation and hygiene have already been listed above. Good sanitation and hygiene can decrease the incidence of opportunistic infection amongst people living with HIV.

1.3 Defining sanitation

The first thing that comes to mind when we talk about sanitation is a latrine, or a toilet. The term 'sanitation', however, is commonly used to refer to a much wider range of activities. Table 2 opposite lists the broad elements that most professionals would classify as sanitation, according to Evans (2005).

12 www.bmj.com/cgi/content/full/334/suppl_1/DC3

13 Adapted from the table included in the UN Millennium Project Task Force report on Water and Sanitation (2005)

14 UNDP Human Development Report 2006

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TABLE 2
Broad elements encompassing sanitation, hygiene and water management

Source: Evans (2005)

Sanitation	• *Safe collection, storage, treatment and disposal/re-use/recycling of human excreta (faeces and urine)* • Management/re-use/recycling of solid waste (rubbish) • Collection and management of industrial waste products • Management of hazardous wastes (including hospital wastes, chemical/radio-active and other dangerous substances)
Hygiene	• Safe water storage • *Safe hand-washing practices* • Safe treatment of foodstuffs
Water management	• Drainage and disposal/re-use/recycling of household waste water (also referred to as 'grey water') • Drainage of storm water • Treatment and disposal/re-use/recycling of sewage effluents

The sanitation and hygiene sector therefore embraces everything from investment in large infrastructure such as trunk sewers, via simple 'on-site' latrines for individual households, to provision of 'soft' items, e.g. support for women's groups seeking to change defecation practices in their community. Different technologies and approaches will clearly be required in different situations. This study has focused particularly on the safe disposal of human excreta and safe hygiene practices (the elements listed in *italics* in Table 2) that are crucial for improving human health and wellbeing, and which are lacking in many poor areas of Africa and other developing countries.

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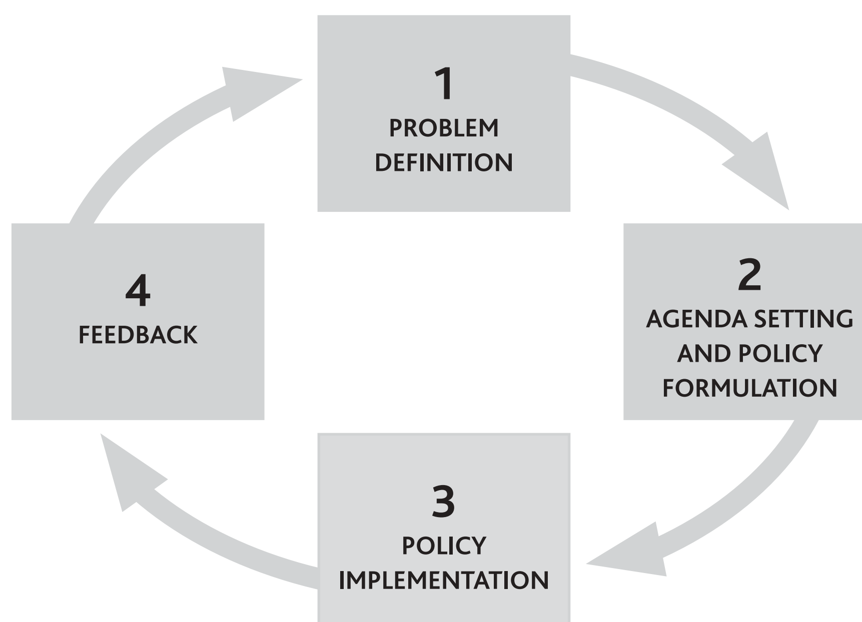
2 The barriers to sanitation

This report identifies blockages which affect the development and implementation of sound policies on hygiene and sanitation. A typical policy process broadly encompasses the four essential stages of: 1 – **Problem definition**, 2 – **Agenda setting and policy formulation**, 3 – **Policy implementation** and 4 – **Feedback**, as shown in Figure 1.

FIGURE 1
The policy process: stages in the development and implementation of public policy



As will be seen, barriers to developing and implementing sanitation and hygiene policies may occur during each of the first three stages. The fourth feedback stage was not covered by this study: this is mainly because none of the countries studied had reached this stage, although clearly it is important in any policy cycle to monitor and evaluate how programmes are being implemented, to feed back lessons learned.

2.1 Problem definition

Table 2 showed the various components which can be covered by the term 'sanitation'. However, interpretations vary and it is safer to assume that not all stakeholders use the term in the same way. Differences of interpretation can undermine efforts to identify and agree the problems which future policies and programmes must resolve.

2.2 Agenda setting and policy formulation

There are five key barriers which can hinder policy development during the agenda setting and policy formulation stage:

2.2.1 Lack of information

Problems are likely if there is a lack of recent, reliable information about the condition of existing sanitation and hygiene infrastructure, including whether or not it is actually functioning. Official statistics on sanitation

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coverage are often inconsistent or inflated. The scale of needs and demands, particularly in more remote rural areas, is frequently unknown, making it difficult to set a coherent and balanced agenda.

2.2.2 Tensions between mindsets

The clash of different mindsets is frequently a barrier to improving sanitation and hygiene. It can lead to conflict over the best policies to pursue, or how to implement them. Three main mindset debates have been identified within the sanitation and hygiene sector.

Some policy-makers argue that sanitation is a household responsibility: public agencies should concentrate their energies on public aspects of sanitation, such as networks for stormwater drainage, sewerage etc. Others advise, however, that removing excreta from living spaces has major health benefits for whole communities and that the health benefits stemming from improved sanitation are essentially a public good. According to this view, the use of public funds for latrine promotion and the more 'private' aspects of hygiene and sanitation may be justified.[15]

The second debate centres around the 'utility model' prevalent in developed countries, which focuses on piped networks, sewers and other large public works, giving much less attention to sanitation at the household level. The UN Task Force (UN 2005) explains the danger of transferring this model to developing countries. A 'utility mindset' usually concludes that sanitation is best institutionally 'housed' within the same ministry or agency responsible for public water supply networks, despite the fact that these agencies in industrial nations have very little direct interaction with the hygiene behaviour of households. Yet, in countries dependent on external aid, national policy-makers and practitioners might be pressured to divert attention away from a household hygiene and embrace the utility vision favoured by international consultants.

There is another clash of mindsets: between those people who give priority to public education campaigns designed to promote behaviour change, and those who favour a more market-oriented approach. Research[16] suggests that low uptake of household sanitation facilities may be explained by sanitation programmes which do not sufficiently understand users and their needs. This is in contrast to those which give users a say in which products they buy. The distinction lies in seeing people not as passive beneficiaries, but as active citizens and consumers.[17] There are some indications that the latter kind of 'social marketing' increases demand and uptake of sanitation. Jenkins and Sugden (2006) make a case for this, although health professionals in public agencies may be instinctively sceptical of marketing techniques, at least those practised by private sector companies (Newborne and Caplan 2006). A recent report for Building Partnerships for Development (BPD) highlights potential barriers for social marketing: where, for example, potential 'consumers' of sanitation products (e.g. latrines) are tenants of low-grade rented dwellings/sites, landlords have little interest in or incentive to invest their own resources in sanitation (Schaub-Jones *et al* 2006).

2.2.3 Lack of coordination

Some commentators point to the lack of clarity in some developing countries over which institution or institutions are responsible for which of the functions referred to in Table 2. It is most common for the Ministry of Water to be the 'institutional home' of sanitation, although sometimes it is the Ministry of Health or another ministry altogether.

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15 Cairncross and Curtis (undated)

16 Social Marketing for Urban Sanitation: review of evidence and inception report, WEDC, Loughborough University, UK. Research carried out by WEDC, UK, in conjunction with the London School of Hygiene and Tropical Medicine, TREND Group, Kumasi and WaterAid Tanzania: www.lboro.ac.uk/wedc/projects/sm

17 Uptake of latrines could increase if they were designed to suit people's demands better: if they offered users the opportunity to sit, and easy access for desludging (emptying); if they had no smell and good ventilation; and if they were cheap to install, less dependent on water and safe for children.

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The range of water, sanitation and hygiene-related activities is so wide, however, that searching for the right 'institutional home' may not be fruitful. It is arguably more important to establish links between institutions, through planning processes which bring together departments from several ministries. The above BPD report calls for tasks to be shared (page 26). Creating and linking budget lines across several agencies may be an effective way of achieving coordinated policies. National WASH[18] platforms, placed alongside but kept distinct from government, can support joint planning by several agencies responsible for sanitation and hygiene, without joint implementation being necessary or appropriate if timescales and skills requirements differ.

2.2.4 Lack of political and budgetary priority, lack of demand

Observers often highlight lack of funds for investment as a limiting factor. Both water and sanitation have been losing out to other sectoral interests in the contest for scarce public funds. For example, in a 2003–2004 survey of Poverty Reduction Strategy Papers (PRSPs) and budget allocations in three countries in sub-Saharan Africa (ODI 2002; ODI 2004), other 'social' sectors, such as education and health, attracted much larger budgetary allocations than water; sanitation was especially under-funded. It casts doubt over whether the political will exists to make sanitation a budgetary priority.

It may be that lack of political priority reflects suppressed demand at the local level. In many instances, expressed demand for sanitation facilities in households and communities is lower than for other forms of support, including drinking water supply. This could be because people have not been educated fully about the links between sanitation and poor health, or perhaps because women's demands are heard less than men's. Sanitation and hygiene specialists note that, for example, *'toilet acquisition may not be a priority expenditure, especially for the poor'* (Cairncross and Curtis, undated, page 1). It is also true that allocating public funds to sanitation facilities in households which have not made them a priority runs the risk that those facilities are not used.

2.2.5 Donors' agendas

In aid-dependent developing countries, donor priorities tend to influence government priorities and sectoral agendas, and if donor programmes are pursued with insufficient regard for the national context, they can undermine efforts to promote collaborative planning. Disproportionate donor support for other sectors may result in less investment in sanitation, or in limited numbers of skilled staff being drawn into other areas.

2.3 Policy implementation

By far the greatest number of potential barriers to improved sanitation and hygiene arise at the level of 'implementation'. International commentators point to the following barriers:

2.3.1 Lack of human and technical capacity

It takes a wide range of different disciplines and skills to improve sanitation and hygiene. While the water sector has tended to be *'dominated by engineers who feel comfortable with technical problems and tend to lean towards technical solutions'* (Jenkins and Sugden 2006, page 7), household sanitation *'requires softer, people-based skills and takes engineers into areas where they feel uncomfortable and unfamiliar'* (page 8). Promoting behaviour change at household level is an area *'where most countries have few skills… and limited capacity. Most public agencies are unfamiliar with or ill-suited for this role'* (Evans 2005, page 25).

18 WASH stands for Water, Sanitation and Hygiene, and is a concept which argues for the combination of improved water sources with better household handling and storage of water, and management of human excreta. It is promoted by the Water Supply and Sanitation Collaborative Council (WSSCC), amongst others.

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2.3.2 Low capacity to absorb funds

Spending in this sector has historically been low so there is a question mark over how quickly flows of finance can be increased, or at least funds channelled through state bodies. It cannot simply be assumed that more resources will translate rapidly into improved outcomes. All development interventions need to take into account constraints in *'absorptive capacity'* (ODI 2005). As well as funds being available, it is important that they *'be used in the right way'* (Tearfund 2005, page 23).

2.3.3 Lack of service providers

The reality in many places in Africa is that the number of sanitation and hygiene providers is limited, whether agencies of local government, community associations, NGOs or private suppliers. In cities in some developing countries, empirical studies have highlighted the activities of small private suppliers (e.g. Collingnon and Vézina, undated; WSP 2005); these include, for example, bricklayers or masons for latrine construction and people to empty pits manually. There are still some doubts as to slum populations' willingness to pay for these services. But the role of small private providers in meeting the needs of poor populations is now widely recognised as significant, where they are able to offer the right product for the right price.[19]

2.3.4 Methods/technology ill-suited to context

The type of sanitation services and facilities needed will vary according to the context: urban and rural contexts, large and small towns, planned and unplanned settlements, different ethnic and social settings.[20] If inappropriate technology options are chosen, they too will pose practical barriers. Our literature review concluded that there is broad consensus that the right choice of technology is critical in determining the extent to which sanitation facilities are requested and used.

2.3.5 Lack of access to credit

Access to credit is commonly lacking in sub-Saharan African countries,[21] particularly micro-credit for small service providers, whether community-based or private (WSP 2003). Loans are often only available for income-generating activities, rather than for improving community and household infrastructure (both sanitation and water facilities). And credit may not be available at affordable interest rates or offer repayment periods long enough for poor borrowers.

2.3.6 Lack of strong messages

Promoting sanitation and hygiene presents a substantial communication challenge. As one Indian specialist explains: '*Statistics make no impact on people, so that it is not enough to state to villagers that diarrhoea kills x thousands of children in their country every year. The real challenge is to make clear the links between common illness and the practice of open defecation*' (WSSCC, undated, page 26).[22]

There are few examples of good public messaging campaigns in the area of sanitation and hygiene. One approach which has developed a strong public message component, however, is Community-Led Total

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19 Recognising that, for very poor populations, the availability of a public subsidy (in whatever form) may be essential.

