Semana temática: Agua para la vida. Tribuna del agua.

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Título de la ponencia: *Promoting Sanitation and Hygiene to Rural Households: lessons from the Southern Nations region of Ethiopia*

Resumen:
Despite low levels of sanitation services and poor hygiene in Africa, it has proved difficult to place Sanitation and Hygiene (S&H) appropriately on policy agendas.

Initially brought to international attention by the Water and Sanitation Programme-WSP, the post-2003 S&H policy of the government of the Southern Nations region (SNNPR) in Ethiopia has now been studied by a DFID-funded research and learning project, the 'RiPPLE' Programme, to look at how success was achieved - and how far.

Latrine construction and use, hand-washing and water storage/handling by households were surveyed, by quantitative and qualitative methods, in six localities in two districts. The project also studied the policy-making and institutional process.

In both districts, the results show a substantial increase in the number of household latrines, achieved in a few years. Some questions do arise as to the technical sustainability of this wave of latrine construction and observations suggest continued poor hand washing and water storage/handling practices.

A combination of political promotion and institutional mobilisation was successful in launching and 'rolling-out' the S&H policy as a 'movement'. S&H was made part of a basic community health package, designed to be politically attractive, and financially and administratively feasible. 'Ignition' documents were written with a strong communication orientation to motivate local politicians and civil servants, alongside more conventional (technical) documentation.

This experience offers, potentially, lessons for other countries in how political and institutional hindrances to promoting S&H strategies may be overcome and hygiene behaviour placed more 'centre-stage'.

Palabras clave: Political leadership; 'Ignition' documents; Mobilising institutions; Leveraging donor support; Sustainability?

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1. INTRODUCTION

1.1 Scope and Purpose of case study

This is a synthesis of the case study on Sanitation and Hygiene in the Southern Nations region ('SNNPR') of Ethiopia commissioned by the RiPPLE Programme - *Research-inspired Policy and Practice Learning in Ethiopia and the Nile Region (http://www.rippleethiopia.org/)* - carried out in 2007. SNNPR borders Kenya to the south, Sudan to the west, and the Ethiopian regions of *Gambela* and *Oromia* to the north and north and east respectively.

In 2003 the SNNPR Bureau of Health (BoH) begun a new community health approach including Sanitation and Hygiene (referred to below as 'S&H'). The BoH approach focused on a small number of "broad-based, low-cost and high-impact oriented" public health interventions in order to improve the status of basic health status across the region. The approach was aimed at reaching households via health extension workers and community health promoters. One important element of this approach was promotion of basic latrine construction and improvement of hygiene practices.

The new BoH strategy put emphasis on raising awareness of communities on S&H and encouraging households (HHs) to take responsibility for action. Once households were convinced of the importance of S&H facilities, they were encouraged to construct them from locally available materials. Hardware subsidies were abandoned. Households were expected to start from simple traditional pit latrines and upgrade their standard as awareness grew and economic development improved.

Initially brought to international attention as a success story by a Field Note of the Water and Sanitation Programme (WSP, 2007), this S&H initiative of the SNNPR government has now been studied by 'RiPPLE', to look at how success was achieved - and how far.

RiPPLE is a research and learning project funded by the Department for International Development of the UK Government (DFID). The purpose and core objectives of RiPPLE are set out in the **Annex**.

This case study was initiated in collaboration with the Bureau of Health (BoH) of SNNPR, and carried out by researchers from Hawassa, Addis Ababa and Jimma Universities and the RiPPLE Office, with the support of researchers of the IRC International Water and Sanitation Centre and the Overseas Development Institute-ODI.

The purpose of this case study has been to draw preliminary lessons from the approach to S&H adopted by the BoH from 2003 onwards - the equivalent of 1996 in the Ethiopian calendar (E.C[2]).

This case study has been one of several sponsored by RiPPLE on aspects of water supply and of S&H, as a contribution to the SNNPR Learning & Practice Alliance (LPA) established in May 2007 (with RiPPLE support).

This S&H case study has comprised three component parts investigating: (i) the technical; (ii) the policy and institutional factors working for (or against) the success of the post-2003 S&H strategy in SNNPR, as well as conducting preliminary research into (iii) the knowledge, attitude and practice (KAP) of households relating to construction and utilisation of household sanitation facilities and to household hygiene. For the technical study, the principal researcher was Worku Tefera, for the policy/institutional study Bethel Terefe with Katharina Welle, and for the KAP study, Tizita Mulugeta. Alemayehu Haddis was in-country research coordinator.

The technical and KAP studies used a sample of households in selected localities (*kebeles* - the lowest administrative unit) within two districts (*woredas*) in SNNPR. The woredas - selected by RiPPLE in consultation with the Regional Government - the BoH and the Bureau of Water Resources (BoWR) - were: *Alaba* Special

interviewed. Many thanks also to the persons from communities in Mirab Abaya and Alaba *woredas* who agreed to take part in the field survey and the health extension workers and community health promoters who provided valuable information.

