EQUITY REPORT ON SANITATION AND HYGIENE 2012

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Abbreviations and Acronyms

AMREF	African Medical Research Foundation
CLTS	Community-led Total Sanitation
CORPs	Community Owned Resource Persons
CSO	Civil Society Organization
DWST	District Water Supply and Sanitation Team
ESDP	Education Sector Development Programme
FBO	Faith-Based Organization
GLOWS	Global Water for Sustainability
GSF	Global Sanitation Fund
GIZ	German Development Cooperation
HIV/AIDS	Human Immuno-deficiency Virus/ Acquired Immune Deficiency Syndrome
INGO	International Non-Governmental Organization
JMP	Joint Monitoring Programme
LGA	Local Government Authority
LGCGD	Local Government Capacity Development Grant
LGSP	Local Government Support Programme
MDAs	Ministries, Departments and Agencies (of the Government)
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania (See NSGRP)
MoEVT	Ministry of Education and Vocational Training
MoHSW	Ministry of Health and Social Welfare
MoU	Memorandum of Understanding
MoW	Ministry of Water
NEHHSAS	National Environmental Health, Hygiene and Sanitation Strategy
NGO	Non-Governmental Organization
NSGRP	The National Strategy for Growth and Reduction of Poverty (see MKUKUTA)
PHAST	Participatory Hygiene and Sanitation Transformation
PMO-RALG	Prime Minister's Office – Regional Administration and Local Government
S&H	Sanitation and Hygiene
SNV	Dutch Development Agency
SWAp	Sector Wide Approach
SWASH	School Water, Sanitation and Hygiene
TAWASANET	Tanzania Water and Sanitation Network
TSSM	Total Sanitation & Sanitation Marketing

UMATA	Usafi wa Mazingira Tanzania (Sanitation and Hygiene Programme in Tanzania)
UNICEF	United Nations Children's Fund
UWSSA	Urban Water Supply and Sanitation Authority
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WSDP	Water Sector Development Programme
WSP	Water and Sanitation Program
WSSCC	Water Supply and Sanitation Collaborative Council

1.0 Introduction

1.1 Background:

This document presents a synopsis of the equity monitoring report on the access to sanitation and hygiene services among marginalised groups in Tanzania[1]. UNICEF, commissioned the Tanzania Water and Sanitation Network (TAWASANET) to conduct a desk study, whose results are to be used to inform the Joint Health Sector Review on the performance of sanitation and hygiene (S&H) development in Tanzania.

1.2 Global perspectives of Sanitation.

Globally, over 2.6 billion people or 39% of the world's population do not have access to improved sanitation facilities. In sub-Saharan Africa alone, there are an estimated 565 million people without access to improved sanitation and, among these, 224 million practice open defecation. Open defecation is one of the riskiest sanitation practices of all as it has great potential for increasing the spread of infectious diseases like cholera.[2] In absence of basic sanitation facility like improved toilet, people are victims to various diseases also leading to untimely deaths to many.

Furthermore, lack of access to sanitation and hygiene facilities adversely impacts on health, the environment and on access to education. Lack of access to sanitation and hygiene is the third most significant risk factor for poor health in developing countries with high mortality rates. Diarrhea alone is responsible for the deaths of 1.8 million people every year, 90% of whom are children under five. However, it is recognized that improved hygiene through hand washing and safe food handling reduces it by 35% and safe disposal of children's faeces leads to a reduction of nearly 40%.[3]

Various approaches have been used by the global community to help improve sanitation particularly in developing countries. For instance the Participatory Hygiene and Sanitation Transformation (PHAST), the SARAR etc were widely employed to promote sanitation and hygiene. Despite all these efforts, still 39% of the world's population does not have access to improved sanitation. At times the subsidy on hardware at household level was introduced to help accelerate the acquisition of sanitation facilities but it could not achieve the goal.

[1] Marginalized groups in this context include - women, children, people living with HIV/AIDS and people with disability.
[2] WHO and UNICEF Reports, 2008;
[3] WSSCC – Investing in sustainable Sanitation and Hygiene, 2010

1.3 Sanitation and Hygiene situation in Tanzania

The Household Budget Survey from 2007 showed that access to improved and basic sanitation facilities has not improved in 5 years. Even though access is close to universal, the vast majority of traditional pit latrines are unimproved and unhygienic according to WHO/UNICEF Joint Monitoring Program standards.

