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Tanzania – SSH4A Results Programme Extension endline brief

Between 2017 and 2019, over 371,000 more people gained access to sanitation and hygiene; over 197,500 more people practised handwashing with soap (HWS) after defecation; and open defecation (OD) rates fell from 34% to 7%. These results are based on the Sustainable Sanitation and Hygiene for All Results Programme (SSH4A RP) household survey conducted in November 2019 in Tanzania's Maswa, Misungwi, Itilima, Msalala/Kahama, Shinyanga, Arusha Rural, Monduli and Hanang districts.

This endline practice brief summarises key achievements since the programme commenced in the eight districts, with progress measured against the baseline survey conducted in January 2017. Disaggregated sanitation and hygiene outcomes are presented, with data on the districts' most vulnerable groups: households in the poorest wealth quintile, female-led households, and households with people living with disability.

At baseline in 2017, only 47% of households had access to sanitation and 34% practised OD. In addition, pit-emptying and collection data showed that 46% of households discharged human waste directly to the environment; either through OD and/or using toilets that discharged to the environment.

Access to sanitation was hampered by high levels of poverty, limited toilet options and cultural

Key achievements by household (2017-2019)

79% have access to a toilet (**47% in 2017**)




81% practise hygienic use and maintenance of toilets (**49% in 2017**)

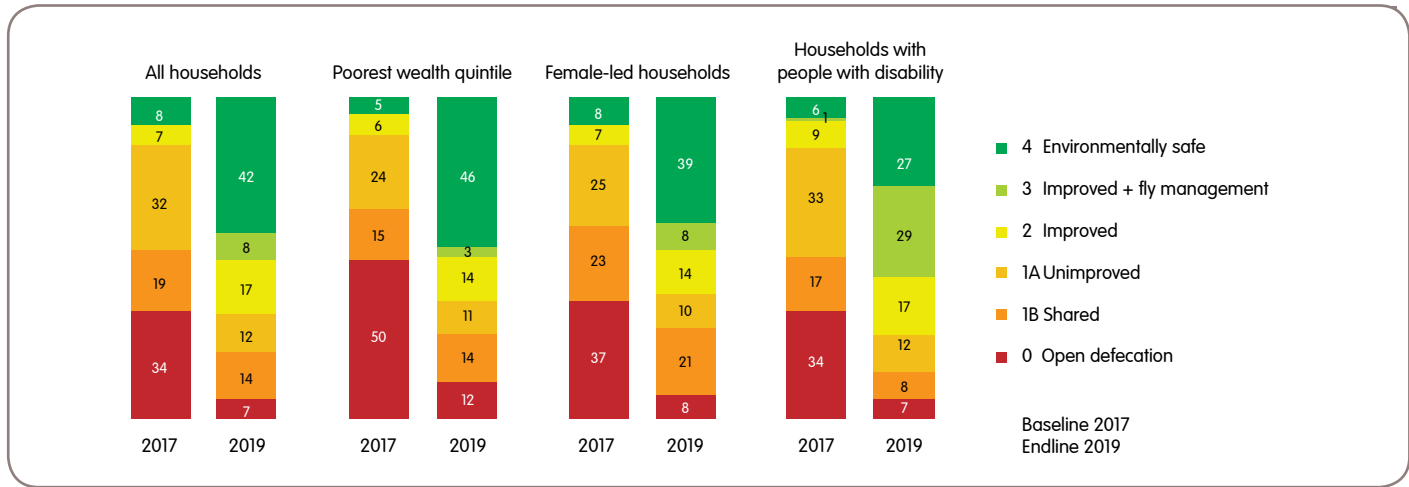


19% have access to a handwashing facility with soap after defecation (**0% in 2017**)



Figure 1: Percentage of households with access to toilets, 2017 and 2019

Access rate: 79% (2019 endline) 47% (2017 baseline) 



Note: Households with toilets categorised as Level 1A through to Level 4 are considered to have access to sanitation, as defined in the programme by the UK Department for International Development (DFID).

traditions. Pastoralism in the districts of Monduli and Arusha contributed to the high prevalence of OD. Sharing of toilets was also a common practice among pastoralist households as men married several wives and these large families all shared a single toilet. More so, large numbers of people lived as extended families in homesteads.

By the endline survey in 2019, overall access to sanitation increased to 79% and OD reduced to 7%, although OD remained high (at 30%) in the pastoralist district of Monduli. Households with/without toilets that discharged directly to the environment decreased to 15%. The SSH4A programme sought to reduce OD by triggering behaviour change in communities through community-led total sanitation (CLTS) efforts, behaviour change communication (BCC) films and in partnership with school pupils to raise awareness in their homes and among neighbours. The programme also established and strengthened sanitation networks – known as *Jirani*¹ sanitation groups (JSG) – to mobilise 10 neighbouring households to construct and use toilets. The programme also sensitised the community through traditional leaders and *Morans*² to reduce the use of shared toilets. Despite these efforts, the strong pastoralist lifestyle of having many wives in a homestead meant that sharing a toilet remained a challenge by the endline survey.