[2] I.e. where EC dates are used, add 7 years to arrive at the timing according to the international calendar.

woreda and *Mirab Abaya* woreda. The three *kebeles* selected from each *woreda* were: in Alaba: *Hologeba Kukie*, *Galeto*, *Amata*; in Mirab Abaya: *Omo Lante*, *Mole* and *Wojifo*.

The second part of the case study (the 'policy study') examined policy and institutional factors working for (or against) the success of the post-2003 S&H strategy in SNNPR, focussing on policy-makers and actors at regional, woreda and kebele levels. The objective was to understand how political momentum for S&H was created, policy messages communicated and policy objectives institutionalised, with outreach to rural communities.

1.2 Definitions

Interpretations of 'sanitation' and 'hygiene' vary. As shown in **Box 1.**, the range of activities potentially included is wide, especially since different contexts (e.g. urban/rural) involve different means of delivering them. To complicate matters, the term 'sanitation' (on its own) and 'water supply and sanitation' ('WSS') are commonly used to include activities in the right and left-hand columns. The result is that a typical view of the S&H 'sector' extends from investment in large and costly items of infrastructure, such as sewerage and waste water treatment plants, via simple 'on-site' latrines for individual households, to provision of 'soft' items, e.g. promotion of hygiene or support to women's groups seeking to change defecation practices.

Box 1.: Broad elements encompassing sanitation, hygiene, and waste water management[3]

Sanitation	Hygiene	Waste water management
• ***Safe collection, storage, treatment and disposal 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).	• ***Safe water storage (by households)*** • ***Safe hand washing practices*** • Safe treatment of food stuffs.	• Drainage and disposal/ re-use/recycling of household wastewater (also referred to as 'grey water') • Drainage of stormwater • Treatment and disposal/ re-use/recycling of sewage effluents.
Source: Evans (2005) - emphasis added		

The focus of this study has been the challenges of improving provision of S&H to households in <u>rural</u> areas, and particularly the following three aspects which are highlighted in Box 2. : (i) **household facilities for human excreta disposal**, e.g. latrines; (ii) **hand-washing** at critical times, for example, after use of a latrine by a household member; and (iii) **facilities for safe storage of drinking water**.

1.3 Methodology

The information for the *technical and KAP components* was collected using a combination of quantitative and qualitative methods: (i) a structured and pre-tested *questionnaire* for households, selected according to systematic random sampling; (ii) a semi-structured, open-ended schedule of questions for *focus group discussions* (FGD) with health extension workers (HEWs), community health promoters (CHPs), and community members, as well as *key infomant* (KI) *interviews* e.g. woreda council officers and local community leaders; and (iii) a check list for *observation* of S&H behaviour and facilities (e.g. use of latrines and hand-washing). The observation of S&H behaviour of household members was important as a complement to the other data: accumulated experience (e.g. Jenkins and Scott, 2007) has shown that respondents' own declarations on use of sanitation facilities and changes in hygiene behaviour to questionnaires do not represent reliable information - without corroboration.

'Technical' factors are, for example, soil type, groundwater level, presence of termites, availability and cost of suitable building materials and technical expertise, e.g. technology choices, availability of masons.

[3] In Box 1. the usual order of presentation of 'WASH' has been adjusted. The key feature of the WASH approach is that it promotes the three components in combination: according to WASH, they go together in policies and practice.

The sample size was a total of 392 HHs for the KAP study and 396 HHs for the technical study from the two woreda[4], with one in five HHs, i.e. 76 HHs, subject to observation. Additionally, 9 FGDs and 5 KI interviews were conducted on technical and KAP aspects. The data collection was carried out from July to October 2007.
For the policy study, key actors involved in the initiation, formulation, communication and implementation of the post-2003 S&H policy were consulted, including officials of the BoH and of wider regional government. Semi-structured interviews were conducted with health, education and water bureau representatives at region and w*oreda* levels, and finance and economic office, w*oreda* cabinet head and rural development office at w*oreda* levels. HEWs were interviewed at k*ebele* level. The policy study further carried out focus group discussions with BoH staff, HEWs and CHPs at kebele level, and in-depth semi-structured interviews with health, education, water bureau, and finance officials at regional and zonal/woreda levels, as well as officers at woreda level.