20 See, for example, Jenkins and Sugden (2006) for a summary of differences in urban and rural excreta management (page 22).

21 There are a few exceptions where the microfinance sector is reported as being more developed, e.g. Benin and Kenya (WSP 2003, page 14).

22 WSSCC is here citing the words of Surjya Kanta Mishra, Minister for Health and Family Development in West Bengal, India, a former doctor and local government leader, who apparently helped launch a well-known pilot project in Medinipur and thereafter promoted a 'total sanitation' campaign in West Bengal (page 8).

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Sanitation (CLTS), which has been pioneered in South Asia. It uses *'peer pressure, shame, disgust and pride to create dissatisfaction'* with existing practices (Jenkins and Sugden 2006, page 15). And it aims to create behaviour change that leads not only to the use of latrines, but also to a range of other activities: the washing of hands, the cutting of nails, the safe preparation of food, the refusal to spit in public places and the vigilant protection of local water bodies from all sources of contamination (page 6). It is this 'attitude of mind, not building toilets', argues the WSSCC, which *'will lead to the really dramatic improvement of public health'* (WSSCC, undated). In parts of South Asia, CLTS seems to have been successful in mobilising whole communities. In other regions, it has been less tried and tested. It remains to be seen how CLTS might be adapted in other cultural contexts.

2.3.7 Lack of arrangements for cleaning and maintenance

The viability of shared and communal sanitation facilities depends hugely on paying for maintenance – cleaning and pit-emptying. Sustained demand for latrines will depend on their being clean and odour-free. If the rota or other system for cleaning breaks down, the facility will become unpleasant to use. The BPD report suggests that for communal facilities *'engaging a caretaker is strongly recommended, preferably a local person paid from usage receipts, rather than a public employee'* (Schaub-Jones ***et al*** 2006, page 7).

2.3.8 Complexities of behaviour change

However compelling the 'societal' reasons may be for investing in sanitation – less disease, reduced public health costs, increased school attendance for girls, greater economic productivity etc – people's 'private' motivations for better sanitation at home may be different. As commentators have pointed out, an individual is likely to be prompted to improve his/her sanitation facilities by a mix of motives, including privacy, safety, convenience and increased social status (WSP and WaterAid 2000).

Predicting when other motivations might become persuasive or compelling for an individual, household or community is a matter of considerable complexity and subtlety. Lessons from projects in Burkina Faso and Zimbabwe suggest that *'the key to changing behaviour is first to understand what drives and motivates it. This issue is far more complex than was once thought. Behaviour change is difficult to achieve and requires considerable resources'* (WSP 2002).

2.3.9 Cultural factors

The international literature refers to further potential barriers: cultural factors which make the intended beneficiaries of sanitation and hygiene promotion projects reticent about or resistant to new facilities. Local customs or cultural taboos may make some technologies or approaches unacceptable, at least initially. Many commentators have also noted variations in the perspectives and behaviour of different groups (men, women, adults, children, ethnic groups etc); attitudes to sanitation and hygiene may also vary substantially between urban and rural contexts.

In the following three country case studies, we examine if the barriers identified in Section 2 are evident in each context, and discuss to what extent they explain lack of progress on sanitation and hygiene to date.

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3 Burkina Faso case study

3.1 Context

Burkina Faso is a small, francophone, landlocked country in West Africa, with a population of around 13.6 million inhabitants (PNUD 2004 in WA BF 2005). Nearly 80 per cent of all Burkinabes live in rural areas (GoBF 2006) and most rural dwellers make a living through subsistence agriculture. The country has an arid climate and a fragile environment. Farming populations are therefore vulnerable to frequent droughts and food insecurity is commonplace. Cotton accounts for about 50 per cent of total exports, which makes the country vulnerable to external shocks (GoBF/UN 2003). The country is very aid-dependent. In the rural water sector, bilateral and multilateral donors accounted for 89 per cent of all investments in the last recorded period from 1996 to 2000 (PEA 2005).

3.1.1 Human Development Indicators

BOX 1
Human Development Indicators for Burkina Faso

Source: UNDP Human Development Report 2006

Development Index ranking: 174 out of 177 countries
Life expectancy: 48 years
Adult literacy: 22 per cent
Infant mortality: 192 out of 1000 children die before the age of five

3.1.2 Access to water and sanitation

According to official sources, 60 per cent of the population have access to an improved water supply and 29 per cent have access to basic sanitation facilities (GoBF 2006; PEA 2005). However, according to WaterAid Burkina Faso (2005a), these average figures need to be considered with caution as they may hide disparities between and within provinces, and the vast majority of those with access live in urban areas. Figures from the Ministry of Agriculture, Water Resources and Fisheries (MAHRH) show that if traditional latrines, which do not live up to official norms, are left out of the equation, latrine coverage remains below 1 per cent in rural areas. The Water and Sanitation Programme (PEA 2005) estimates that the country would have to increase its capacity to deliver sanitation services more than six-fold to reach the Millennium Development Goals by 2015 – a mammoth task for a country with limited resources. It is also estimated that 56.8 per cent of all consultations at health centres for children under 5 are linked to diarrhoea.

3.1.3 Context for the local study

The local study for this report focused on five villages around the city of Bobo-Dioulasso. This city is the second largest in the country, with 410,000 inhabitants, and is situated in the west, 365 km from the capital Ouagadougou. It is the capital of the Haut-Bassins region and of the Houet province, which comprises nine local government areas (*communes*). Table 3 summarises the situation in each village studied. All villages have a basic health and education infrastructure (considering Borodougou and Yegueresso as part of one settlement); three villages also have some form of agricultural infrastructure, such as mills. All have access to improved water supply but only Santidougou meets the national water supply target of providing at least one water point per 300 persons (WaterAid Burkina Faso 2005).

TABLE 3
Profile of the villages included in local action research

Source: PNGT (2000a, 2000b, 2002); Accedes field observations

Village	Distance from Bobo	Inhabitants	Social infrastructure	Water supply and sanitation facilities
Borodougou	15 km, non-tarmac road	1,281	1 school (4 classes)	1 borehole 1 dug well 10 latrines (7.8%)
Farakoba	12 km, tarmac road	4,191	1 school (6 classes) 1 basic healthcare centre 1 pharmacy 1 agricultural centre 1 agricultural and forestry college 1 rice-processing plant INERA[23] research centre	2 boreholes 2 dug wells Number of latrines unknown
Kouentou	30 km, national road, non-tarmac	2,317	1 school (6 classes) 3 mills train station	2 boreholes 3 dug wells 10 latrines (4.3%)
Santidougou	13 km, non-tarmac road	1,491	1 school (6 classes) 1 basic healthcare centre 1 pharmacy 1 oil press 2 mills	1 borehole 4 dug wells 16 latrines (10.7%)
Yegueresso	14 km, national tarmac road	2,128	1 school (3 classes) 1 secondary school 1 dispensary 1 pharmaceutical depot	1 borehole 38 latrines (17.9%)

No official statistics on latrine coverage were available from the agencies visited for our research, either for the region, the local government area or any of the villages. According to counts of household latrines carried out by the local healthworkers, the coverage ranged between 4.3 per cent for Kouentou and 17.9 per cent for Yegueresso, based on an average household size of ten people.[24] The majority of these latrines were traditional: a dug hole covered with wooden planks and a basic straw structure around it to ensure privacy. The field research also found that neither of the two existing local marketplaces had latrines and that, in one case (Kouentou), the local school did not have any sanitation facilities. The only public sanitation facilities available were attached to churches and mosques. This means that most villagers go to the bush or use plastic bags to defecate.

According to the three healthworkers for Farakoba, Kouentou and Santidougou villages, the main complaints they have to deal with are diarrhoea, stomach aches, vomiting, malaria, dysentery, bilharzia and meningitis. Farakoba, in particular, saw a rise in dysentery in 2005, which prompted the local health centre to encourage latrine construction in the village.

23 *Recherche sur l'agriculture, Institut de l'Environnement et de la recherche Agricole*

24 This is the estimated average household size used by GoBF (2006).

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BOX 1
Sanitation and hygiene in Farakoba

Source: Interviews with villagers of Farakoba conducted by researchers as part of this study
Photo: Laura Webster

Farakoba is a village of 4,191 inhabitants, 12 km from Bobo-Dioulasso, the second largest city of Burkina Faso. In Farakoba, only a small number of households own a private latrine. The rest of the villagers go to the bush to defecate in the early morning hours and after dark, when the night provides more privacy. Mr Kabre Moussa, father of 11 children, does not consider this as a problem. According to him, this has been the tradition since time immemorial. He does not think that his children's illness is related to a lack of sanitation or safe hygiene practices. These events are in the hands of God in his view. The health worker in Farakoba, Mr Issa Toure, thinks differently. In 2004, a dysentery epidemic occurred in the village. In his view, it was the lack of safe latrines and hygienic practices that led to this calamity. He is now encouraging people to build latrines in the village but admits that convincing people to spend their scarce resources on the construction of latrines is still a challenge.

Mr Kabre Moussa

3.2 Findings

Desk studies and interviews were carried out at both the national and local level to test if the potential barriers outlined in Section 2 exist in Burkina Faso, and if they could be used to explain the lack of progress to date. The methodology is set out in more detail in Annex A1. Table 4 overleaf sets out institutional responsibilities for sanitation and hygiene in Burkina Faso and provides the context for these findings.

3.2.1 Problem definition

Burkina Faso's first policy document on sanitation was the National Sanitation Strategy of 1996 (MEE 1996), which was developed during the restructuring of the urban sanitation sector (which took place with World Bank assistance) and focused primarily on urban wastewater and excreta management. It did not take into account all aspects of environmental protection or make an explicit connection with hygiene promotion. No guidance was given for improving sanitation in rural areas and new developments under decentralisation over the last few years were not taken into account (according to interviews for this study and MEE 1996).

A new national sanitation strategy has now been commissioned. It was due to go to the Council of Ministers, according to an interview with the General Directorate of Drinking Water Supply (DGRE), in October 2006. The draft identifies gaps that need to be plugged and sets out the institutional framework for implementation, it calls for a demand-based approach, involving the promotion of behaviour change and participatory approaches and it sets out a priority list of appropriate technologies for rural and urban areas. A national policy for hygiene promotion was also developed in 2004 (MS 2004). This document clarifies the responsibilities of key actors, and sets out the need for overall coordination, and capacity development. The strategy focuses on hygiene promotion in rural areas and schools, and on the development and capacity-building of technical services in towns and cities. Between them, these strategies suggest that the government is now working to a more comprehensive definition of sanitation.

At the local level, the focus group discussions revealed that people generally found it difficult to define exactly what is meant by sanitation and hygiene. Several people could not differentiate between hygiene practices like handwashing with the use of latrines for defecating. The local language reflects this vagueness around hygiene and sanitation issues: in Jula the term *nyege* refers to both shower and any type of latrine, while the Jula word for hygiene, *sanyia*, also means cleanliness, sacredness and sanctification. According to a government survey, only 12.8 per cent of all women understand the causes of diarrhoea (MAHRH 2006c), which would suggest low demand for sanitation at the local level.

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TABLE 4 Ministerial responsibilities for sanitation and hygiene promotion in Burkina Faso

Ministries	Related offices / departments	Responsibilities
MINISTRY OF AGRICULTURE, WATER RESOURCES AND FISHERIES – MAHRH	General Directorate for Drinking Water Supply – DGRE	• Development of sanitation framework, and control of its implementation • Development of national policies for wastewater and excreta management
	National Water and Sanitation Office – ONEA	• Sanitation in urban areas
MINISTRY OF HEALTH – MS	Directorate for Public Hygiene and Health Education – DHPES	• All issues regarding public hygiene
MINISTRY OF ENVIRONMENTAL AND LIVING CONDITIONS – MECV	General Directorate for the Improvement of the Living Environment – DGACV	• Issues regarding environmental protection such as pollution and the management and control of solid, industrial and medical waste
MINISTRY OF TERRITORIAL ADMINISTRATION AND DECENTRALISATION – MATD	General Directorate for the Development of Local Governments – DGDCT	• Ensuring the implementation of the decentralisation process
MINISTRY OF BASIC EDUCATION AND LITERACY TRAINING – MEBA		• Hygiene and sanitation through school curriculum
MINISTRY OF INFRASTRUCTURE, TRANSPORT AND HABITAT – MITH		• Stormwater management
MINISTRY OF ECONOMY AND DEVELOPMENT – MEDEV		• Coordination and implementation of PRSP
MINISTRY OF FINANCE		• Provision of budget for the sub-sector
Coordinating bodies		
NATIONAL COORDINATION GROUP FOR WATER SUPPLY AND SANITATION – CCP-AEPA		
TECHNICAL WATER COMMITTEE – CTE		
NATIONAL WATER COUNCIL – CNE		

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3.2.2 Agenda setting and policy formulation

The development of the strategies mentioned above is clearly a positive step. However, the research identified some barriers to good policy formulation and agenda setting, which may undermine these strategies.