Despite that demographic and health survey (2005) indicates the overall sanitation coverage in Tanzania to be as higher as 87% (98% in urban and 83% in rural areas), only 21% and 32% rural and urban population respectively have access to improved latrines meeting the standards for improved sanitation (impervious floor, adequate privacy, and adequate safety for the users including children, not overflowing or full and situated at least 50m away from nearby water sources) and hygiene behaviour is not well understood in Tanzania.

Household surveys have not included indicators relating to hygiene, but a smaller survey conducted by UNICEF in 2009[4] found that hand washing is not common after attending to a child who has defecated or before handling food. Fewer than 40% of respondents reported washing hands after using the toilet.

Further, the ministry of Health and Social Welfare in 2011 survey revealed that in Tanzania the overall access to improved sanitation stands at 25% where 27% is for urban and 23% for rural areas (MoHSW 2011). This concludes the existence of the gap between urban and rural. This situation is more critical due to the fact that access to improved sanitation and hygiene are critical to health, economic and social development.

In Tanzania, a significant amount of waterborne and other communicable diseases could be prevented through better access to adequate sanitation facilities and better hygiene practices. Furthermore, the available information and statistics on Sanitation and Hygiene in Tanzania, especially on coverage are flawed. For example, MKUKUTA II documented that only 24 percent of households use improved sanitation facilities in Tanzania (the Joint Monitoring Programme, 2010), and data from Demographic Health Survey (TDHS, 2010) estimated that only 13% of households in the country use improved toilet facilities that are not shared with other households. However, all the available data on improved sanitation is silent on the marginalized social groups if they are benefiting from the service or not. To alleviate this challenge, Tanzania has adopted the Millennium Development Goals (MDGs) on sanitation target of halving the number of people without improved sanitation by 2015. Additionally, under the Vision 2025, Tanzania has pledged to provide improved sanitation to 95% of the population

[4] UNICEF (2009), Government of Tanzania/UNICEF Interventions in 7 learning districts

by 2025. However, a number of studies raise concern that the realization of MDGs will be most unlikely.

This is true because the baseline statistics proposed for the MKUKUTA II indicate that only 23% and 27% of the households have access to improved sanitation in rural and urban areas respectively. As indicated, the figures of access to S&H facilities are higher in urban areas, low in rural areas and lowest in nomadic communities with sanitation access at 12%[5].

However, all the above statistics have been computed on a generalised background which has not taken into account groups of community which have special needs. For instance, people with disabilities cannot access S&H facilities even if they are available and improved. Unfortunately, little attention has been paid to the needs of such people with disability, despite the fact that the right to equal access for all international development initiatives is guaranteed in the new United Nations Convention on the Rights of Persons with Disabilities. The consequences of this neglect impinge on the peoples' health, dignity and aggravate economic and social exclusion, and especially increase the burden on women in community.

Therefore, the inadequacy of access to improved sanitation facilities contributes significantly to increased prevalence of sanitation related diseases such as diarrhoea, typhoid, dysentery and cholera. Use of improved sanitation on the other hand could save thousands of lives every year, and it can reduce diarrhoeal diseases one of the leading causes of child mortality in Tanzania, by about 36 per cent.[6]