2. CONTEXT

2.1. Regional - SNNPR

Before 2003, SNNPR had one of the lowest S&H coverage levels in the country, recorded (according to official figures) at 16% (BoH Health Ignition doc. No.8, 2006). The extent of the regional budget allocated to health was also amongst the lowest with only 0.4% of the health budget attributed to S&H activities (Shiferaw Teklemariam, 2003). The scope of education on S&H was at that time limited, due to lack of appropriate strategies for community education & mobilisation (Shiferaw Teklemariam, 2003). The main means of communicating messages on S&H was when community members came to health institutions to obtain health services. S&H education was mainly done by volunteer community health agents trained for 3 months, each volunteer expected to reach some 5,000 people in a *kebele*. **The approach to S&H was supply-driven, with health authorities raising the expectations of households that incentives to improve S&H practices would be provided by government.** The BoH records that, as a consequence, household demand for S&H services had been low.

2.2. District - Alaba and Mirab Abaya[5].

Alaba Special woreda has a total land area of 974 square kilometres. The centre of Alaba, Alaba Kulito, is located 90 kms south-west of Hawassa. The altitude range is from 1,554 to 2,149 metres above sea level. The climatic zone of the woreda consists of mainly mid-land (*weinadega*) (86% of woreda) and low-land (*kola*) (14%). The mean annual temperature ranges from 17 to 20°C. The main soil type in Alaba is mostly silt and ash (white, volcanic) characterized by high water infiltration capacity and fragility. Such unstable soils may cause latrine pits to collapse.

Administratively, the woreda is organized into 78 kebeles, 2 urban and 76 rural. Projected population size of the woreda, as of July 2005, according to official figures, was 251,385, with an estimated population growth of 3% per annum. The proportion of male to female was about 49% to 51% respectively. The dominant ethnic group is *Alaba* followed by *Silte*. The dominant religion is Islam (93.8%).

Alaba faces water scarcity problems. Annual rainfall varies from 857 to 1,085 millimetres. The main sources of safe water are deep bore holes, with water tables in 150-300 m range; and rainwater harvesting. Ground waters have usually high levels of fluoride, up to 26mg/litre. Man-made ponds are also used as alternative water sources.
The water supply coverage (source: woreda Water Resources Office) was 41% in 2007. Woreda information indicated that the sanitation coverage in Alaba rose from 10% (2003) to 48% (2004), a drastic increase claimed by the S&H campaign in SNNPR.

Mirab Abaya woreda is located in Gamogofa Zone. The centre of the woreda is Mirab Abaya 230 kms from Awassa. Lake Abaya is situated near Mirab Abaya town - the name of the woreda means 'West of Lake Abaya'. The woreda land area is c.1,613 sq. kms, with a total population in 2006 of 69,036, average population density is 43 inhabitants per sq. km. Male to female ratio was 1:1.027. The majority (91.8%) of the population live in rural areas. The woreda is composed of three climatic zones: lowland (62%), mid-land (27%) and highland areas (11%). Soil types are predominantly sandy (55%), silt (30%), and clay (10-15%). Farming in Mirab Abaya is composed of crop, livestock and mixed systems. Main crops are maize, sorghum, wheat, barley, cotton and banana. Livestock includes cattle, sheep, goat, poultry, horses, mules and donkeys. Bee-keeping is another economic activity.

[4] The technical and KAP data were collected by ten graduating students from the Department of Environmental Health of Hawassa University, supervised by two staff members of the same Department, as well as the principal researchers.
[5] The principal source of this information is the Alaba woreda Agricultural and Rural Development Office, Jan 2008, as cited in the paper of Worku Tefera.

Administratively, the woreda is divided into 24 kebeles, one urban and 23 rural. The dominant ethnic group is *Gamo* (85%) followed by *Wolayita* (9%). The main religions are Protestant (52%), orthodox Christian (41%), Muslim (5%) and Catholic religions (2%).

Coverage in water supply was 27% in 2006 (source: woreda Water Development Office). The main water source is ground water found at a depth range of 6 to 108 metres. Of the 57 water schemes, about 40 were functional[6] (2006, source woreda Water Development Office). According to the Woreda Health Office, the latrine coverage in Mirab Abaya reached about 52% in 2005. The woreda is among one of the food insecure areas in the region.

2.3. Local - the six selected kebeles

Tables 1. and **2.** outline information on the three kebeles selected for study in the two woreda.

Table 1. Alaba: the three kebeles with data on estimated population, distance to Alaba Town etc.

Name of Kebele	Estimated Population	Estimated Distance from Alaba Town	Availability of			
			HEWs (Y/N)	S&H programmes (P/FS/Na)	Water source (Y/N)	
Hologeba Kukie	3,443	5km	Y	NK	N	
Galeto	1,638	3km	N	NK	N	
Amata	2,241	8km	Y	NK	Y	

Table 2. Mirab Abaya: the three kebeles, with data on estimated population, distances etc.