Lack of information

There is a lack of up-to-date information on sanitation and hygiene needs in Burkina Faso. In the rural local government area of Bobo-Dioulasso, Accedes could not obtain any official sanitation statistics. Furthermore, there is little information about NGOs working in the sector and so little harmonisation between approaches.

Tensions between mindsets

Sector stakeholders in Burkina Faso reported that the different mindsets prevalent in the various sectors had, at times, prevented different ministries from reaching a common understanding. While the Ministry of Environment and Living Conditions (MECD) is concerned with safeguarding the environment, the Ministry of Agriculture, Water Resources and Fisheries (MAHRH) conceptualises sanitation as wastewater and excreta management, and infrastructure development. The Directorate of Public Health and Hygiene Promotion (DHPES) under the Ministry of Health is, in turn, concerned mostly with health-related issues and emphasises behaviour change. Some sector actors still have concerns about the clarity of policy direction that the national sanitation strategy gives. Questions around providing subsidies remained unanswered and, as of October 2006, the overall financing of the sector had not yet been secured. Some local officials interviewed did not perceive sanitation as a public responsibility; rather, the construction of latrines, was regarded as a private household affair. The only representatives who said they had some responsibility for hygiene promotion and awareness-raising about latrines were healthworkers at different levels.

Coordination

Coordination is clearly important, given that, as seen in Figure 3, responsibility for sanitation and hygiene promotion activities is fragmented between five different ministries. Three further ministries have some impact on the sub-sector. This in itself is not unusual or necessarily problematic. A formal coordination platform, the CCEAPA, was established in 2005, to develop a 'road map' for water supply and sanitation, with the ultimate aim of developing a sector-wide approach. This platform includes all major sector ministries, the Ministry of Territorial Administration and Decentralisation and donors; it is also open in theory to civil society and private sector stakeholders. This provides a good mechanism for coordination. The main question is how effective this platform will be in coordinating activities and driving forward implementation of the strategy.

According to the Director of Sanitation (who sits in DGRE), previous ambiguities over which ministry has responsibility for which part of the strategy have now been resolved. Yet, doubt remains over the relative levels of ownership and coordination between the different ministries. A representative from DPHES stated that during the development of the hygiene strategy, some ministries kept their involvement at the lowest level, sending representatives without adequate decision-making power or technical expertise to contribute meaningfully to discussions. Also,the National Water and Sanitation Office (ONEA), whose aim is to increase sanitation coverage by promoting behaviour change, does not collaborate with the Ministry of Basic Education on a regular basis. Despite initial attempts to 'join up' activities, *'la mayonnaise n'a pas pris'*,[25] according to one official.

Coordination between central government and the regions also seemed to be a problem. Since the early 1990s, Burkina Faso has been undergoing a process of decentralisation, which has had a big impact on the institutional arrangements for delivering sanitation and hygiene. The former rural *départements* and urban municipalities have been reorganised into urban and rural *communes* functioning as local government entities. The first local elections took place in April 2006 and established local governments as the bodies responsible for implementing service delivery – including water supply, sanitation and hygiene promotion (GoBF 2006). There is now due to be a 'fast-track process' for transferring a number of core responsibilities to local governments. According to government officials, this has already begun. Donors currently supporting the process of decentralisation in the field, however, remain cautious; in their experience, they say, the Ministry of Finance has found it difficult to loosen its control over financial resources.

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25 In English: 'The collaboration has never really come together'.

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Political priority

Whilst steps have been taken to formulate policy, there are doubts about the political priority given to the sector, particularly in terms of budget allocation. Water and sanitation were poorly represented in Burkina Faso's first PRSP (2002), which contained no sanitation coverage figures (Mehta and Fugelsnes 2003). In the second PRSP – finalised in July 2004 – sanitation and hygiene were recognised as priority areas but there was no separate budget line for them. According to some of the stakeholders interviewed, there was minimal coherence between the sub-sector and the overall PRS process in 2006. The General Directorate for Water Resources now plans to start a campaign to lobby the Ministry of Finance to provide a sanitation budget in the next financial year. MAHRH's success or failure in making a case for the sector with the Ministry of Finance and the Ministry for Economic Development will be critical in shaping sanitation interventions in the future.

Donors' agendas

The government of Burkina Faso (GoBF) expects to receive continued support from the international community to implement the draft strategy (according to an interview with DGRE). The two main donors supporting sanitation and hygiene promotion are the Danish International Development Agency (Danida) and UNICEF. Danida's institutional and financial support is directed towards MAHRH, the ministry responsible for water supply, with the long-term goal of establishing a sector-wide approach for both water and sanitation. UNICEF prioritises hygiene promotion and focuses its support on the directorate for hygiene promotion and health education under the Ministry of Health (DHPES). A number of other donors, including the World Bank, the African Development Bank, German development agencies, the European Union and the French Development Agency (AFD), provide support to the sub-sector. However, recent sector studies by GoBF (2005) and WaterAid (2005) indicate that their activities have so far focused mainly on urban and peri-urban areas, one example of donors' agendas skewing results in-country. In October, MAHRH had entered into negotiations with other donors for additional support to the sector. The provision of subsidies was a key point of discussion as donors had different agendas from the government – another example of different mindsets being a potential barrier.

3.2.3 Policy implementation

Lack of human and technical capacity

The GoBF has recognised that, if its strategy is to be implemented, it will have to rely heavily on the support of NGOs and the private sector, as well as strengthen inter-ministerial cooperation and intensify the capacity-building of local governments and line ministries (GoBF 2006; interview with DGRE). However, the evidence suggests that there is currently a lack of human and technical capacity, not only in central and local government but also in the NGO and potentially the private sector too.

Lack of human resources at the municipal level has led to serious crises in various municipalities. Many municipal councils are effectively run as 'one-man shows' by the local executive (according to an interview with MATD); they are seriously understaffed and under-resourced. It can be assumed that, in many cases, they are not even aware of their sanitation-related responsibilities and some interviewees were of the opinion that it would take at least another five years until local governments were able to take on these responsibilities (interviews with DGRE, MATD).

There is also a lack of capacity within national ministries. Only one person was assigned to sanitation in MAHRH, in August 2006. Compared with all other line ministries involved in hygiene promotion and sanitation, the Directorate for Public Hygiene and Health Education (DPHES) at the Ministry of Health has by far the most decentralised structures. At regional level, it works through health and sanitation education centres (CRESAs), which oversee the health districts in each region. Each health district has a team of healthworkers responsible for information, education, communication and sanitation (SIECA), and they supervise centres for health and social promotion (CSPS) at village level. The SIECA covering the local government area of Bobo-Dioulasso is responsible for 30 CSPSs (according to an interview with SIECA). The CSPSs are normally staffed by nurses, midwives and pharmacists carrying out basic health education and providing medical services for several villages.

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However, lack of capacity is also evident here and healthworkers often have little time or financial resources. In Bobo-Dioulasso, the CSPSs stated that they are regularly overstretched with curative work, which leaves virtually no time for preventative activities such as hygiene education. The SIECAs who are supposed to support CSPSs in their individual health districts do not have any budget for providing back-up support to local healthworkers. In the Haut-Bassins region, SIECAs were only able to carry out three inspection tours in 2006, using vehicles lent by another department (according to interviews with CRESA, SIECA and CSPS representatives).

Lack of service providers

It appears that overall there is a dearth of potential service providers in Burkina Faso. According to Accedes' interviews, neither representatives from the administration nor private NGOs are currently engaged in latrine construction in the rural local authority area of Bobo-Dioulasso. Some NGOs are active in the water sector but the total number is unknown. The only NGO (Pasud) found to be involved in sanitation was working in an urban area of Bobo-Dioulasso on solid waste management and hygiene education in schools. At the national level, 26 NGOs formed a water and sanitation network in 2004 – the NGO Coordination Group for Water supply and Sanitation (CCEPA). Its mission is to improve coordination across sector NGOs and lobby at the national level. According to member organisations, CCEPA is still in the early stages of developing a common lobbying approach for sanitation. This opinion is echoed by donor organisations that consider the network's voice on sanitation- and hygiene-related issues still to be weak. As regards private suppliers, ONEA said in an interview that it supports private entrepreneurs to produce latrine components such as slabs. However, the government does not know the capacity of the private sector overall; indeed, it seems to have been largely ignored as a potential partner for increasing sanitation coverage and for activities around hygiene promotion in the past (according to interviews for this study).

Lack of financial resources

An important constraint that many of the focus groups mentioned was the lack of financial resources at household level. Several people said that they did not have money to buy soap. Others said that they did not have the resources to pay for someone to dig a hole for a latrine or buy the necessary materials such as cement or a slab. It could be that these items were not considered essential, and therefore not made a high enough spending priority. However, this part of Burkina Faso is also very prone to drought and food crises, and it may be that, at least sometimes, people are living hand-to-mouth in many of the villages. This suggests that, in some cases, some kind of subsidies may be necessary.

Appropriate methods and technology

People also reported that the sandy soil in Farakoba and Borodogou made latrine construction difficult, while people in Kouentou had the opposite problem: rocky and granite soils. Because technical expertise is lacking, there was a general feeling that it was not worth bothering to try, even though it would presumably be possible to find methods and technologies appropriate to each context.

Cultural factors

The focus groups also clearly revealed many cultural norms and taboos which need to be tackled in the villages if sanitation and hygiene practices are to be improved. All focus group discussants lacked an understanding of the links between hygiene practices and water-related diseases. While people agreed that excreta are 'bad', none of them made the link between contaminated water and disease. The general reason given for diarrhoea, for example, was malaria. Latrines and hygiene practices were also subject to local taboos and traditions. People discussed, for example, a practice of making children drink the water that the whole family has used for washing their hands. This is said to make children stronger. With regard to latrines, there is a taboo among some groups that 'two holes should not face each other'.[26] On a more general level, some of the discussants felt that entering a latrine was like entering a house – and indeed one that was smelly and, as such, rather unpleasant to be in. Being in an enclosed space was regarded as an inappropriate environment for defecating.

There was a strong notion in all discussions that the decision to invest in and to construct a latrine falls within the male domain. As such, even if a woman wanted a latrine, she would still be dependent on her husband. *'The man takes the decision: he indicates the location, digs the hole and pays for the materials.*

26 In French: 'Deux trous ne se regardent pas'.

However, men do not generally see latrines as a priority,' according to one villager. The importance of these gender roles was underlined by the fact that in the villages of Borodougou and Kouentou, the women's groups refused to talk about the topic of latrines for this reason.

On the other hand, the discussants also identified a number of factors that encourage latrine construction. Women, in particular, raised fears of being bitten by scorpions or snakes when defecating in the open and talked of their need for privacy. Both men and women observed that it is becoming increasingly difficult to find suitable coverage close enough to their village, especially during the dry season. Some discussants associated latrines positively with urban life and as *'a white man's affair'*[27] which they wanted to imitate. This was particularly the case where members of a family had migrated to the town. Both priests interviewed said that they mention the importance of hygiene and cleanliness in their sermons and in Kouentou, the local priest had undergone training on latrine construction and, had started to motivate the Christians of the village to construct latrines as part of a communal effort. In Farakoba, the local healthworker had developed a plan for increasing latrine coverage after an alarming increase in cases of dysentery in the village; as a result the discussants in Farakoba generally acknowledged the importance of latrines for health and were convinced of the need to increase latrine coverage.

3.3 Conclusions

At each stage of the policy cycle, there are some factors in Burkina Faso that back the drive for better sanitation and hygiene. The national government has identified these issues as important, and have begun to define the problem, and its response to it, in the new draft strategy. Although local communities may not have identified sanitation and hygiene as a top priority for improving health and livelihoods, there are other favourable factors at the local level. These include: decreasing natural cover from foliage, the desire to emulate urban dwellers and foreigners, the desire for increased security and the positive influence of community leaders such as healthworkers and religious leaders.

It is encouraging that a national coordination mechanism has been established and that the PRSP identifies sanitation and hygiene as priority areas. In terms of policy implementation it seems that:

- some help is being offered to some private sector suppliers
- NGOs are taking first steps towards coordination, and
- there is some capacity at the local level in the form of local healthworkers.

However, it is also clear that there are considerable barriers to improved sanitation at every level, and at the policy implementation stage in particular.

Problem definition

It is important that the new national strategy fully defines sanitation to ensure that all elements are covered. More education is also necessary at the village level so that communities and families begin to see lack of sanitation and hygiene as an important issue.

Agenda setting and policy formulation

More accurate information about the extent of coverage would be helpful at all levels. Whilst the draft sanitation strategy and the hygiene policy formulation will have been helpful, certain tensions between different mindsets apparently remained unresolved during this process, and may yet cause problems during the implementation phase. The coordination mechanism in place does not yet seem to have full buy-in from all of the necessary departments, and the agenda of both donors and the national government seems to favour urban areas over rural ones.