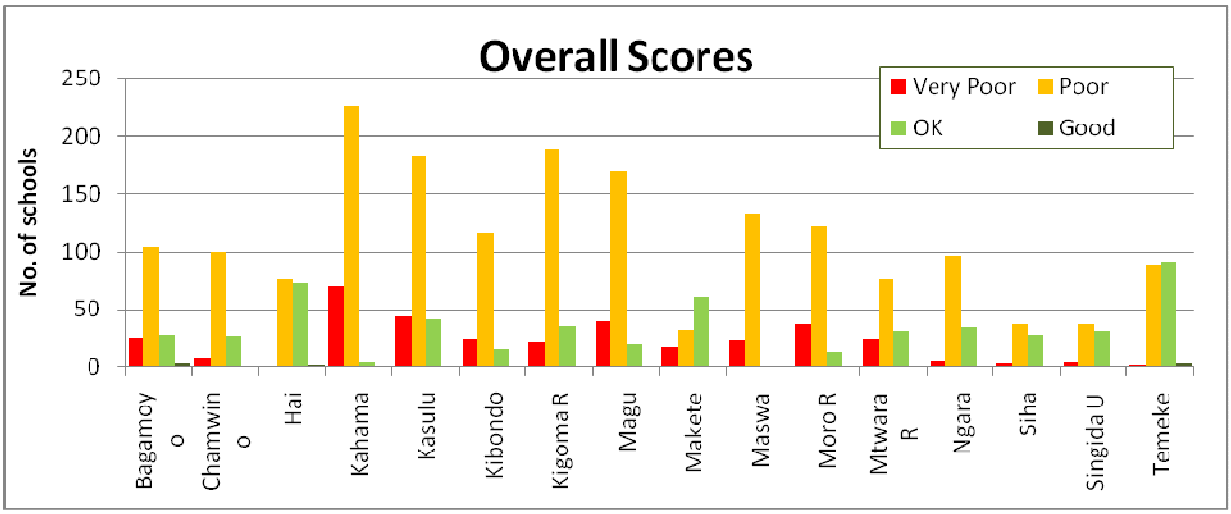
1.4 School Sanitation and Hygiene in Tanzania

School sanitation and hygiene contribute to children's learning and school experiences in many ways; It improves cognitive function and attention; reduces days missed from school; provides more time on the learning task; and increases dignity and safety. Because of inadequate school Sanitation and Hygiene many children are therefore currently not meeting their learning potential; children as a group can be affected by lack of basic services like sanitation and hygiene facilities at home and schools, there are groups of children who face more challenges given their livelihood conditions. These include children living in the streets and Orphans and Vulnerable Children (OVCs).

[5] Annual Water Sector Status Report, 2006-2007
[6] http://www.wateraid.org/documents/ch24_creating_userfriendly_sanitation_services_for_the_disabled

Despite the success in increasing school enrolment, dropout rates remain high and completion rates remain low. There is an urgent need to focus on providing quality education and retaining pupils, especially girls. A mapping of school WASH in 16 districts (2,697 schools) carried out jointly by SNV, WaterAid and UNICEF in 2009 shows that the provision of sanitation and hygiene in pre, primary and secondary schools in Tanzania is lamentable. Internationally WHO guidelines recommend the provision of one toilet per 25 girls and one toilet plus one urinal per 50 boys[7]. In reality, it is common to find hundreds of children sharing one decrepit latrine, irregular water supply and no hand washing facilities.

Chart 1: The overall situation for School WASH in the 16 mapped Districts



Source: Water Aid, UNICEF, SNV (2011)

Chart 1 above explains that only 9% of schools were found to have "clean" latrines, and only 11% of schools meet the MOEVT minimum standard for the number of pupils/drop hole (20 girls and 25 boys per drop hole). In some schools the number of pupils per drop hole was found to be as high as 400 to 600 and in all districts a number of schools were found without a single drop hole. Although 55% of schools have a water point within or near the school compound, this does not guarantee that these schools will have water all year round or throughout the day. WASH facilities that are suitable for children with disabilities are found in only 4% of schools. Some

[7] International WHO guidelines 2006

52% of latrines for girls do not have doors, depriving them of privacy and their dignity. Also the mapping exercise revealed that only 1% of schools have soap available; 8% of schools have adequate water and only 14% of schools have facilities for hand washing, making conditions for good hand washing practice virtually impossible for children. Furthermore, the School WASH mapping research showed that[8] 96% of schools do not have facilities that are suitable or accessible to children with disabilities.

Also the Number of pupils per improved school latrine is reported at 58 and 64 for girls and boys respectively, which is far beyond the national minimum standards. While there is no official baseline data on availability of hand-washing facilities in schools, schooling mapping exercises indicate only 2% of schools hand- washing facilities have soap and only 10% have water.[9] Furthermore, it is important to mention that data on access to sanitation has been inconsistent from study to another. This situation, in part, shows the low level of importance accorded to the S&H sub-sector.