Name of Kebele	Estimated Population	Estimated Distance from Mirab Abaya	Climatic Zone	Availability of		
				Latrines/ Coverage	Safe Water source, coverage (Y/N)	
Omo Lante	3640	25 km	Mid-land	NK	Y, NK	
Mole	4260	5 km	Mid-land	NK	Y, 34%	
Wojifo	3900	18 km	Mid-land	87%	Y, 36%	

2.4. National - Ethiopia

The goal of achieving universal access to water supply and S&H in Ethiopia is a key government objective, for both the water and health sectors. The Universal Access Plan expresses this goal for water. The '*National Millennium Hygiene & Sanitation Movement*'-MHSM is the vehicle which the federal Ministry of Health has been developing (to be launched in June 2008) for achievement of the goal in relation to S&H. The declared aim of the MHSM of the federal Ministry of Health (MoH) is: '*Sanitising (cleaning up) all Homes, Kebeles and Towns for the new millennium*" (Ethiopian calendar). The MoH's approach has key elements which the Minister of State employed in SNNPR (in his former position as Head of the BoH), as studied by this RiPPLE case study on S&H.
The MoH's Health Service Extension Package comprises a total of 17 elements, of which 7 relate to 'Hygiene and Environmental Sanitation'.

3. FINDINGS - from the technical and KAP studies

Latrine construction and use, hand-washing and water storage/handling by households were surveyed by the researchers, in the sample households in the two districts in the six localities. Characteristics of the respondents to the questionnaire are outlined in **Box 2**.

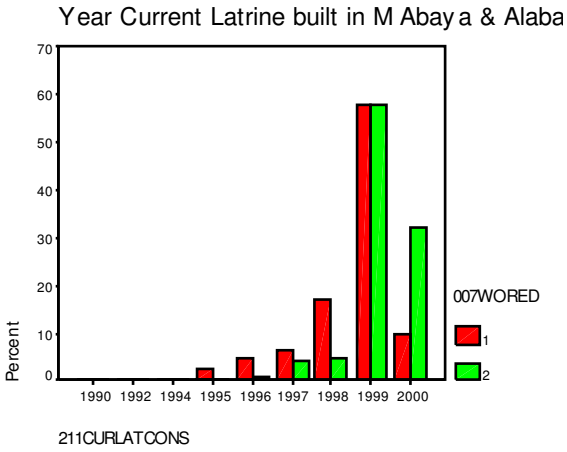
Box 2. **Description of the Respondents to the Questionnaire**

- Gender: 43.6% male, 56.4% female;
- Age range: 15 to 99 years;
- Family size: average is similar in the two woreda: 7.04 and 6.49 respectively;

[6] A further case study commissioned by RiPPLE on the 'sustainability' of water points has investigated levels of functionality in both Mirab Abaya and Alaba: see the RiPPLE website: www.rippleethiopia.org/pdfs/infosheets/GaP.pdf

- Religion: in Alaba, 97.8% of respondents said they are Muslim; in Mirab Abaya, 96.5% are Christians of different denominations;
- Ethnicity: in Alaba, 97% are *Alaba*; considerable ethnic diversity in Mirab Abaya (e.g. *Gamo*, *Wolayta* are the most predominant ethnic groups).

The results of the research show a substantial increase in the number of household latrines, in a few years, from 16% to 94% coverage in *Mirab Abaya* and 10% to 69% in *Alaba*. Despite a certain percentage of latrine owners who dropped back off the 'sanitation ladder' (10% in Alaba, which seems significant; 2% in Mirab Abaya),there is, overall, evidence of high impact of the BoH approach in the study areas. The use of locally-available materials in the construction of latrines meant the BoH approach was indeed low cost.



NB: As regards the base figure, the large jump in S&H coverage is, in part, accounted for by the previously low level.

Some questions do arise as to the sustainability of this wave of latrine construction (e.g. need for technical improvements) and the field observation suggests that hand washing and water storage/handling practices are still poor.

The following are the main achievements of the S&H approach adopted by the SNNPR BoH:-

- **Main technical findings**

- latrine coverage: in Mirab Abaya coverage increased by some 78% from ≈16 (2003) to 94% (2007); in Alaba by some 59% from ≈10 (2002) to 69% (2007);
- latrine construction: radical change observed in recent years: 80-90% in last 2 years (mid 2005- mid 2007) in both woredas; more than 50% of ever-built latrines were constructed in the past 2-3 years (in both woredas);
- latrine use: while HHs claim 100% latrine use, observation by proxy points to 93% of latrines utilised;
- use of local materials: all latrines made of local materials; about 16% have concrete slab or 'sanplat'; probably many or most will have been provided by NGOs as free slabs;
- hand washing facilities (HWF) and practice: good (declared) knowledge on hand washing (according to questionniare); but actual practice seems poor; hand washing facilities (HWFs) present in 82% of HHs; however, most (64%) located inside the house; only 6% near the latrine.