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27 In French: 'C'est une affaire de blancs'. (Villager from Farakoba)

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Policy implementation

Lack of human and technical capacity and an overall lack of service providers seem to be by far the biggest challenges that the sector faces. There are simply not enough people working on sanitation and hygiene promotion, and the few who are need more money and more technical assistance to be effective. This is compounded by a lack of finance and poor access to credit at the village level, and unhelpful cultural and social traditions and taboos, which will need to be challenged if greater progress is to be made.

There was some optimism, however, that some of these barriers can be overcome. The group which met for the final research seminar made the following recommendations for moving forward:

1. The development of a national sanitation strategy and implementation plan is a positive step. Unresolved issues such as the provision of subsidies and the development of support structures for implementation now need to be clarified as soon as possible.
2. Decentralisation is now taking shape. This offers new opportunities to improve sanitation service delivery and sanitary and hygiene services at the local level. The transfer of staff competencies, skills and financial resources should be driven forward vigorously to enable local governments to take up their responsibilities.
3. Each local government should include a sanitation and hygiene promotion strategy for the urban and rural areas under its jurisdiction in its local development plan. Adequate financial resources should be made available for implementation, and progress should be reviewed on a regular basis.
4. Each local government should develop a framework for harmonising the activities of different actors (civil society, NGOs, private sector) involved in hygiene promotion and sanitation.
5. Religious leaders should take an active part in promoting safe hygiene behaviour and the adoption of latrines.
6. Formal and informal education programmes should reinforce aspects of hygiene and sanitation promotion.

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4 Madagascar case study

4.1 Context

Madagascar has a surface area of 587,040 square kilometres (a little larger than France) and is situated in the south-west of the Indian Ocean, separated from Africa by the Mozambique Channel. It is frequently affected by tropical cyclones and depressions, which can cause major damage to crops, forests, roads and other infrastructure. The population, according to the 2004 census, was 17.5 million, and is mostly rural, with a recent proliferation of unplanned slums around towns. The Madagascar Poverty Reduction Strategy Paper (PRSP) of July 2003[28] notes that poverty in the country is substantially a rural phenomenon, with farmers being particularly vulnerable.

4.1.1 Human Development Indicators

BOX 2
Human Development Indicators for Madagascar

Source: UNDP Human Development Report 2006

Human Development Index ranking: 143 out of 177 countries
Life expectancy: 55 years
Adult literacy: 29 per cent
Infant mortality: 123 out of 1000 children die before the age of five

4.1.2 Access to water and sanitation

The PRSP cites access rates to sanitation for households at 87 per cent in urban contexts and 52 per cent in rural contexts, with an overall coverage rate of 58 per cent. WaterAid, however, cautions against the unreliability of official figures (WaterAid 2006); it estimates that 7.5 per cent of the rural population and 27 per cent of the urban population have access to adequate sanitation. Pronounced differences in coverage apparently exist between provinces.

Sixty per cent of child deaths are thought to be caused by either poor sanitation or poor water quality (Republic of Madagascar, undated). Water and sanitation-related illnesses are also thought to cost the country 3.5 million school days (African Development Bank 2005) and 6 million working days (DEA, undated), every year.

4.1.3 Context for the local study

The local study was carried out in the province of Mahajanga, in the district of Madritsara, within the region of Sofia in the north of the country. Mandritsara is the most densely populated district in the region (Republic of Madagascar 2003) and more than 85 per cent of the population rely on subsistence agriculture, with many families in extreme poverty (FFBBM). The district has minimal infrastructure, and in general the local rural economy is weakly integrated into markets. There are approximately 10,800 inhabitants per qualified doctor (Republic of Madagascar 2003), and access to medical centres for rural people typically involves substantial journeys on foot. Only 16 per cent of children in the region attend primary school (RPGH 1993, *Recensement Général de la Population,* cited in Republic of Madagascar 2003).

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28 Document de Stratégie pour la Réduction de Pauvreté, July 2003, approved by IMF/World Bank in October 2003.

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Again, statistics on regional access to water and sanitation vary considerably. According to WaterAid (2005), combined access to water and sanitation for Mahajanga province is estimated at 36 per cent, compared with 87 per cent in the province of Antananarivo where the capital is located. According to the African Development Bank, sanitation coverage in the province of Mahajanga is estimated at 6.19 per cent (drinking water supply: 13.54 per cent). In the ***communes*** in which it works, FFBBM reported very low, almost non-existent, levels of sanitation and hygiene before it began its support to the villages. The three principal causes of morbidity in the region are malaria, acute respiratory infections (ARIs) and diarrhoea (according to Republic of Madagascar 2003). The local study was based on a survey of 138 households in seven rural villages in the Mandritsara district, details of which are included in the table below.

TABLE 5
Names and geographical locations of villages included in the questionnaire

Source: FFBBM/HVM Département de santé communautaire (FFBBM/HVM 2004)

Village name	D	RC	PS	UL	KL	ML	US	S
Andilana	8 km	T	32%	12.5%	83%	75%	56.25%	100%
Maetsamena	35 km	T	22%	47%	94%	59%	55%	91%
Ankisaka	35 km	U	20%	53%	85%	70%	26%	79%
Antsarika	70 km	U *	11%	23%	92%	77%	25%	44%
Ambodilengo	11 km	U	10%	27%	73%	65%	15%	60%
Ambaky	80 km	U *	10%	58%	100%	50%	12%	50%
Antsomika	65 km	U *	0	0	92%	0	27%	27%

KEY
D – Distance from Mandritsara town
RC – Road connection, (**T**) tarmacked or (**U**) untarmacked road
* asterisks indicate villages impassable for motor vehicles during rainy season
PS – percentage possessing latrine slabs
UL – percentage of use of a hygienic latrine
KL – percentage of knowledge on the risk of diarrhoea because of lack of use of a hygienic latrine
ML – percentage of willingness to maintain latrine and keep latrine clean after use
US – percentage of use of soap for handwashing
S – percentage of protected storage practices

4.2 Findings

As in Burkina Faso, a desk study was carried out and interviews conducted at national and local levelto test if the potential barriers outlined in Section 2 exist in Madagascar, and if they could be used to explain the lack of progress to date. The methodology used is set out in Annex A. Figure 2 below sets out the institutional framework for sanitation and hygiene in the country, which provides context for these findings.

4.2.1 Problem definition

Madagascar's PRSP recognises the importance of improving some aspects of sanitation and hygiene. As well as access to drinking water, the (long) list of 'priority' measures in the PRSP includes an *'improved rate of access to excreta disposal facilities'*, as well as *'implementation of a new legal and institutional framework for water and sanitation'*. The number of latrines in the country is one of 31 indicators for monitoring PRSP implementation; positive change in behaviour as regards hygiene is also noted (page 122) as an element of the sanitation programme. However, some other key aspects of sanitation, as outlined in Table 2, are missing. For example, in the Action Plan annexed to the PRSP there is mention of sanitation under urban infrastructure, but no reference to it in the actions listed under the health section.

The Department for Water and Sanitation has been responsible for drafting a new National Policy and Strategy for Sanitation, which is available in draft form but was still awaiting final sign-off from ministers

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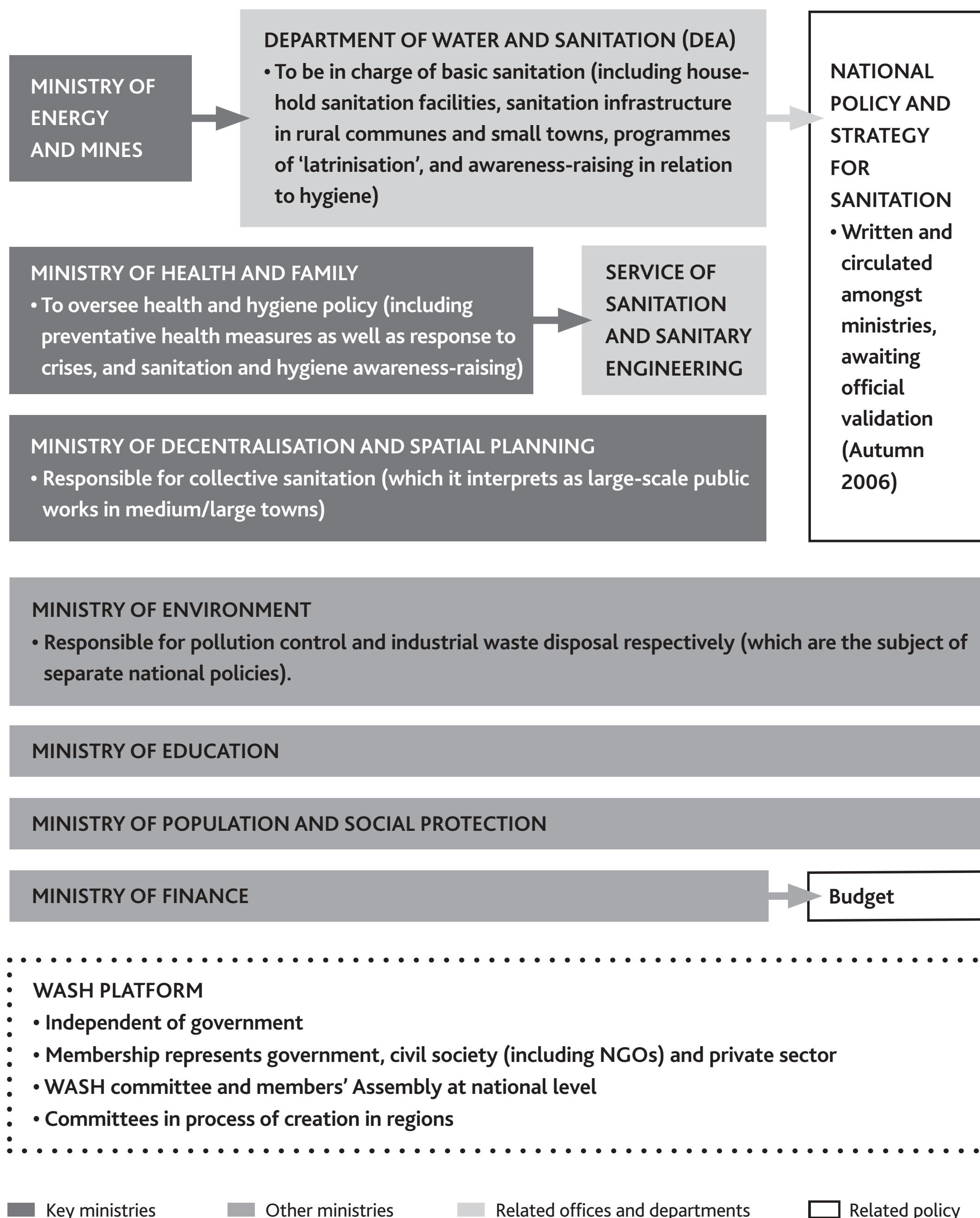
FIGURE 2
Key actors – sanitation, hygiene and water sectors in Madagascar



from other departments towards the end of 2006. After a two-year gestation period, this Policy and Strategy provides important definitions which should mean, once it is finalised, that the first hurdle in defining key terms has been cleared. Respondents to this study said there was a need to develop more detailed technical definitions (e.g. of concepts such as 'improved' sanitation), but they suggested that this would not delay the second and third stages of the policy process.

4.2.2 Agenda setting and policy formulation

Lack of information

There is a lack of up-to-date, accurate information on sanitation and hygiene needs. On the basis of such data as is available, the gap in sanitation coverage is clearly substantial, particularly in rural areas, but more reliable data would enable more accurate policies and strategies to be developed.

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Tensions between mindsets

Given the overall lack of service providers, there did not seem to be a strong tension between different mindsets on the role of the private and public sectors in creating demand for or providing sanitation facilities. However, interviews did seem to suggest some lack of understanding between those who work in the public and private sectors in Madagascar, including some scepticism about the role of private providers which are profit-making.

Interviews also suggested that an engineering perspective predominates in the sector, which could lead to the 'utility mindset' referred to in Section 2. The Ministry of Energy and Mines has prime responsibility for water and sanitation because the main source of drinking water in the country is groundwater; most hydro-geologists work in this department. Sanitation was added to the remit of that ministry more recently and the Department of Water and Sanitation (DEA) was created. At the University of Antananarivo, out of 50 subjects taught to students training for a diploma in 'hydraulic engineering', none is designed to broaden students' perspectives on issues like education/awareness-raising and community engagement.[29]

On the other hand, several people consulted observed that health policies and programmes in Madagascar tend to focus on cure, rather than prevention. The predominant mode of intervention seems to be treating the symptoms of illness, in response to demand for medicines, rather than addressing the underlying cause of illness, which may often be low standards of hygiene. As a result, sanitation programmes in Madagascar still tend to prioritise major infrastructure projects, concentrating, for example, on urban drainage.