2.0 The S&H Policy in Tanzania

The MoHSW has been leading the development of the National Sanitation and Hygiene Policy, the draft of which has been submitted to the Cabinet. The objective of the policy is to strengthen the countries resolve to improve sanitation and hygiene practices and it details harmonized definitions, the first step to developing and implementing an effective M&E framework for sanitation and hygiene in Tanzania. At the time of this writing, the National Sanitation and Hygiene Policy had not yet been finalized (approved). This is testimony of the fact that sanitation and hygiene has not been given the priority it deserves despite the understanding of the life-saving benefits of the use of improved sanitation. Besides, the position of national policy on responsibility for financing household sanitation lies on the members of the household.

On the other hand, public sanitation facilities and set –up are different and operated commercially. This position overlooks the fact that there are marginalised groups in community (i.e. the poor, those with disabilities, children, the elderly and PLWHAs). Also to speed up implementation of the MDGs, the MoHSW has also developed a ten-year National Environmental Health, Hygiene and Sanitation Strategy (NEHHSAS) 2008-2017, which outlines options for improving sanitation that include promotional, educational and participatory approaches and methods. Within the first five years of its implementation, the NEHHSAS has demonstrated some improvement in terms of

[9] MoHSW, …….2011

increased access to improved sanitation facilities. Statistics on access to improved sanitation from the Tanzania Demographic and Health Survey 2010 indicate that access to improved sanitation has increased from 22% to 27% in urban areas and from 9% to 23% in rural areas[10]. However, the statistics reflect a generalized picture which does not cover access by marginalized social groups. Due to this omission, the above statistics might as well be construed to be unreliable.

The situation of equating sanitation to sewerage is also seen in the National Environmental Policy of 1997 whereby the policy objective on Sanitation is not included in the section of Water and Sanitation. This situation revealed that there is a lot to be done by the network so that Sanitation and Hygiene is given its on budget line instead of the current system of budgeting which does not give Sanitation and Hygiene the priority it deserves.

3.0 Multiple Institutional Involvements in S&H Development

The institutional framework for the provision of sanitation and hygiene services in Tanzania involves a number of government ministries, departments and agencies (MDAs). The overall responsibility for the protection of public health through the provision and promotion of adequate sanitation and hygiene falls under the Ministry of Health and Social Welfare (MoHSW). However, other key players in the sector include – the Ministry of Water (MoW), Ministry of Education and Vocational Training (MoEVT), and the Prime Minister's Office-Regional Administration and Local Government (PMO-RALG). There are also other non-governmental actors which are, as well involved in the provision of sanitation and hygiene services. These include – UN organizations like UNICEF, development partners such as the WSP and GIZ, development organizations and international NGOs like AMREF, WaterAid (T), Plan International (T), World Vision, Oxfam, Concern Worldwide and a wide range of national NGOs and FBOs including networks such as TAWASANET.

This multiple involvement by ministries and departments has resulted in overlap of roles and responsibilities. The overlap has been blamed to be one of the reasons that have led to the lagging behind of sanitation development in Tanzania. In response to the challenges posed by this situation, in 2009, the four ministries developed a memorandum of understanding (MoU) to outline a coordinated mechanism for the implementation of sanitation, hygiene and school WASH as well as to feed into three national sector programmes – Health, Water and Education.

[10] Tanzania Demographic and Health Survey (2010) and MoHSW Survey (2011)

4.0 The Role of Local Government in S&H Development.

The implementation of S & H development interventions is done at community level within local government authorities' (LGAs) areas of jurisdiction. The LGAs are comprised of urban authorities and rural district councils. The urban authorities include cities, municipalities, towns and townships while rural local authorities are comprised of rural district councils. A wide range of structures, institutions (governmental and quasi-governmental) have been established to handle issues relating to S&H. The LGAs provide resources and guidance for setting; achieving and maintaining the targets set by institutions/ structures established in the LGA planning system. They advocate at national and district levels for equitable and adequate resources as well as coordinate local environmental health service providers. Also, they monitor and supervise implementation of water, sanitation and hygiene guidelines in schools and health facilities as part of the routine monitoring and inspection process

The LGAs provide S&H training and advice to education and health staff together with their community institutions; ensure appropriate and cost effective design and construction of WASH facilities in community (including schools and health facilities); ensure appropriate and cost effective maintenance of school and health facility WASH facilities and training of local caretakers and maintenance staff. They organise regular on job training or tailor made courses for education and health staff responsible for S&H education and share reports on district budgets for sanitation among stakeholders to enhance transparency and accountability. In LGAs receiving support from donors or INGOs, they plan and coordinate school and health facility WASH competitions, they assess health facility and school WASH facilities and ensure procurement procedures are adhered to.