- **Knowledge, attitude and practice-KAP**

- Significant rise in awareness and knowledge on S&H which led to *some* changes in attitude and behaviour;
- through the work of health extension workers (HEWs) and community health promoters (CHPs): positive dialogue at community & household level; the result was effective mobilization (a broad-based result);
- empowerment of HHs by HEWs and CHPs: resulted in ownership of S&H process by the community: HHs construct their own latrine and hand-washing facility; both men and women participated in the process. However: decision-making on design and construction mostly by men; women hardly involved in siting and design, although they were involved in providing materials and plastering.

Factors supporting the above technical and KAP achievements were:-

- involvement of HEWs and CHPs in grass-root community approach in S&H;
- woreda health staff and HEWs have performance contracts;
- kebele councillors and cells involved; policy enforcing on HH latrine construction;
- political accountability to woreda;
- promotion of locally available materials which means latrines became affordable to the poor;
- acceptance of any type of pit or latrine means any latrine is counted as 'covered';
- cultural change towards less acceptance of open defecation (i.e. some collective behavioural change);
- increased demand for privacy among women.

Challenges which remain are as follows:-

- lack of technical support from higher level (at woreda level) to HEWs and to CHPs (e.g. on knowledge on most suitable design, best places for latrine siting) due to lack of resources; substantial drop-out of voluntary CHPs;
- lack of follow-up and refresher courses for CHPs (S&H part of total package) due to lack of resources;
- limited monitoring on S&H at kebele and woreda levels: lack of monitoring system and guidelines;
- lack of consistency in mobilisation of follow-up issues by kebele and woreda officials;
- poor cleaning practice of latrine (it is not a routine);
- lack of durable construction materials due to lack of money and little innovation; lack of good latrine designs which lead to problems during flooding, problems in loose soils and high groundwater tables (Mirab Abaya);
- poor latrine design, use of poor materials cause HHs to drop off sanitation ladder (about 10% in Alaba);
- many latrines have no doors, poor walls: features of traditional mode of construction due to lack of innovation;
- foul smell and fly breeding from poor design and operation;
- problem of termites (in Alaba) from poor design and choice of construction materials;
- latrines are not women- & child-friendly (limited privacy, big hole, poor floor): not involved in latrine design;
- provision of free slabs by NGOs creates expectations, increases waiting time to actual construction and promotes dependency on aid; potential solution would be to promote HHs to use and buy slabs, and community entrepreneurs to produce slabs;
- poor behavioural practice in relation to hand-washing with water and soap or equivalent;
- poor hand washing facility design and use of dirty water, while HWF is not near latrine - results in dirty hands;
- lack of public latrines at gathering places forces people to open defecation.

4. FINDINGS - from the policy study

In 2003, an internal assessment made by the SNNPR BoH noted the low priority attributed to S&H in the regional government's plans and budget, despite the attention to S&H in national health policy which had previously been issued in 1993. The limited effectiveness of S&H education was also a concern. A review by the BoH in the same year (2003) highlighted that much of the disease burden in SNNPR was linked, directly or indirectly, to poor S&H practices (Shiferaw T/Mariam, 2003). Also five of the principal causes of morbidity were associated with poor community awareness about basic health (interview with BoH, 2007).

Suggestions were made to develop a comprehensive community basic health education strategy, reaching people at village level. To overcome funding problems on S&H, the proposal was also made to combine S&H education with other public health education programmes. Accordingly, **the region's new strategy of S&H post-2003 was developed as one component of a package for improvement of basic health**, i.e. at the outset of preparation of the policy, S&H was subsumed in a wider movement for improvement of basic health services in the region.

As noted above, the new BoH philosophy put emphasis on raising awareness of communities on S&H, encouraging HHs to take responsibility for action. Following the 2003 assessment, a comprehensive document was developed on basic community health *education*. This became the first amongst a series of health 'ignition' documents that followed (interview with BoH, 2007). These 'ignition' (also 'revitalization') documents were produced to engage government and non-governmental actors, including communities, on discussions on basic health. These documents addressed a range of issues from basic health education and awareness, to citizens' right to basic health and (related) accountability to citizens of health service institutions, i.e. issues with political significance and resonance. They also raised institutional issues related to financing and management of the sector, ongoing civil service reform, performance in implementation of five year strategies etc. From the outset, promotion of S&H occupied an important place. **The ignition and revitalisation documents were intended to raise awareness, build consensus and also mobilise support to basic health improvement initiatives.**

In a development external to the BoH, a USAID funded project, called 'Essential Services for Health in Ethiopia' (ESHE), had, since 2001, been piloting in SNNPR a programme promoting community basic health awareness using volunteers selected from the community. One community health promoter (CHP) is selected for about 50-60 households. The CHPs receive training for a time ranging between two days up to a week and refresher trainings once a year. Criteria for CHP selection included a requirement that 50% or more be women. The volunteers were trained to communicate simple do-able actions on five basic health themes, namely sanitation (basic pit latrine construction, hand washing and safe water storage), immunization, family planning, malaria prevention and HIV/AIDS. The programme was piloted in four *woredas* in SNNPR including *Alaba and Mirab Abaya*. After a year, the pilot project was evaluated and found to be a success.