Coordination

Lack of coordination has historically been a problem in the sector. One source lamented that, in the past, there had been very *'scattered responsibilities'*, which had constituted *'a key stumbling block, hindering strategic solutions and problem-solving'* (Republic of Madagascar, undated, page 13). As well as the Ministry of Energy and Mines, there are three other ministries with partial responsibility for sanitation and hygiene: Health and Family Planning; Decentralisation and Spatial Planning; and Education. Until recently, those ministries have had no clear definition of their respective mandates. The National Policy and Strategy for Sanitation aims to clarify institutional roles, and the ministerial responsibilities designated in the draft Policy and Strategy have been included in Figure 2 above.

Apart from these ministries and departments, the Water and Sanitation Regulatory Agency (ORSEA) is responsible mainly for compliance with quality standards and tariff provisions of the Water Code (2005, page 3). The national water and sanitation authority, whose acronym is ANDEA, is only referred to in relation to environmental protection.

It is now important that these different actors work together to implement the various parts of the strategy. There do, however, appear to be several factors hindering this coordination. Some interviewees still questionned whether sanitation is appropriately housed within the Ministry of Energy and Mines and some were reluctant to see sanitation coming under the remit of the Ministry of Health, given the predominant engineering mindset mentioned above. As one person put it, sanitation is to some extent an *'orphan with reluctant foster parents'*.

Respondents noted that local government could play a key role in coordinating activities at the level of the communes, but it was not clear how this would happen in practice. The communes, equivalent to 'municipalities', are designated as the bodies responsible for managing the financing and contracting of sanitation (and water) providers at local level. However, decentralisation appears to be happening very slowly in Madagascar: in reality, resources and responsibility are still highly centralised.

A WASH[30] platform was launched in August 2002 and is another potential mechanism for coordination, at least between water, sanitation and hygiene sectors.

29 Judged from the subject headings listed in a document supplied by the university.

30 WASH stands for Water, Sanitation and Hygiene, and is a concept promoted by the Water Supply and Sanitation Collaborative Council (WSSCC), amongst others.

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The WASH Committee is chaired by the Minister of Energy and Mines; the ministries of health and education are also represented, although the closure of a relevant department in Education has apparently cast doubt on the extent of its participation. A clear gap in the committee is absence of the Ministry of Decentralisation and Spatial Planning. WaterAid acts as Executive Secretary to the committee. Other members include Care, the Catholic Relief Service (CRS), the NGO network Réseau Eau and individual Malagasy NGOs. Meanwhile, the National Assembly of WASH is open to all who wish to participate; it currently has some 100 members. According to people interviewed during this study, the WASH process overall is a positive factor in policy development in the sector in Madagascar. There is doubt, however, as to whether WASH can, or should try to, replace inter-ministerial dialogue.

Political priority

According to interviewees, the prime minister has made several speeches recently highlighting improved hygiene as a national priority. These declarations had given interviewees the impression there was high-level political interest in the sector. However, according to DEA, the budget share to support sanitation was 0.3 per cent of the total allocation to water supply and sanitation, which is itself 3 per cent of the national budget. While the latter figure equates to that in some other countries in sub-Saharan Africa (ODI 2004), the figure of 0.3 per cent is very low.

Lack of demand

The interviews at national level in Antananarivo suggested that demand for access to drinking water, as expressed by households and communities, is higher than for sanitation and that latrines are not a high priority, especially in rural contexts. This seems to be supported by a Madagascan study conducted with Cornell University (Cornell 2001), where focus groups rated water as a sixth priority for development and no reference was made to sanitation. However, in Mandritsara district, communal and regional development plans (PCDs and PRDs), which are the key elements of the new bottom-up planning approach, are beginning to articulate demand for sanitation and hygiene.

Donors' agendas

As public funds are scarce and sanitation/hygiene starts from a very small share of the national budget, external funds will be very important. Several donors are currently supporting the sanitation and hygiene sector financially. The African Development Bank (ADB) has been funding the PAEPAR project in the rural south of Madagascar (2003–2007). It provided US$ 11.5 million to construct new water points, 5,000 latrines and some hygiene education activities. The next phase of funding will run for three years and is intended to support construction and rehabilitation of water and sanitation facilities in rural areas as well as information, education and communication activities. Funding includes an 'institutional support' and training component for government and NGOs. The main beneficiaries are to be households, schools, basic health centres and public markets where drinking water and sanitation facilities will be built. This funding includes the engagement of NGOs experienced in studies of behavioural change to carry out KAP studies (knowledge, aptitude practices),[31] as well as collaboration with UNICEF to disseminate hygiene promotion messages on local radio. This project will include eight regions (over three provinces), including the region of Sofia where Mandritsara is located.

UNDP and UNICEF have financed a project to build 150 productive boreholes in the rural south, and a key focus of UNICEF's effort is on more effective education for children about hygiene practices. The Intercoopération Suisse has also been supporting the sector since 2003 with a programme covering six regions. Its approach combines the three elements of WASH.

The Pilot Project for Rural Drinking Water Supply (PDWSSR) was a World Bank-financed project which began in 1998 and was completed in 2005. The Bank has also sent consultants to work with the Ministry of Energy and Mines on a budget support exercise. Its focus is on how to increase the targeting of budgetary allocation to sanitation and hygiene (and avoid what has apparently happened in the past when all available funds have been absorbed in administrative salaries and costs).

Despite these interventions, interviewees clearly felt there was a lack of external funding for the sector. They believe that the lack, until recently, of a national policy for sanitation may have been a cause of this; they

31 In French, CAP studies: *comportements, attitudes, pratiques.*

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also felt the sector has something of an image problem. They also cited the difficult logistics of monitoring and measuring this sector as a potential deterrent. While donors are participating in the WASH initiative, no donor coordination committee currently exists for WSS to harmonise – and focus – donor support.

4.2.3 Policy implementation

Lack of human and technical capacity

As in Burkina Faso, it is the problems associated with policy implementation which pose the biggest blockage to improvement in Madagascar. The country lacks both human and technical capacity, in terms of both the number of people in the sector and the range of skills required, with engineers outweighing other disciplines. One interviewee highlighted the need for a technical centre providing training and acting as a resource for information on sanitation and hygiene. Although the government has apparently produced a simple-to-use manual, it does not seem to have been disseminated. Non-governmental stakeholders commented on the lack of government officials to whom needs/complaints could be referred. The lack of teaching manuals on sanitation and hygiene for school teachers also means that sanitation and hygiene are still little or inadequately taught at (primary) schools.

Another interviewee commented that decentralised agencies do not know how to implement sanitation and hygiene programmes effectively. There are substantial doubts over capacity – technical, administrative and financial – at the level of *communes*. The draft National Policy, explicitly recognises (page 3) that *'the communes currently have, for the most part, neither the technical capacity nor the means, material and financial, to take on their leading role'*, and stresses that this capacity needs to be strengthened. ADB notes in its appraisal document for PAEPAR (ADB 2005) that the communes *'lack the human and financial capacity to carry out their responsibilities'*. The Annual Progress Report (September 2004) of the PRSP (IDA/IMF 2004) also referred to wider issues of budgetary management; it noted some progress in implementing public expenditure management reform – adding that *'sustaining this momentum is crucial'*. The intention is that the WASH process will create support committees at the communal level to bolster this process.

Low capacity to absorb funds

Donors' reticence to fund sanitation and hygiene programmes in Madagascar may reflect the country's low capacity to absorb funds. The planning system for development is cumbersome, with a slow flow of information from the communal level, via district and regional levels, to central government. Each commune is supposed to have its own development plan, but it seems many of them currently lack both the funding and the staff to produce such a plan (WaterAid 2005). There tends to be a long wait before development proposals are translated into programmes and a tendency for each level in the bureaucracy to blame the level immediately above or below for delays.

Lack of service providers

While it cannot just be assumed that there is capacity to absorb aid within the state agencies and municipalities, there are also questions as to whether other sectors have significant capacity to act as service providers instead. The impression is that international or national NGOs have provided much of the innovation relating to sanitation and hygiene projects, in the absence of any dynamism on the part of public institutions in the past. Pilot projects of NGOs (such as WaterAid and local Malagasy associations) have signalled how local communities may be successfully engaged in sanitation and hygiene activities, e.g. via the entry point of water supply and through programmes educating children. However, few NGOs are active in Mandritsara district. FFBBM/HVM have helped to install 240 latrines in 20 villages in Mandritsara and are contributing to rural hygiene promotion using their specific expertise in preventative health. However, this activity would need to be scaled up considerably if more significant progress is to be made.

ADB says the private sector is present in urban centres, but hardly at all in rural areas (ADB 2005). The draft National Policy states, *'Although it is difficult to provide a complete picture of the private sector in relation to sanitation and hygiene in Madagascar, it is clear that there are few (commercial) private actors – for construction and operation of sanitation and hygiene facilities – and those that do exist are concentrated in Antananarivo and the area around it, with an almost exclusive focus on urban contexts.'* (PAEPAR 2004)

Appropriate methods and technology

One positive factor was that most of the service providers interviewed recognised the need to ensure that the methods and technology used suit the context. WaterAid reported that its policy is to carry out Behaviour, Attitudes and Practices studies before all new projects, through its local partners. One NGO leader pointed to the importance of training facilitators drawn from the communities with which any given sanitation/hygiene project is intending to work. Another said that messages could be conveyed using drama, with trained 'animators'. At this stage it is not clear how context-driven the national and communal development strategies will be.

Lack of finance and access to credit

The replies given in both the rural villages and the urban focus group suggested that lack of financial resources and the unavailability of credit were barriers to acquiring water storage vessels or soap for handwashing, and to building household latrines. WaterAid reported that it is commissioning a study to look at the demand for and availability of micro-credit for sanitation services. This cost barrier may, however, be part of a broader issue: people living away from the town and having poor access to its markets, which replies to the questionnaire suggest is also a factor which prevents people buying materials for improved hygiene practices. Many of the rural poor in Africa are to be found in areas *'weakly integrated into markets'*: the location of poverty matters (Farrington and Gill 2002).

Complexities of behaviour change

Several interviewees commented that latrines have an 'image problem'. On that basis, a clear targeted message is needed to promote sanitation and hygiene effectively. Despite recognising the importance of promoting behaviour change, one interviewee said that it was *un travail de géant* ('a task befitting a hero'). That said, levels of awareness can be changed: FFBBM/HVM found that, in six out of seven rural villages studied, levels of awareness of, latrines rose to 73 per cent and above after its interventions over several years. Many actors were optimistic about the potential to work with children as a starting point for behaviour change messages. However, while hygiene is part of the school curriculum in Madagascar, it is not included as a separate discipline. Despite the enthusiasm of many individual teachers, other subjects took precedence, according to one interviewee. And while the Ministry of Education has produced materials to support classroom learning on hygiene, they have lacked resources to distribute them. It is also difficult to 'preach' improved hygiene habits to children without their being able to practise them. That means including latrines as an integral part of newly constructed classrooms. Apparently, this is not yet a requirement by law and one donor confirmed that schools are still being built without latrines. There is currently a lack of information on the number of schools that have sanitation facilities and a sample study is due to be commissioned by UNICEF.

The extent to which hygienic practices are adopted in rural villages lags behind the level of knowledge about such issues in all seven cases. This underlines the fact that awareness does not translate immediately into action, and that changing behaviour is a complex process.

Cleaning and maintenance

The local study produced some slightly confusing results on arrangements for cleaning and maintaining latrines. This suggests that people may have been evasive in their replies, although it is not clear why this would be the case. Several interviewees at national level commented that it has been common practice to make badly behaved schoolchildren clean the school lavatories Which may have contributed, at least in part, to creating a culture where the cleanliness of latrines is not a priority because the task is viewed as a punishment. The urban focus group suggested that most people in their *quartiers* prefer to defecate in bushes near their dwellings rather than endure the smell and blue flies in and around the non-hygienic latrines.

Cultural factors

Cultural factors which act as a brake on behaviour change are more pronounced among adults and in rural communities, according to interviewees. One donor representative referred to taboos over men and women using the same sanitation facilities, or simply resistance to change among community leaders. Other interviewees in the capital said that latrines were perceived as luxury items in basic rustic dwellings and that clean hands might be seen as a sign of laziness in rural communities used to working the land.

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4.3 Conclusions

Some positive steps towards improved sanitation and hygiene can be noted in Madagascar. The sanitation and hygiene policy has been drawn up and is likely to be approved soon. There is some stakeholder dialogue and coordination in Madagascar, led by the national WASH platform. Those actors which are active in the sector appear to be aware of appropriate methods and technology. However, there are substantial barriers still in evidence.

Sanitation and hygiene are given low budgetary priority, relative to other development areas. The education ministry is a secondary player in sector policy-making, with the result that sanitation and hygiene are inadequately represented in education policy and programmes. The problems of a 'utility mindset' and an emphasis on cure rather than prevention in the health sector still need to be addressed. There are major gaps in capacity at local level. The national WASH campaign has the potential to help create more coordinated and effective action on sanitation and hygiene at decentralised levels, but lack of capacity at the level of communes remains a substantial challenge.The slow take-up of improved sanitation and hygiene practices at the local level seems to be linked with communities' remoteness from town and markets (*enclavement*). This raises the issue of choice and sequencing of different types of development intervention.