In urban LGAs there are Urban Water Supply and Sanitation Authorities (UWSSAs) which own, manage and develop water supply and sewerage assets; prepare business plans to provide water supply and sewerage services, including capital investment plans. They secure finance for capital investment and relevant subsdies; contract and manage service providers; and formulate by-laws for S&H service provision.

In LGAs there have been established structures like the Council Health Services Board; the District Water and Sanitation Team (DWST); the Ward Development Committee; the Village Government; the Water and Sanitation Committee at village level (WATSAN Committee); the school committees (in each school); Health Facility Committees (at each health facility); Private sector, Local artisans, Construction companies, CBOs, local NGOs and FBOs - all of which take responsibility to promote S&H development interventions at community level.

5.0 Government Efforts on S&H Improvement.

Tanzania has implemented a number of Sanitation programs and approaches since independence. However, attaining improved sanitation has remained a big challenge. The "Mtu ni Afya" campaign is recognized as the key Government successful campaign which hauls up positive thinking towards the use of toilet rather than open defecation in 1973-78, but lacked continuity. Currently, the government through MoHSW, MoEVT, MoW and PMO-RALG is implementing a four year National Sanitation Campaign and the Usafi wa Mazingira Tanzania (UMATA) programme funded by the Global Sanitation Fund (GSF). Both programmes aim to enhance the pace of achieving the MDGs targets on sanitation. Further, following the Government's commitment on the High Level Meeting on Sanitation and Water for All, it is envisaged that a well structured approach is put in place to help expedite the achievement of the targets.

Other efforts that have been made over the past few years to change the sanitation and hygiene improvement situation includes -

i) Development and signing of the MoU for sanitation and hygiene by 4 Ministries;

ii) Implementing the MoU to bring together key sanitation and hygiene actors in a coordination structure at national level;

iii) Advocacy to keep the sanitation and hygiene and SWASH activities in the Water Sector Development Programme for implementation of sanitation and hygiene in every district in the country;

iv) MoHSW has developed the Draft National Sanitation and Hygiene Policy;

v) MoHSW has developed the National Environmental Health, Hygiene and Sanitation Strategy (NEHHSAS);

vi) MoHSW, MoEVT, MoWI and PMO-RALG and other actors developed the SWASH Strategic Plan; under leadership of MOEVT

vii) Advocacy alliance activities to raise the profile of sanitation and hygiene with policy makers and also to communicate with communities and households across Tanzania;

viii) SWASH partnership to support the four key Ministries to develop harmonised SWASH guidelines and toolkits and their piloting;

ix) The Health Village and Environmental Health and Sanitation Programme supported by the MoHSW;

x) A regular annual Environmental Health and Sanitation Competition is conducted by MoHSW;

Some efforts have been made to influence the national surveys to improve the indicators to use standard definitions and to measure sanitation and hygiene more accurately, but more needs to be done in terms of effective communication of these efforts to health consumers and interested stakeholders in order to prevent duplication of interventions.

Apart from the nationwide efforts there are many other area-based sanitation and hygiene initiatives implemented by NGOs, FBOs, development partners and organizations. These include:

i) The Water Sector Development Programme (Water SWAp) with a sanitation and hygiene component to water projects and also in the early stages of developing plans for supporting a national sanitation and hygiene campaign (which will include some funding and activities in all districts in the country as well as a range of national IEC activities using the mass media);

ii) The Total Sanitation and Sanitation Marketing (10 districts) and Hand Washing Programme supported by the Water and Sanitation Programme (WSP);

iii) School WASH partnership between the 4 key Ministries (MoHSW, MoEVT, MoWI, PMO-RALG), two Universities and a range of national and international NGOs supported by SNV, WaterAid and UNICEF to develop the National School Guidelines and Toolkits and pilot in a number of districts across Tanzania (in 8+ districts);

iv) There is an 'advocacy alliance' of actors working on sanitation and hygiene, who have been coordinating efforts to advocate for sanitation and hygiene across Tanzania using the mass media and event based activities;

v) There are also significant SWASH or S&H programmes by: GLOWS in Morogoro (SWASH); GIZ in Mbeya (SWASH); UNICEF in 11 districts in Tanzania and on the 10 districts of Zanzibar (S&H – PHAST and sanitation artisan training and SWASH); WaterAid – S&H; integrated behaviour change communication; and SWASH (in a number of districts).

vi) There are many other National , local NGOs and Networks working in this area of sanitation and Hygiene improvement in the country such as WASH coalition and TAWASANET which their effort is not or is very little recognized .