Following the evaluation of ESHE, the BoH - looking for a new strategy to promote community basic health education and preparing its first health 'revitalization' document - decided to scale up the CHP approach, region-

wide. In the second half of 2003, ESHE also agreed to scale-up the approach from 4 to a total of 20 operational *woredas* in the region (interview with ESHE, 2007). In this way, the CHP approach, introduced by ESHE, was adopted by the BoH and applied across the SNNPR region, in parallel with the community mobilisation campaigns.

Other developments in the health sector also contributed to the institutionalisation process, for example, the mode of S&H education changed: active and direct house-to-house S&H education was promoted to reach people outside health service institutions. The means of behavioural change communication also changed so as to be more interactive, dialogue-based, through community conversations, coffee ceremonies and other social gatherings. The communication/S&H education was to be done by CHPs who were part of the community and who could easily be listened to and accepted by members of the community (interview with BoH, 2007).

The ignition documents outlined a system of 'cascading advocacy' designed to mobilise staff of several sectors (not only health, but also water, education, agriculture), and existing local government structures, to communicate messages on basic health, based on the revitalization and ignition documents. This system for working through the different levels of government (regional, woreda and kebele) was presented to the Regional Cabinet by the Head of BoH at that time, Dr Schiferaw, and was approved

The factors which made the BoH proposals acceptable to the Regional Cabinet were:-

- the S&H approach was packaged, in the health ignition/revitalization documents, in such a way as to make it politically attractive (or at least not politically offensive) to the other Bureau heads and other high-level politicians at regional level, in order to win their backing - and endorsement of the BoH approach;

- the S&H policy, as outlined by the BoH, did not conflict with the existing policies at a federal level, e.g. the Ethiopia National Health Policy of 1993[7];

- the messages accompanying the policy, relating to a right to basic health, participation in health service decision-making, accountability of health service institutions to citizens, added to attractiveness of the package;

- the ignition documents read as communication rather than technical documents, aimed at inspiring, persuading and mobilising, written (in Amharic) in layman's rather than technocratic language;

- a striking feature of the S&H policy is that its key elements were formulated in brief and general terms, to such an extent that it seems the new approach of the BoH was nowhere described in detail in accordance with the conventional manner of documenting a policy strategy; this allowed flexibility: the BoH approach continually evolved, incorporating within it new initiatives from regional and national levels as they were piloted and were seen to be successful (e.g. adoption of the ESHE pilot using CHPs, and of the 'PHAST' approach Participatory Hygiene and Sanitation Transformation, supported by UNICEF, to strengthen hygiene education);

- the strategies outlined in the BoH approach were manageable within existing financial resources and available technology. By removing any hardware subsidy, the approach required little cost, save for consultation workshops and training of CHPs for two days. Implementation mainly relied on household's own resources: in technical terms, the policy of promoting construction of basic-pit latrines using local materials did not pose, it was argued, insurmountable technological problems - the traditional pit latrine-TPL was a technology which could be made available in rural communities;

- the BoH approach was also administratively feasible in that it would rely, essentially, on existing government structures - the additional reinforcing element being the CHPs.

Once cabinet approval had been obtained, the health revitalization documents were first shared internally in BoH, then discussed at *zone*, *woreda* and *kebele* levels, with the health sector leading. Other sector staff and NGOs participated in the discussions. At *woreda* level, the *woreda* councils took responsibility with the health office to communicate the messages contained in the revitalization documents down to *kebele* level. *Woreda* councils also coordinated other sectors to play a role in the communication process. At *kebele* level, the *kebele* council was lead.

[7] The 1993 policy had identified environmental health as one priority area. The S&H strategies proposed in 2003 by the SNNPR BoH, e.g. of use of informal community structures for S&H education, were in line with the national health policy strategies, so far as they applied to promotion of S&H. Thus, the BoH could argue that its new S&H approach found a strong base in the existing body of policy - it was implementable at regional level.

Another development on S&H has been the incorporation of the Participatory Hygiene and Sanitation Transformation ('PHAST') approach into the regional S&H strategy. The development emanated from reviews made on the strategy implementation, in 2005 by UNICEF and BoH, which showed that although there was a strong political commitment to improved education and the BoH-promoted campaign of advocacy was stimulating latrine construction, the messages transferred about hygiene practice were incorrect and vague. UNICEF supported the scaling up of the PHAST approach in the region by training health office staff and 'front-line' implementers including Sanitarians, HEW and teachers (Interview with UNICEF, 2007).
Contextual factors combined to support the launch and implementation of the S&H policy, which the Head of the BoH and his team of senior BoH colleagues applied to their advantage, for example, the timing of the development and communication of the first ignition documents in late 2003/ 2004 coincided with rallies for the 2005 national election. The way the S&H approach was presented to the regional cabinet was in line with the political need of the ruling party to solicit public support for igniting a movement relating to improved delivery of basic health services. Further, recognition of the success of the piloting of the CHP approach introduced by ESHE, and especially the S&H component, provided the tool required for achieving 'outreach' of the BoH approach[8].