At an end-of-project seminar in Antananarivo, the following steps were identified as being necessary for improved progress on sanitation and hygiene in Madagascar:

1. Parliament needs to give final approval to the National Policy and Strategy for Sanitation.
2. The draft action sheets attached to the National Policy need to be further developed into an action plan for implementing the policy.
3. Existing regulations, under the recently passed Water Law, should be used as a vehicle for enforcing the National Policy, as an interim measure, until new regulations have been passed.
4. An inter-ministerial committee should promote coordination between the three principal ministries responsible.
5. Coordination between donors should also be encouraged, through either a donor committee on sanitation and hygiene, or a sector review body which includes national agencies and donors.
6. Budget lines within the three principal ministries responsible should be created to increase coordination of public funds entering the sanitation and hygiene sector.
7. The WASH initiative should be progressively extended to all regions (and eventually *communes*).
8. Strong messages should be formulated to communicate different aspects of WASH, including a means of promoting latrines.
9. More effort should be made to attract donor funding for the sector.
10. Capacity at communal level must be strengthened, and additional support given to non-governmental providers operating in communes where public provision is absent.
11. Demands expressed in local development plans must be translated into real programmes which will progressively fill the gaps in sanitation and hygiene.
12. More links should be made between the education system and sanitation and hygiene. Teachers should be given support to teach these issues at school. Awareness-raising programmes are also needed.
13. All sector actors should contribute to collating and maintaining information on progress in the sector in a database at the office of the national WASH coordinator.
14. Other development programmes should be pursued to connect remote rural areas by road and telephone, and with electricity, to reduce isolation.

5 Democratic Republic of Congo case study

5.1 Context

The Democratic Republic of Congo (DRC) is a huge country – three times the size of Zambia and nearly ten times that of Uganda. It is just moving out of a period of conflict which has left more than 3 million people dead and has had a significant impact on many parts of the country.

A new constitution was signed in December 2005 and elections for a new president and national assembly took place in 2006. The country has now been divided into 25 provinces, with Kinshasa remaining the administrative and political capital. The size of the national territory is such that the provinces have been sub-divided into 'districts', which contain 'territories', subdivided into 'collectives' and then 'groupings', with 'localities' at the bottom of the ladder. The sheer number of sub-divisions surely poses a substantial challenge in itself, in terms of policy formulation and implementation.

The political prospects for DRC are brighter now than they have been for two generations. But the development challenges facing the country are very substantial.

However, the transition from conflict to reconciliation and reconstruction, and then on to the post-conflict stage, provides an especially challenging backdrop for the sanitation sector (and indeed all sectors). The term 'post-conflict' is not used to suggest that conflict is absent from all locations in DRC: it may be more accurate to refer to a context of continuing insecurity. Low levels of investment over a period of 30 years have created very large gaps in public services, even aside from the destruction of war. Where state capacity is absent or lacking, NGOs have to some extent been filling the gaps.

5.1.1 Human Development Indicators

BOX 3
Human Development Indicators for DRC

Source: UNDP Human Development Report 2006

Human Development Index ranking: 167 out of 177 countries
Life expectancy: 44 years
Adult literacy: 33 per cent
Infant mortality: 126 out of 1000 children die before the age of five

5.1.2 Access to water and sanitation

There are considerable disparities between figures cited for levels of sanitation coverage in DRC. According to WSP, access to sanitation was 8 per cent and 10 per cent in urban and rural areas respectively in 2004 (WSP, undated).[32] These are dramatically low figures even compared with coverage levels in other countries of sub-Saharan Africa. UNICEF, meanwhile, points to the substantially higher 2001 figures of 61 per cent access to 'hygienic latrines' in urban contexts, and 39 per cent in rural contexts, i.e. a national average of 46 per cent, according to the MISC 2.[33] The term 'access' as used by WSP is not specifically defined, but it clearly measures a different standard from the 'hygienic latrines' of the UNICEF-commissioned study. A key point is that coverage levels have been decreasing over recent decades. The task of improving sanitation and

32 Quoting a series of Congolese sources: CNAEA, PNA, REGIDESO and the PRSP.

33 Enquête Nationale sur la Situation des Enfants et Femmes, MISC (multi-indicator cluster survey) 2/2001.

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hygiene facilities in DRC is a huge one: to meet the DRC's national sanitation target under the MDGs, an estimated 30 million more people will need to be served by 2015.

5.1.3 Context for the local study

The local study was conducted in the territory of Beni, in the province of North Kivu. This is in the north-east of DRC, adjoining the frontier with Rwanda and Uganda. The province has an area of nearly 600,000 km^2 and a population estimated in 2003 at 4 million. It comprises five territories, including Beni, and three towns: Goma, Butembo and Beni Town. Approximately 70 per cent of the population in the province are small-scale farmers, both livestock and arable. In North Kivu, as in other parts of the Congo, inter-ethnic violence has occurred since 1993, especially between 1996 and 1998. The killings and disruption aggravated the already critical socio-economic plight of many people in North Kivu, increasing their vulnerability. Between September 2002 and June 2003, an estimated 120,000 people fled the inter-ethnic violence in Ituri.

The most significant illnesses present in Beni, apart from malnutrition, are malaria, intestinal worms, sexually transmissible diseases, and water-related diseases, including cholera (PPSPP). As part of the process of preparing participatory poverty assessments for the PRSP, North Kivu and Beni were asked to present a list of their priorities in order (DRC 2005). In Beni, among the 20 most important problems listed, difficulties of access to water and also to health treatments/medicines are seen as high-ranking (third and fourth priorities); but lack of sanitation is not listed as a priority. This is despite the 2005 report by Health Zone officials (Zone de Santé de Mutwanga 2005), which observed the 'crying lack of latrines' in one health area in the zone where, for a population of 8,200, there were only five latrines.

Women's focus group, Mbelu, DRC

Photo: PPSSP

5.2 Findings

As in the other countries, a desk study and interviews were carried out at national level, as well as interviews and focus groups at the local level to test if the potential barriers outlined in Section 2 exist in DRC. The methodology is set out in more detail in Annex A. Figure 3 below sets out the institutional framework for sanitation and hygiene in the country, which provides context for these findings.

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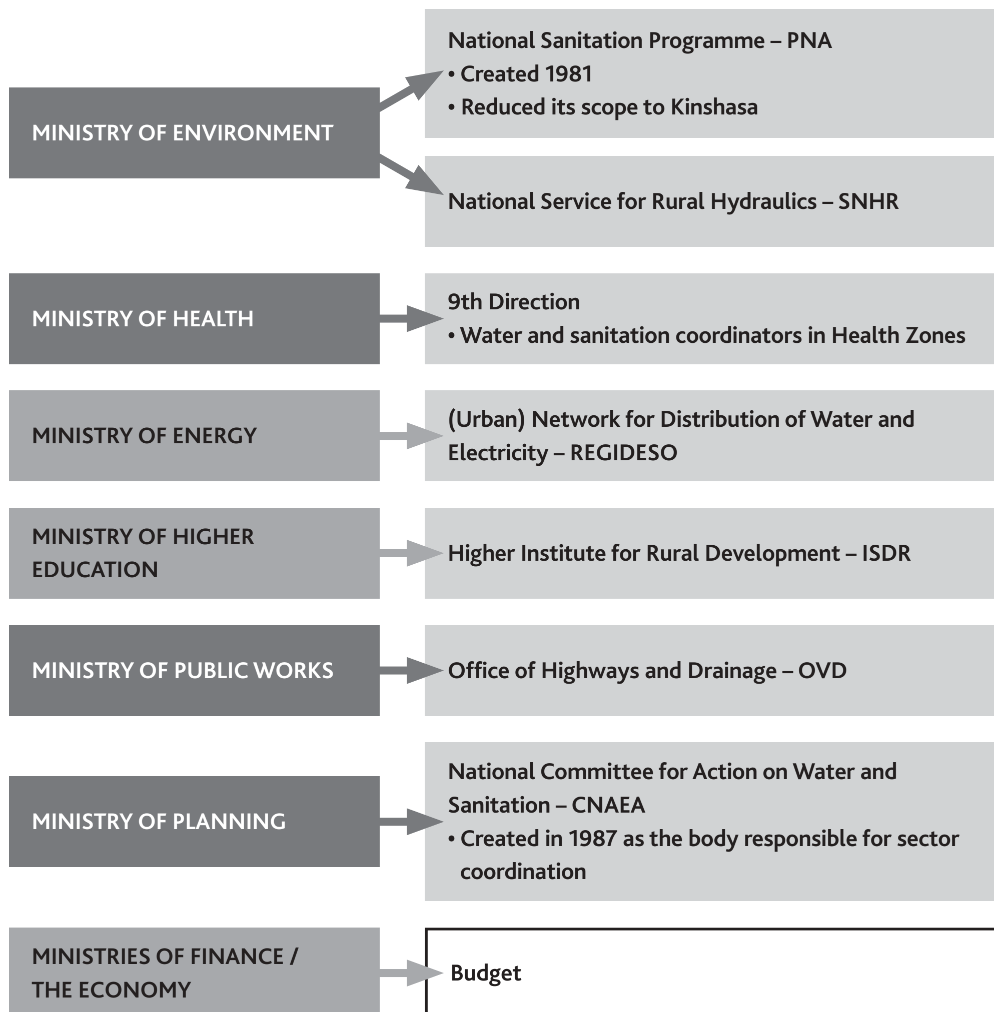
FIGURE 3
Key actors in the sanitation, hygiene and water sectors in DRC

Adapted from Tableau Institutionnel provided by UNICEF



5.2.1 Problem definition

There has been little problem definition or analysis of the sanitation and hygiene sector in the DRC. No national policy document exists which sets out a common understanding of what 'sanitation' means (or at least none was referred to in the interviews). The same policy void also applies, it seems, at provincial level – at least if the province of North Kivu is typical. The picture seems to be the same in the Territory of Beni in North Kivu: state officials (such as exist) are working *without* a frame of reference, either official policy guidance or programme plans setting out operational objectives.

Lack of sanitation and hygiene facilities are cited in early drafts of the Poverty Reduction Strategy Paper (PRSP) as causes for concern, but not as the most urgent priorities for action. However, in the final version of the PRSP, published in 2006 (but not available during the researchers' visit for this study), sanitation, hygiene and water are apparently identified among six key poverty reduction priorities. Meanwhile, the current legal framework for the sector in DRC is old and outdated and in-depth review and reform has not occurred for more than a generation.

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5.2.2 Agenda setting and policy formulation

Lack of information There is a lack of up-to-date information on sanitation and hygiene needs in DRC. The studies that are available point to great need in large sectors of the population. A more accurate picture of coverage would be helpful when the process of formulating policies begins.

Tensions between mindsets The people interviewed did not refer to tensions between different mindsets in relation to sanitation and hygiene in the case of DRC: there is no policy on sanitation and hygiene, and little open policy debate. However, in the country overall there are likely to be challenges as people move from a conflict/emergency scenario into a developmental one.

Coordination In terms of coordination, there seem to be significant problems with both horizontal coordination – between different departments – and vertical coordination – between different levels of national government hierarchy. Decisions and approvals relating to sanitation and hygiene matters are made at several different levels, and within the institutional structure it is often unclear who is accountable.

The division of tasks between the different ministries is also unclear: with no single, strong institution to lead on sanitation and hygiene. There are four ministries with related responsibilities: Environment (the full name of which is Environment, Nature Conservation, Water and Forests), Health, Public Works and Planning, plus other ministries which seem to have some involvement, e.g. the Ministry of Higher Education via the Higher Institute for Rural Development (*Institut Supérieur de Développement Rural* – ISDR).

The National Sanitation Programme (PNA) comes under the Ministry of Environment. Its mission, according to its founding Regulation of 1981,[34] is *'to render healthy the living environment of people'*. Its task list includes the *'supervision of drinking water quality, combat against vectors of disease (mosquitoes, other insects), control and disposal of solid waste, treatment and evacuation of excreta, household hygiene, prevention of pollution'*. A more recent government document (République Démocratique du Congo 2003)[35] confirmed these functions of the PNA, and also its *'specific tasks'* in relation to *'information, education and communication on environmental health issues'*. However, its activities have been limited to Kinshasa for more than a decade because of lack of funds and operating reach. It is effectively an administrative body rather than an implementing agency.

The 9th Direction at the Ministry of Health should have responsibility for water and sanitation coordinators in the local Health Zones. However, at the time of the research visit to Kinshasa, this unit had just been created and was not fully operational. The *Office des Voiries et Drainage* (OVD) is responsible for highways and drainage. It used to receive part of a tax on petrol, but that has been discontinued. The institutional focus of the National Service for Rural Hydraulics (SNHR) is in rural areas, but its capacity has also been very limited since donor programmes came to a halt during the conflict years. The Network for Distribution of Water and Electricity (REGIDESO) works in urban areas only and predominantly in Kinshasa itself.