6.0 Strategic Direction for S&H in Tanzania

The S&H sector players have been looking for possibilities to harmonize the various approaches currently being applied in the respective areas of intervention. The process which started in March 2010, involved the four key Ministries (MoHSW, MoWI, MoEVT and PMO-RALG) as well as a range of development partners / NGOs and the LGAs. Among the interventions studied include the sanitation centres supported by WaterAid, the implementation of sanitation and hygiene under the WSDP and the TSSM approach being supported by WSP.

The key recommendation from the study was an agreement to harmonise efforts to support the TSSM approach for scaling up across Tanzania but with some modifications such as including sanitation centres to provide alternative options to the sanplat. The TSSM approach has been implemented as part of a multi country research funded by the Gates Foundation. Whilst challenges have been faced and are expected to continue to be faced by this approach (as are faced by all sanitation and hygiene approaches) and learning is on-going, the approach provides a simple methodology focussing on two main aspects: hand-washing facilities and hand-washing and the promotion of the simple sanplat as a first step on the upgrading ladder. It was concluded that it has a clear and simple focus that can be replicated as a base for all programmes across the country. Rather than all actors supporting small projects in different places using different approaches, it is felt that more progress will be seen if there is one base approach on which other activities can build on.

7.0 Sustainability of S&H Initiatives in Tanzania

In order to sustain the achieved S&H benefits the government, in collaboration with S&H sector players should strengthen the national capacity and of LGAs, communities and their institutions, a factor which is expected to contribute positively to sustainability. The capacity building interventions should cover activities like - training of S&H facilitators, local artisans, masons, teachers, NGOs, CBOs and the private sector on the importance of and how to implement and market / promote improved sanitation and hand washing and the various sanitation technological options available to them.

Initiatives like, the WaterAid establishment of a sanitation centre for the provision of S&H services and products will, apart from developing S&H in community, also sustain the cultural/ behavioural change attained. There should also be efforts to strengthen the supply chain.

Teachers have to be trained on how to improve the effectiveness of their S&H teaching including how to incorporate S&H in other subjects, , which is expected to have an impact as pupils will be ambassadors carrying S&H into communities.. The guidance on improved teaching of S&H in the curriculum, National School WASH Guidelines and Toolkits and a handbook for teachers should be taken-up by MoEVT and PMO-RALG for inclusion to the school curriculum. The trained teachers should be encouraged to facilitate establishment of sanitation clubs in schools for the purpose of communicating S&H messages and promoting action and behavior change towards better hygiene and sanitation.

To sustain all the above sustainability strategies, LGAs in collaboration with communities and their local institutions should be urged to contribute resources (human and financial) toward the implementation of S&H interventions in schools. This is another sustainability factor as the LGAs and their communities will oversee the developments by regulations and by-laws.

8.0 Financing the S&H sector

Similar to many developing countries, Tanzania has not accorded sanitation the priority it deserves; it is not widely recognized that good sanitation policies and practices underpin socio-economic development. Poor sanitation costs Tanzania TZS301 billion each year (US$206 million). This sum is the equivalent of US$5 per person per year or 1% of the national GDP[11]. It is also stated that 26 million Tanzanians use unsanitary or shared latrines; 5.4 million of them have no latrine at all and defecate in the open. The poorest quintile is 41 times more likely to practice open defection than the richest. Open defecation costs Tanzania US$46 million per year. Eliminating the practice would need approximately one million latrines to be built and used.

The current sanitation investment in Tanzania is less than 0.1%[12] of the GDP. Increased investment in sanitation and hygiene promotion is required not only to realize the health and welfare benefits of sanitation but also to avert large economic losses

Sanitation and hygiene are included within the WSDP with 20Million USD funded by the AFDB under the Rural Water and Sanitation Programme; however a little more than token allocations has been given, mostly for the urban sewerage. Roughly 1 percent of

[11] Taylor, B (2008), Financing of Sanitation: a discussion paper, WaterAid Tanzania.