After launch of the S& policy, several factors helped to keep S&H issues on the political agenda of the regional government: the initiation in 2004 of the 'Health Extension Program'-HEP reinforced the focus on environmental health, with 7 out of its 16 extension packages dedicated to that; the implementation of WASH programs in selected *kebeles*, supported by the World Bank and the African Development Bank (ADB) and the formation of steering committees from various sector offices for WASH implementation, backed by the civil society WaSH movement. The HEP was significant in that it served to *institutionalise* the movement for improvement of basic health, including S&H, which had recently been launched. The deployment of trained HEWs in each *kebele* meanwhile served to raise the quality of message communication on S&H education including construction of latrines. The recurrent outbreak of acute watery diarrheoa-AWD has been another focusing event, provoking employment of more sanitarians.

As to the roles of specific actors, the **Head of the BoH**, Dr. Schiferaw, combined technical knowledge of preventative health, based on his background as a health professional, with strong communication skills. He was supported by senior officials in the BoH Department of Disease Prevention and Control who helped develop the S&H strategy and contributed to preparation of the health revitalization and ignition documents. The Head of the BoH was a member of the regional cabinet - the regional cabinet comprises Heads of Bureaus and the approval of the S&H strategy provided the political lever to 'institutionalise' the policy, to put the issue on the agendas of the bureaus for the relevant sectors (including the BoH) to implement.

The BoH policy was striking, in a country with a high aid dependency, for being regionally-inspired, rather than driven by **donors**. Implementation of the S&H strategy was, however, supported by donors, e.g. the flow of ideas and finance from international sources, such as the CHP approach (an experience taken by USAID from Madagascar) and, later, PHAST, as well as international NGOs which have financially supported the implementation of the approach, training CHPs. Despite the BoH approach being 'low-cost', from a *hardware* perspective, implementation required support to the '*software*' elements, (e.g. CHPs) essential to 'roll-out' of the BoH approach and the donors t provided critical funding for these implementation aspects.

The **HEWs and CHPs** were significant to the success of the strategy. The CHPs significantly raised the number of community level communicators from the previous 1 community health agent for 2,000 households in a *kebele* to 12-28 CHPs for a *kebele* , or one CHP per c. 50 households. It made reaching a wider number of HHs possible. The CHPs are also members of the community and have easy access to HHs and can be easily heard. The HEWs were the main 'frontline' health workers, instrumental in institutionalising the community mobilisation. They are also important in bringing some technical input (e.g. on latrine construction) and in improving S&H education and message communication.

HEWs and CHPs have commented to the researchers on the inconsistent nature of incentives. Initially, public recognition of HEWs with best performance, coverage reports, occurred, serving as a good motivating factor. However, that recognition system has not been consistent which has been discouraging to some HEWs (HEW at Galeto, *Alaba*). Similarly, CHPs complain of lack of consistency in recognising their contribution to S&H implementation. In the initial period of 2003 and 2004, public recognition was given to their efforts and they were awarded certificates in public festivals and gatherings prepared by BoH. However, this has apparently ceased.

[8] The ESHE pilot had started in 2001 and it may be that it had influenced the BoH in its writing of the assessment paper and the internal review, since some of the forward actions suggested in the assessment report reflected the CHP strategy (the CHP model still had to be promoted politically).

Quotas were assigned to different health line offices of the number of latrines that needed to be built or the coverage levels to be reached annually. Assignment of quotas combined with performance agreements helped to create accountability and responsibility of different actors to raise coverage. However, the quotas were sometimes very ambitious and the focus on quotas (by their nature, directed at coverage) diverted attention from utilization of latrines and behavioural change issues (interview with Rural Women's Development desk in Alaba).

5. CONCLUSIONS of the case study

5.1 Lessons from the SNNPR experience

The purpose of this case study was to investigate whether the household-focused approach to S&H promotion in the SNNPR region of Ethiopia, led to improved S&H coverage in SNNPR, based on a supportive political and institutional environment.