The National Committee for Action on Water and Sanitation (CNAEA) was created with donor support (USAID) in 1981, to identify strategic options and priorities, carry out sector studies, mobilise resources and strengthen capacities in the sector. It is situated within the Ministry of Planning, and the Ministry of Environment is also represented on the board.[36] However, the impression from this study's interviews is that the CNAEA has largely failed to catalyse action and has, in practice, functioned mainly as an agency which commissions studies.[37] The CNAEA has focused largely on water, mapping water resources, and carried out some sanitation activities, such as training sanitation 'brigades' and providing support to households. This

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34 The PNA was originally called the National Sanitation Service in 1981.

35 Setting out the ToRs of a consultancy mission, but which also included a useful summary of the PNA and its role.

36 The other members of the board include 11 ministries (including Health, Rural Development, Energy, Finance, Budget), as well as a representative of the National Electricity Company and the President's office.

37 Through its three 'commissions', on Drinking Water, Sanitation and Research (hydrological and hydro-geological), each chaired by a different agency.

source of support, however, ceased in 1992 when the USAID programme in the country was closed due to the conflict. To date the CNAEA as 'coordinating' body has not resolved the issue of lack of clarity over the division of tasks. This lack of coordination between the ministries which have partial responsibilities for sanitation is debilitating.

Interviewees referred to several different laws which had been drafted and proposed over the years by different ministries, including the Ministry of Environment and the Ministry of Energy, but which had not progressed beyond draft stage. This duplication was caused, it seems, by ministries being unwilling to allow others to lead the process. Work is apparently now in progress at the CNAEA to review sector laws and prepare a new draft, but it is not clear at this point how this will buck the previous trend of new laws being blocked by rival interests. One person also noted that, during the period of political transition, each organisation, including NGOs, has tended to collect its own information and make its own assessments and judgements about its agenda for engagement, according to individual institutional priorities and criteria. The people of Mbelu, for example, talk of competition between NGOs. In a new era, more inter-NGO coordination will surely be needed.

Political priority

A lack of political will and leadership means that the situation described above is irresolvable, at least for the time being. No leader or champion of sanitation and hygiene is evident within government, at national, provincial or territorial level. The effects of misrule/poor governance and conflict have been to paralyse government, which has amounted to the collapse of the state.

Sanitation currently receives very little financial support from the state – even by the standards of the limited national budget in DRC – attracting about 1 per cent of allocations from public funds. Furthermore, according to a senior official at provincial level, there is no budget line for sanitation in the provincial budget. This means that sanitation does not feature within the official plan for state agencies' interventions in the province of North Kivu. It emerged from the interviews that the Health Zones of Beni and Mutwanga are paying less attention to providing sanitation services to households and communities than to disposing of medical waste and supporting Health Committees.

The latest version of the PRSP seems to indicate a positive first step towards water, sanitation and hygiene policy. Yet, several interviewees reported that government departments have generally not 'bought in' to the PRSP to any great extent. Their lack of interest is interpreted as being due to the political transition and raises the question of whether the PRSP will be taken seriously by the new government. Several people noted that some donors have been holding back on establishing and approving development programmes until the situation has stabilised after the elections; this transition period has led to even more uncertainty than usual within government.

Lack of demand

The evidence in DRC did not seem to suggest much local demand for sanitation. And, where there is intense competition for scarce resources, there is not likely to be much incentive for politicians to create that demand. One interviewee noted that people in DRC commonly talk of needing *public* latrines at markets, schools and health centres – more than individual household latrines. He considered that this is due to people's expectation that public latrines, like water supply, will be provided by the state, as part of its responsibilities, whereas household facilities are not.[38] But, he continued, even if people express relatively little demand for household latrines, this does not necessarily mean there is no need or indeed that there would be no demand, were the state to take active steps to offer services and incentives to households, or if education and awareness-raising activities to be carried out. The comments of the focus groups in Mbelu and Lubiriha (if typical) suggest that demand is mostly articulated by women, whose voice is less likely to be heard in the policy-making process.

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38 A response to this view is that the nature of the support that the state can usefully provide in relation to creating private latrines at household level is different.

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Donors' agendas

As public funds are scarce and sanitation/hygiene starts from a very small share of the national budget, external funds are important to support the sector. Only a few donors are currently, it seems, willing to fund sanitation and hygiene programmes in DRC, as compared with the nine donors who have committed funds to the water sector. UNICEF is working with three ministries to design and obtain approval for a water and sanitation programme. It is also intending to collaborate with the CNAEA to build capacity in the sector, including through policy work. This will mean pursuing with government the idea of a framework water law, which in UNICEF's view would also include a code for sanitation. WSP is carrying out a three-year pilot project on waste disposal in Kinshasa, in collaboration with PNA. In addition, the African Development Bank is planning to make a loan of US$ 50 million for water and sanitation supply in rural areas, but has not yet determined which activities will be funded.

Interviewees felt that donors are risk-averse: they choose to support projects which are less risky in terms of achieving results and to work in counties with less challenging circumstances. The government of DRC's own lack of focus on the issue also means that it is unlikely to be able to put forward a compelling case to donors. One of the key issues to be addressed now is how to move from donors funding a short-term, essentially reactive, humanitarian response to their backing medium-term development programmes. As the political transition progresses, it remains to be seen whether donors will switch the channel of their funds from UN agencies and NGOs to government – a shift which would signal the beginning of an effort towards capacity-building government institutions.

Some interviewees also mentioned donors' tendency to fund major health programmes (e.g. to bring medicines etc), which absorbs large number of competent staff within the country. This causes a 'brain drain' towards the big international agencies and towards the sectors which they chose to work in (and, by assumption, away from the sanitation and hygiene sector).

5.2.3 Policy implementation

Lack of human and technical capacity

Despite the number of government ministries involved in sanitation and hygiene, the sector still seems to be hugely under-resourced, with a severe lack of human and technical capacity at all levels. A PNA inventory of functioning equipment for dealing with waste (République Démocratique du Congo 2003) revealed that the Programme had two lorries for emptying septic tanks and one lorry for collecting rubbish for the whole of Kinshasa and its 6 million-plus people. The laboratory for checking drinking water quality ceased to operate in 1991. The head office of the PNA (which was visited for this study) is itself in a very dilapidated state, suggesting sustained low investment over 15 years. As noted above, the work of other departments is also being heavily constrained by a lack of resources.

Trained personnel in the sanitation sector are very limited. Interviewees considered capacity to be somewhat greater for health. The School of Public Health at the University of Kinshasa trains students in a wide range of subjects: water supply (including quality), disposal of domestic wastewater, drainage, latrines and disposal of solid waste (household, industrial and biomedical), as well as anti-disease vectors. However, the director of the School of Public Health highlighted the fact that most young students aren't aware of the 'public health' profession, and that levels of remuneration and working conditions are often unattractive when compared with other opportunities for graduates.

The lack of available staff is compounded where recruits are allocated between the various ministries currently responsible for sanitation and hygiene and given functions which make inefficient use of their skills. One example is a case several years ago where the functions of one ministry (Environment) were transferred to another, but the staff with the relevant expertise stayed at the Ministry of Environment. The local study also revealed that, in the Health Zone of Beni, one officer is nominally responsible for 441 villages in 28 health 'areas'. Meanwhile, the Health Zone of Mutwanga – which encompasses an estimated population of 189,000 in an area of 500 square kilometres – has one (intermittently) functioning motorcycle.

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Lack of service providers

As well as lack of capacity within state bodies, there is also an overall lack of service providers from other sectors. Good examples of innovation can be found. In the absence of state services, small private sector operators – men with large, low barrow-like carts on wheels – collect household rubbish for a fee from those who can pay. The PNA engineer interviewed said that they would like to collaborate with these barrowmen, whose association is known as the ASSECECO. PPSSP also cites the example of the Fédération des Entrepreneurs du Congo (FEC), a 'trade union of business owners' which used its own funds to build public latrines by the market in Oicha, Beni territory, where some of its members work. However, the local association of 'stone operators' (bricklayers) did not contribute to similar projects at Mbelu. The activities of PPSSP are an example of an NGO which has provided innovation and initiative in the field of sanitation and hygiene in the past; there are other NGOs carrying out similar work. However, the overall coverage figures are still extremely low. It must be assumed that the NGO and private sectors have insufficient capacity to scale up to meet the MDG target in that region.

Low capacity to absorb funds

Donors' reticence about funding sanitation and hygiene programmes in DRC may reflect its limited capacity to absorb funds. Given the constraints above, it is difficult to see how increases in finance could be spent quickly and effectively. However, without some additional funding, it is impossible to see how the sector can break out of this vicious cycle.

Appropriate methods and technology

It emerged from one of the focus group discussions that interventions by state agencies responsible for sanitation and hygiene have sometimes amounted to harassment and distortion, rather than support. One example is agencies imposing heavy fines for alleged infringements of waste regulations. These methods seem ill-suited to the context. The focus group also thought that the fines were pocketed by individuals instead of going into public funds.

Lack of finance and access to credit

The 2006 Human Development Report (UNDP 2006) refers to a poverty barrier to improving sanitation: *'even low-cost improved technology may be beyond the financial reach'* of poor populations (page 119). While interviewees in DRC did not specifically comment on a lack of finance and credit being a barrier to their access to sanitation, poverty levels are such that they are likely to have an impact in many areas. In one of the communities included in the local study, most of the villagers did not operate in a cash economy – instead, trading goods with one another.

Lack of strong messages

A study by the School of Public Health of the University of Kinshasa (Ecole de Santé Publique 2002) provides some insights into an apparent lack of strong public education messages on sanitation in the DRC. Based on the provinces of Kangu in the west and Katanga in the south-east, the study noted the lack of educational materials and concluded that there was a need for better communication about the need for behaviour change. For example, only a few posters were found explaining anti-cholera measures.

Cleaning arrangements and maintenance

The local focus groups suggested that a lack of arrangements for cleaning and maintenance would be a barrier if public latrines were built. The women of Lubiriha did not support the local sanitation and hygiene improvement project when faced with the prospect of cleaning community latrines without being paid.

Cultural factors

Interviewees in the capital suggested some cultural factors which may also explain the apparent lack of interest in and attention to sanitation and hygiene issues. One person suggested that the concept of cleanliness in DRC is closely associated with outward appearances, with Congolese citizens paying much attention to their clothes, even in poorer districts. Cleanliness in the home is not generally considered as important and, for example, the toilet of a friend's house, even in a middle-class neighbourhood, may be less clean than one would expect. The emphasis people put on the need for privacy when using latrines differs from place to place. Some ethnic groups feel that privacy is very important: latrines have to be constructed so that the person using it cannot be seen from the outside. In other areas, people apparently take a more relaxed view, which will affect the kinds of technology most likely to be effective.

Another cultural factor which may be important is the fact that poor people reportedly lack confidence to hold their representatives to account. According to many, the prevalent notion is that ministers are

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untouchable, rather like feudal leaders in Congo's history. Several interviewees commented that there is a culture of impunity and a lack of accountability, and PPSSP similarly referred to colonisation's legacy of a culture of 'imposition', rather than education. One interviewee said that civil society needed to make a considerable effort to increase its participation in advocacy and back claims up with facts. The support of international NGO networks will also be important, he said, to add external leverage to a national lobbying effort.

5.3 Conclusions

DRC is currently facing the great majority of barriers to developing and implementing sanitation and hygiene policies as identified by international commentators. There is a policy and planning void which runs from national to local level. Some of the explanations for this are to be found within the sanitation sector itself; others relate to DRC's current political economy This research has identified wider factors acting as barriers to policy development and implementation, such as lack of political leadership, abuses of power, and an overall lack of capacity, which are by no means confined to the sanitation sector. This has been compounded by the conflict, which paralysed government and caused a virtual 'collapse' of the state. The consequence was that efforts, where possible, were principally devoted to emergency relief and humanitarian response; development programming was shelved. Public funding for any state services in DRC is limited, and has been for several decades.

Meanwhile, the observations of field staff from NGOs working in different parts of the country suggest there is a great need to improve sanitation and hygiene conditions for large parts of the population. This is corroborated by such studies as are available. The interviews for this study revealed some positive signs that progress is possible:

- The leadership shown by certain individuals and organisations, in the difficult conditions of recent years
- Many actors in the sector expressing a desire for change, including state officials
- Support in principle from some donors to reform the sector (both water supply and sanitation); this would apparently include a donor coordinating group being set up
- Existing funding commitments from three donors for sanitation and hygiene programmes.[39]

Elections in late 2006 have resulted in a new government, which should be supported with external funds to pursue development programmes – including programmes on sanitation and hygiene promotion. This study concludes that this will mean starting from the first stage of the process of policy development. The task of setting out clear roles and distinguishing between the functions of government agencies and other actors, as well as establishing mechanisms for coordination and information-sharing between them, will be an essential basis for re-energising the sector in the future.