[12] Ibid

the total WSDP budget is expected to be spent on sanitation and hygiene, three quarters of which is for sewerage systems that will serve wealthy communities in a few towns. A very small amount is allocated to rural sanitation, which is not earmarked and therefore easily reallocated. The Health Sector Basket Fund preventive health funds could be used for sanitation and hygiene promotion, and education sector development funds could be spent on school latrines but there is no national coordination between these different mechanisms. Besides, it has not been made clear as for whether how much of the money will be spent on sanitation promotion for the marginalized groups.

The main sources of funding for the sanitation sector are mainly – the Central Government Ministries - MoHSW's, MoEVT, MoWI and PMO-RALG which mainly utilise basket funds. Also funds are contributed from sector development partners and other agencies such as UNICEF, WaterAid, GTZ, USAID (GLOWS, iWASH) programme and a range of NGOs.

External funding agencies contributing to the basket funds of Water SWAp, which currently has the largest contribution to sanitation and hygiene, include: the World Bank, AfDB, The Netherlands Government, KfW, Belgium, the French Development Agency and others. The Water Sector Development Program (WSDP) 2006 – 2025 has an overall target budget of over 2.85 billion USD for the entire period. It includes water and sanitation but with a much lower proportion of the budget for sanitation and hygiene related activities (referred to under the Water SWAp as 'Sanitation'). The contribution of the AfDB funds for the WSDP for sanitation and hygiene including household and school sanitation and hygiene is expected to be at total of USD 20 million for the period 2011-15.

The Education Sector Development Programme has targets for school sanitation and hygiene and also in the design of the Primary School Development Programme II (PEDPII) there were also budget lines for sanitation and a separate one for water supply. However it is not clear how much funding has specifically gone into these areas and funding can sometimes get used for other purposes. Part of the challenge for the education sector is that the PMO-RALG is responsible for the schools, but the MOEVT reports on the progress and data transfer between the two Ministries is thought to cause complications for accurate reporting. As funds under the ESDP generally come from the General Budget Support rather than for a specific thematic area there have also been challenges for the sector to get the required funds for specific targeted activities such as SWASH. Hence some funds have been used and allocated for sanitation in primary schools from the Education Sector but the amount is currently unclear and thought to be small to the overall need. The Secondary

School Development Programme II (SEDPII) has recently been approved and includes a substantial contribution for both water supply and sanitation along with electricity and classrooms for secondary schools.

Under the Health Sector Programme III, funds for sanitation and hygiene can be requested from the basket by LGAs, but in order for this request to be made the LGA has to prioritize it above other more high profile activities including HIV/AIDS, malaria and a range of curative activities. The staff responsible for the sanitation and hygiene in the LGAs therefore often report that their requests are often not put forward to the basket.

The formula-based Local Government Capital Development Grant (LGCDG) under the Local Government Support Programme (LGSP) which aims to strengthen LGAs has provision of Capacity Building Grants. The grants allocate US $ 35,000 per year to each LGA for broad capacity building across all sectors. These grants open a small window of opportunity for LGAs to meet their respective capacity building needs for implementing the NEHHASS. There is much to be done in the budgeting process to iron out specifically the fund set aside for implementation of S&H practice at all levels such that the budget should reflect all allocations towards S&H.

9.0 Access to S&H Facilities by Marginalized Groups

The marginalized social groups referred to in this report include - people with disabilities, PLWHAs, the elderly, children and the poor in general. These groups are understood to be locked in a vicious cycle of poverty. Poverty is both a cause and a consequence of disability. People with disabilities are more likely to be poor because of inadequate medical treatment, lack of education or employment, discrimination and isolation. At the same time, poor people are more likely to fall into disabilities because of poor nutrition, hygiene and sanitation, poor health care, hazardous living and working conditions and lack of education. Disability impacts the whole family, through increased treatment costs, increased workload of careers (usually women and girls) resulting in reduced income, and general reduction in well-being.[13]

Lack of sanitation keeps people poor, unhealthy and unable to improve their livelihoods. Disabled people have the least access to these services, which compounds their isolation, poor health and poverty in the drive to meet development targets such as the Millennium Development Goals of poverty reduction, improved health and access to sanitation, service providers recognize the need to target the

[13] DFID, 2000; and Tesfu & Magrath, 2006

poorest sections of society. It is therefore apparent that to provide more equitable access to basic services, the needs of disabled people need to be considered and addressed. However, when looked into critically, it is not only disabled people, but many others, such as frail elderly people, pregnant women, girls, parents with small children and people who are injured or with chronic illnesses, including HIV and AIDS, may experience difficulties accessing sanitation facilities and services.