This study has yielded the following insights into how the SNNPR S&H policy was promoted:-

- the initiative was regionally-inspired, not donor-driven;
- S&H was made part of a basic community health package (Health Service Extension Programme), within the responsibility of the health authorities;
- the key elements of the S&H component, as described by the BoH, were: "*broad based*", "*household-centered*", "*low cost*" (that is hardware subsidy-free, promoting use of local materials) - for "*high impact*";
- the key to success was in developing a strategy expressed in general terms, aligned with the existing body of policy, and presented in such as way as to make it politically attractive to the regional cabinet (resonating with the values and goals of the ruling party), as well as financially and administratively feasible;
- the S&H strategy was approved by the regional cabinet, as part of a 'movement' to bring improved services to rural communities, promoted at election time;
- being approved by the regional cabinet made it a multi-sectoral 'movement' with a centre-point in the BoH, with other regional bureaux supporting it to some extent (or at least not opposing it);
- 'ignition' documents were written to motivate local politicians as well as civil servants - successfully;
- alongside those communication-oriented documents, more conventional technical ones were written;
- the political campaign was accompanied by measures to institutionalise the policy;
- implementation tools piloted by donors in the region (e.g. Health Education Program) were opportunistically applied by the BoH, and donor funds leveraged (for software aspects);
- two cadres were developed and intensively involved: health extension workers (financed by regional government and donors) and community health promoters (volunteers);
- the results of the research show a substantial increase in the number of household latrines, in a few years, from 16% to 94% coverage in *Mirab Abaya* and 10% to 69% in *Alaba*. Despite a certain percentage of latrine owners who dropped back off the 'sanitation ladder' (10% in Alaba, which seems significant; 2% in Mirab Abaya), there is, overall, evidence of high impact of the BoH approach in the study areas;
- the use of locally-available materials in latrine construction meant the BoH approach was indeed low cost;
- local environmental conditions, such as loose soils, high groundwater tables, floods, termites attacking construction timber, and lack of timber, threaten to make the lifetime of latrines short;
- some questions do arise as to the sustainability of this wave of latrine construction (e.g. need for technical innovative improvements, yet low cost) and the field observation suggests that hand washing and water storage/handling practices are still poor;
- this echoes a weakness in the way messages were communicated, whereby the focus given to coverage – responding to the ambitious quotas for latrine construction - diverted attention from latrine utilisation and behaviour change in personal hygiene, those being socio-cultural issues harder to change than hardware;
- further, reduction over time of rewards and recognition to CHPs is resulting in them dropping out as volunteers.

Overall, the above activities - a combination of political promotion and institutional mobilisation - achieved a large measure of success in launching and 'rolling-out' the S&H policy which (as noted above) resulted in a substantial rise in latrine construction. Five years later the BoH maintains this policy and its ingredients are being applied and adapted at federal level for further application.

5.2. Issues for further research

The BoH, RiPPLE, NGOs active in SNNPR and other stakeholders in the region recently formed the 'Technical Research Group' (TRG) - part of a regional 'Learning and Practice Alliance' (LPA) in SNNPR. Both the TRG and LPA met in the first quarter of 2008 and have requested that RiPPLE facilitate further collaborative research on S&H. The proposed research priority areas were around information management, technical and behavioural

aspects. Within RiPPLE itself, the future research focus, including on S&H, will be defined by the RiPPLE 'Research Advisory Group'.

The following is an outline of possible S&H areas for future research highlighted by the SNNPR LPA:-

- 'information management': in relation to S&H (and water): how to strengthen the information collection system so as to be more supportive of the 'front-line' health workers (HEWs and CHPs), including incentivising the CHPs to carry out community-based monitoring with households, with sensitivity to equity issues, while providing reliable information for aggregation and use at woreda, regional and federal level;
- 'technical innovation and behaviour change': the importance in SNNPR of these related topics was confirmed by both the TRG and LPA. Research could usefully field-test selected technical innovations in S&H and measure the cost-effectiveness in mitigating experienced problems. It could also study which approaches and methodologies implemented by HEWs and CHPs have the greater cost-effectiveness on S&H behavioural change of different categories of household members. A further consideration relates to finance: how funds and other resources invested in rural S&H can trigger improvements which are significant, are affordable, and cost-effective ,validated by reliable reporting.

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Annex

'RiPPLE' Programme: Purpose and objectives

'RiPPLE', *Research-inspired Policy and Practice Learning in Ethiopia and the Nile Region,* is 5-year program of action research working with partner institutions at all levels. It comprises a consortium of institutions, funded by the UK Department for International Development- DFID, focusing on water supply and sanitation in Ethiopia and the Nile region.

The RiPPLE Program's key purpose is to advance evidence-based learning, on water supply and sanitation (WSS) financing, delivery and sustainability, which leads to measurable improvements to the equity of water and sanitation access for the poor in Ethiopia and the wider Nile region.

RiPPLE core objectives are:

- to create research structures and processes that enable effective collaboration across all RiPPLE partner institutions and key stakeholders;
- to establish a set of research program activities that lead to strengthened sector financing approaches and the delivery of WSS services that maximize opportunities for pro-poor growth; and
- to build long-term approaches to training and capacity building that help reinforce development of research capacity in Ethiopia/Nile region.