These factors will need to translate into, and combine with, other drivers for reform if the legal and institutional stalemate is to be broken.

39 At the time of visiting Kinshasa in February 2006. This compared with nine donors committed to supporting water supply projects.

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6 Removing the barriers

It is evident then that the blockages and barriers identified in Chapter 2 are indeed present, to a greater or lesser extent, in each of the three sub-Saharan African countries studied. Whilst each country is clearly different, some blockages seemed to come through particularly strongly in all three cases:

- Sanitation and hygiene are not prioritised by donors, national governments or local people
- There is huge under-investment in sanitation at all levels
- There is a need for much better coordination between all key players
- There is a massive lack of human and technical capacity amongst state and non-state actors
- Changing behaviour is a complex process, and cultural factors will have to be carefully considered.

Of course, we cannot say for certain that these will be the most important barriers in other countries, but the literature review does suggest that these constraints are likely to be prevalent elsewhere, at least in other African countries. Overcoming the blockages will not be an easy task, but will be essential if the Millennium Development Goal target on sanitation is not to become just a pipe dream. We believe that this will require a change of mindset around sanitation and hygiene; political commitment at the highest levels; a new global framework for action; national strategies and coordination mechanisms; and inclusive and culturally appropriate techniques, championed at the local level.

In terms of mindset, 'water and sanitation' is a phrase that slips off the tongue, and WASH is a concept that most development practitioners are familiar with. However, this study raises questions as to the conventional wisdom of allying sanitation and hygiene so closely to water. Whilst this combination is clearly effective for preventative health, this concept seems harder to translate institutionally, and in policy terms. In each country studied, the ministry with responsibility for water also had partial responsibility for sanitation, but was having difficulty coordinating with other relevant ministries and attracting resources from the finance ministry. Hygiene is more likely to be considered one of the (many) responsibilities of the ministry for health. In the absence of effective coordination mechanisms, this can result in narrow definitions of sanitation being adopted, in little money being allocated via the budgetary process and in a lack of appropriate human resources being available within state bodies at the local and national level.

Whilst the links with water are clearly important, sanitation is such a fundamental building block for development that it needs to be linked more closely with other sectors too. Mantras such as 'health and sanitation'; 'education and sanitation', and 'urban planning and sanitation' now need to be taken up as well. 'Mainstreaming' is an over-used word in development circles, but sanitation does need to be 'adopted' by other sectors, and to be factored in to all development planning. This could be an important first step in reversing the lack of political and financial priority accorded to the issues identified by this study.

The priorities and policies of donors, multilateral bodies and other institutions clearly do have some impact on the policy landscape within developing countries. As noted in the DRC, when there are few skilled workers within a country, they are likely to be drawn to the sectors receiving most international support, where they are more likely to receive adequate payment for their work. And there is a greater incentive for a national government to draw up plans and strategies for a sector if there is likely to be funding to actually help put them into action. One of the most common ways for the international community to indicate that it is committed to serious action on an issue is for a common target and framework for action to be debated and agreed upon. The agreed target for sanitation has been present since 2002, as part of MDG 7. There have also been a number of global frameworks or action plans agreed for both water and sanitation to date.[40] However, as the UN Millennium Project Water Taskforce (2005) rightly points out, these do not set how

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40 These include the Framework for Action outlined in the WSSCC's document, 'Vision 21: A Shared Vision for Hygiene, Sanitation, and Water Supply and A Framework for Action' (2000); the Bonn Plan of Action (2001), the 'Framework for Action on Water and Sanitation' prepared by the WEHAB Working Group for the World Summit on Sustainable Development (2002) and the G8's Evian Action Plan (2003).

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they will actually be implemented, do not provide clarity about who is responsible, and do not set adequate indicators for measuring success. They have, in summary, fallen short of the mark.

We believe that a new Global Framework for Action on Water and Sanitation is required. This should take on board the mindset outlined above and should identify water and sanitation as two equal but different components and recognize that the dynamics of delivering progress on both will be different. The Framework for Action should be fully linked to and integrated with delivery frameworks for other relevant sectors (such as health and education). It is important that the right political body is found to take the framework for action forward. The G8, although essentially an undemocratic body, is probably best placed to take the initial lead This is because action is needed quickly, and because the G8 nations tend to have a disproportionate influence in international institutions and on other nations, and they will be key if the plan is to be fully funded. However, this new Plan of Action is likely to fail, like those before it, unless it is taken beyond the G8 and is actively supported and shaped by all nations.

Increased international profile for sanitation and hygiene will only be important if it results in change at the national and local level There were many similarities between the recommendations for national and local action made by stakeholders in each of the countries studied. The need for a comprehensive strategy for sanitation, and an action plan for making this happen was identified in each case. Better coordination between difference ministries and between central and local government was also called for in each country – with the ultimate goal of ensuring that this brings more financial and human capacity at the local level. The Global Framework for Action needs to call on all countries to develop a national strategy and coordinating mechanisms for sanitation and hygiene, and needs to offer support to countries as they try to implement these. National political leaders also need to speak about this much-neglected issue – helping to break down the taboos surrounding it.

The role of the international community and national governments has been explored, and will be important for ensuring that the right priorities are set and the right conditions for progress are created. However, as has been seen, encouraging people to change their behaviour is a complex process, and it is change at the community level which will be the most important driver for improved sanitation. Several actors interviewed stressed the need for increased education and community mobilisation. The role of teachers, community health workers, non-governmental organisations, local entrepreneurs and religious leaders from within the community have all been mentioned as crucial in terms of empowering and motivating communities to make the change for themselves. Whilst a top-down approach may be needed to drive sanitation up the political agenda, a bottom-up approach is advocated in terms of sanitation programming and practice. The right policy framework and regulatory regime should help to support and coordinate these existing efforts as well as encouraging new and more ambitious interventions by local actors, as current coverage figures seem to suggest a step-change is required.

Increased profile and priority at the international and national level should lead to additional financial resources being available for the sector. These resources must be used to address the key barriers that participants in this research identified. They should be channelled into education, awareness raising campaigns and community mobilisation programmes – creating the demand, rather than building services that no one will use. They should also be channelled into building human and technical capacity – good higher education and vocational training will be important. Support is needed for overstretched health workers, teachers and local government workers, who are currently trying to achieve the impossible on the ground. And, given that in many cases state structures will not have the capacity to absorb sufficient resources to meet the MDG target single-handedly, some support should also be available to the private sector, trade bodies, local NGOs and other non-state actors, who can help to create demand at the local level, as well as holding officials to account for delivering their responsibilities.

The parallels between sanitation and HIV have been made by several authors (Evans 2005; UNDP 2006). Both affect women disproportionately, both are unlikely to be fully understood by local communities without specific education, and both are subject to many taboos. Once the international community and national governments realised the enormity of the HIV pandemic however, they were spurred into action,

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despite these constraints. As has been shown, a lack of sanitation also has a huge impact of health and should be addressed with the same sense of urgency. In summary,

DONORS SHOULD:

- **Increase the high-level political attention given to these issues** by agreeing a new Global Action Plan on Water and Sanitation. This plan must recognise the different dynamics of delivering sanitation and hygiene compared with water. It must set out a comprehensive strategy for ensuring progress internationally.
- **Mainstream sanitation and hygiene into other sectors** – so that health, education, urban, rural and other relevant strategies contain specific sanitation components and indicators. No donor-funded schools or health facilities should be built without adequate sanitation.
- **Ensure that all national plans for sanitation are fully funded**. This will be vital if human and technical capacity are to be increased. Resources should be specifically targeted at addressing the key barriers identified in this report and should not, therefore, be spent simply on subsidised latrine-building as a stand-alone activity.
- **Promote innovative and community-led approaches which are culturally sensitive**. This study has revealed different cultural and social barriers in each context, which demonstrates that a one-size-fits-all approach is unlikely to be effective. Local ownership will be key.

NATIONAL GOVERNMENTS SHOULD:

- **Give high-level political attention to the issues of sanitation and hygiene** – breaking the taboos which surround them.
- **Put a national plan and coordination mechanisms in place**. This means bringing all relevant departments together to devise and implement a sanitation and hygiene strategy.
- **Ensure that the sanitation and hygiene strategy is prioritised within the national budget**. This is likely to require specific sums set aside for sanitation within the budgets of several government departments, as well as within local government budgets.
- **Ensure all new schools and health facilities are built with adequate sanitation facilities**.
- **Improve data collection** to help monitor progress – or lack of it – in the sector.
- **Promote innovative and community-led approaches which are culturally sensitive**.
- **Invest in appropriate training and capacity-building for key players** within central government departments, local governments and also non-state actors.

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ANNEX Methodology

Burkina Faso

Tearfund and the ODI worked with Accedes ('Christian Alliance for Economic Cooperation and Social Development') to carry out research in Burkina Faso. Accedes was founded in 1995 with the vision of supporting economic cooperation and social development in Burkina Faso. Based in Bobo-Dioulasso, Accedes operates in 14 different provinces and focuses on food security, education, micro-finance, environmental protection and health. Accedes' interest in sanitation is linked to its health interventions: these include providing water and promoting hygiene in 30 villages in three regions over the last two years, with Tearfund's support.

The research was based on a desk study of relevant policy and materials in-country and on semi-structured interviews with representatives of government, NGOs and donors – both sanitation and hygiene specialists as well as actors from other sectors. This was complemented by a local study which included semi-structured interviews with representatives of local government and NGOs, and focus group discussions in the five villages mentioned above.

In each village, gender-separated focus group discussions of ten men and ten women were held to explore issues around hygiene practices and identify drivers and barriers for latrine construction. Also, key players such as teachers, health workers, priests and administrative representatives were consulted to triangulate the results of group discussions. Representatives of each of the five villages met with representatives from local government, a central government ministry, Accedes and other national NGOs to discuss the findings of the research in October 2006. The aim was to bring together the information gathered and to identify and agree the findings of the study, as well as to formulate recommendations for action.

Madagascar

In Madagascar, the research was carried out jointly between the ODI, which took the lead at national level, and the Association of Bible Baptist Churches of Madagascar (FFBBM), Tearfund's local partner, which implemented the local-level research. FFBBM's operational activities are carried out in five communes: Ambalarirajy, Antsoha, Ambaripairy, Ambohisoa and Kalandy. HVM, Hôpital Vaovao Mahafaly (the 'Good News Hospital'), is a medical initiative begun by FFBBM in partnership with African Evangelical Fellowship in 1995, with the encouragement and support of the Malagasy Regional Department of Health. The HVM hospital serves Mandritsara and surrounding districts, providing medical, surgical and ophthalmic services, and a wide-ranging community-based village health programme.

It also runs a primary school in Mandritsara. The doctors in the Community Health Department of HVM have recorded the number of consultations they make in rural villages and noted the benefits: from 2002, when the doctors' consultations began, to 2005, Maetsamena village saw a reduction in incidences of diarrhoea and malaria from 235 to 25, and 185 to 131 respectively.

The research is based on a desk study of relevant policy and materials in-country and on semi-structured interviews at national level with representatives of government, NGOs and donors – sanitation and hygiene specialists, as well as other development practitioners. This was complemented by a questionnaire distributed to 138 households in seven rural villages in Mandritsara district (details of the villages studied are included in Table 5). The questionnaire asked villagers about their knowledge of water-related diseases; water storage and use; their knowledge of human excreta management and the use and maintenance of latrines; and their knowledge of links between hand-washing, soap usage and disease. There was also a focus group in an urban context and some further interviews with actors at subnational level in Sofia. Further input came from a discussion between FFBBM, ODI and invited sector actors at a seminar held in Antananarivo in October 2006; its aim was to identify and agree the findings of the Madagascar country study.

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Democratic Republic of Congo

In DRC the research was carried out jointly between the ODI, which took the lead at national level, and the Programme de Promotion des Soins de Santé Primaires en Zones de Santé Rurales (PPSSP), Tearfund's local partner, which implemented the local-level research.

PPSSP's mission is to contribute to improving people's quality of life by promoting good public health practices and minimising the impact of trauma caused by war, conflict, sexual violence and HIV. PPSSP is working in the Health Zones of Beni and Mutwanga (two of the four zones in the territory). Its presence fills gaps in public health capacity so, in the absence of state personnel, it acts as the replacement health provider. PPSSP's operational activities include close working relationships with local health facilities, and PPSSP personnel sit on local government health committees.

As with the other case studies, the ODI carried out a desk study of relevant policy and materials in-country and conducted semi-structured interviews with representatives of government, NGOs and donors – both sanitation and hygiene specialists, as well as other development practitioners. PPSSP also carried out interviews in the regional capital of Goma, and with local government officials in Beni to see what state policies and programmes (if any) were present to guide and oversee state provision of sanitation and hygiene services. PPSSP also conducted focus groups in two urban localities (Mbelu and Rubiriha).

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