Currently, in Tanzania policy makers and legislators have been blind to notice the special needs of marginalized social groups, leave alone acknowledging the existence of such social groups. Hence, most of the decisions and plans for development of S&H have been lacking content for supporting the marginalized groups.

10.0 Conclusions

The report concludes that the performance of sanitation and hygiene (S&H) development in Tanzania, like in other developing countries, is poor. It notes global statistics which show that over 2.6 billion people (39% of the world population) do not have access to improved sanitation. In Tanzania, only 23% and 27% of the rural and urban population respectively, have access to improved sanitation. This inadequacy in access is related to diseases such as diarrhoea, typhoid, dysentery and cholera. Studies have shown that in schools access to S&H facilities is also poor as the drop-hole: pupil ratios are for boys and girls are over and above the MoEVT standards.

The development and provision of S&H services in Tanzania involves multiple institutions. While the overall responsibility for the provision and promotion of adequate sanitation and hygiene falls under the MoHSW, other key players in the sector include – the MoW, MoEVT and PMO-RALG. There are also other non-governmental including – UN organizations like UNICEF, development partners such as the WSP and GIZ, INGOs like AMREF, WaterAid (T), Plan International (T), World Vision, Oxfam, Concern Worldwide and a wide range of national NGOs and FBOs including networks such as TAWASANET. This multiple institutional involvement has led to an overlap of roles and responsibilities which is believed to be one of the reasons that have led to the lagging behind of sanitation development in Tanzania.

The formulation of the S&H policy has been stagnated reflecting the low priority that S&H has been accorded. Despite that shortcoming, the government has been involved in several S&H interventions which could have been more effective in the presence of a national S&H policy. Furthermore, there are significant SWASH or S&H programmes by: GLOWS in Morogoro (SWASH); GIZ in Mbeya (SWASH); UNICEF in 11 districts in

Tanzania and on the 10 districts of Zanzibar (S&H – PHAST and sanitation artisan training and SWASH); WaterAid – S&H; integrated behaviour change communication; and SWASH (in a number of districts).

The way forward for Tanzania is towards harmonizing efforts to support the TSSM approach for scaling up across the country with some modifications such as including sanitation centres to provide alternative options to the sanplat. A broader involvement of non-state actors will add significant impact to the sector's development. To sustain the achieved S&H benefits the S&H stakeholders should strengthen the national capacity and that of LGAs, communities and their institutions to ensure the change is carried forward taking into account the needs of marginalized social groups.

Together with the above, the report notes that the government is blind on the existence of marginalized social groups and that is why there have been no plans and budgets towards addressing their special needs. With regard to funding of S&H the study concludes that in spite of all the efforts exerted in funding S&H development, there is still a problem of having a clear funding line with regard to S&H at all levels. Special S&H needs of marginalized groups have not been visible in plans and budgets at local level as well as at the central level.

11.0 Recommendations

Based on the conclusions above, the report makes the following recommendations:

1) The lead ministry (i.e. MoHSW) needs to put in place practical mechanisms to facilitate improved coordination and collaboration in the sector to increase focus on and improve delivery of sanitation services to marginalized social groups.

2) The MoHSW should conduct a study to identify issues hampering access to S&H by marginalized social groups and suggest policy and legislative interventions to enforce their implementation

3) The MoHSW should ensure that the private sector and civil society are supported so that they supplement the government S&H interventions to enhance service provision capacity;

4) The MoHSW should improved S&H information sharing and dissemination to enable the public understand the importance of S&H so as to cultivate attitude and behaviour change in society

5) The MoEVT and PMO-RALG should provide guidance on improved teaching of S&H in the curriculum; disseminate National School WASH Guidelines and Toolkits and the handbook for teachers to be included to the primary school curriculum.

6) The MoHSW, MoEVT and PMO-RALG should formulate supportive inclusive policy, legislation and regulatory framework for the S&H sector that takes into account the rights of marginalized groups in access to S&H services

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