Access to toilets up by 32 percentage points, access to improved sanitation up by 52 percentage points (fig 1)

The endline (2019) results show that access to improved sanitation went up by 52 percentage points across all households,³ while OD fell from 34% at baseline to 7% at endline. These achievements are attributed to the strong local leadership and community mobilisation that was created through the sanitation networks established at community level, as well as the roll-out of BCC films that targeted attitude change. By introducing the concept of improved traditional pit toilets through thatching and compacting floors, the SSH4A programme has aided the construction of durable toilets.

Access to toilets increased by 39 percentage points overall in the poorest wealth quintile, with 46% of the poorest households having invested in environmentally safe toilets at endline compared to 5% at baseline. OD also reduced among this group by 38 percentage points. Among female-led households, access to sanitation increased by 31 percentage points and OD fell by 29 percentage points. These results stem from the programme’s efforts to encourage the participation of women. Working with women as health promoters, they were specifically targeted and invited to all meetings, and their proposals were implemented.

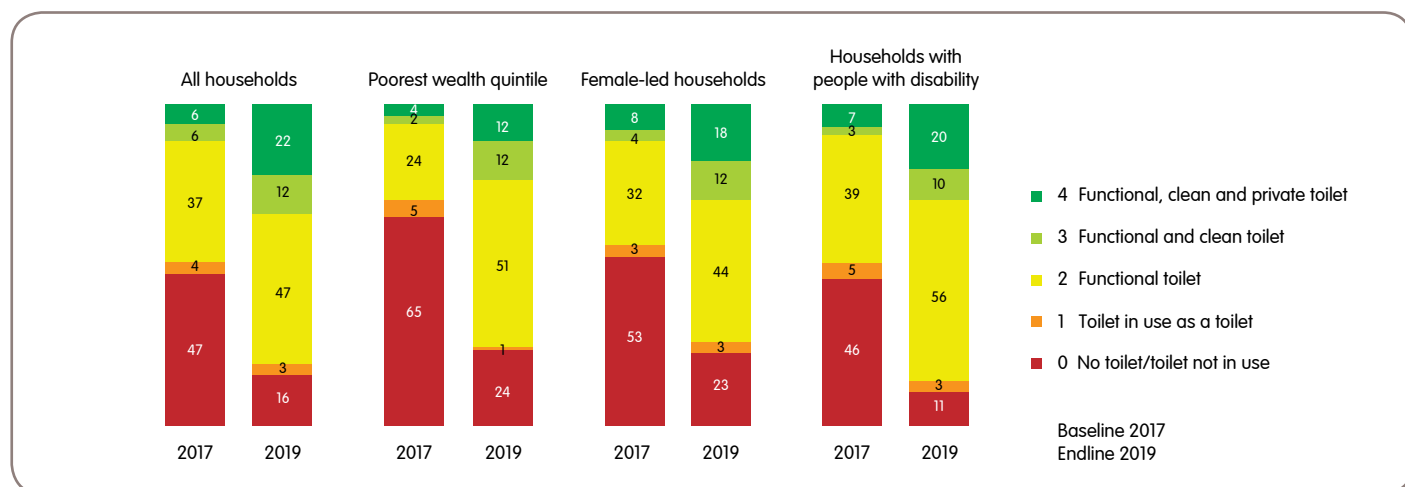
¹ Swahili for ‘neighbour’.

² Masai men.

³ All percentage changes (increases and decreases) are given in absolute not relative terms – that is, we give the percentage-point difference between baseline and endline results.

Figure 2: Percentage of households with hygienic use and maintenance of toilets, 2017 and 2019

Use rate: 81% (2019 endline)
49% (2017 baseline)



Note: Levels 2 through 4 are considered to indicate improvements in hygienic use and maintenance of toilets.

In households with people with disability, access to toilets increased by 36 percentage points, with a 57 percentage-point increase in households with improved toilets (levels 2–4). Local communities continued to support the elderly and people with disability to access local materials such as trees and grass for construction of improved traditional toilets. Additionally, the project carried out door-to-door campaigns and engaged with families living with people with disability and the elderly on the importance of providing accessible toilets such as with pedestals.

Sanitation and hygiene sensitisation was conducted (and will continue) through the 10-cell⁴ sanitation networks to increase access to environmentally safe toilets. By endline the majority of households had pit toilets with improved substructures, leading to a 52 percentage-point increase in households using improved toilets overall. This increase is attributed to the construction of demonstration toilets to improve traditional pits in each village, which were then replicated by most households. To complement these demo toilets, *Safi*⁵ toilets were introduced in all districts as an alternative option to enhance the quality of and access to sanitation in each area.

Hygienic use and maintenance of toilets up by 32 percentage points (fig 2)


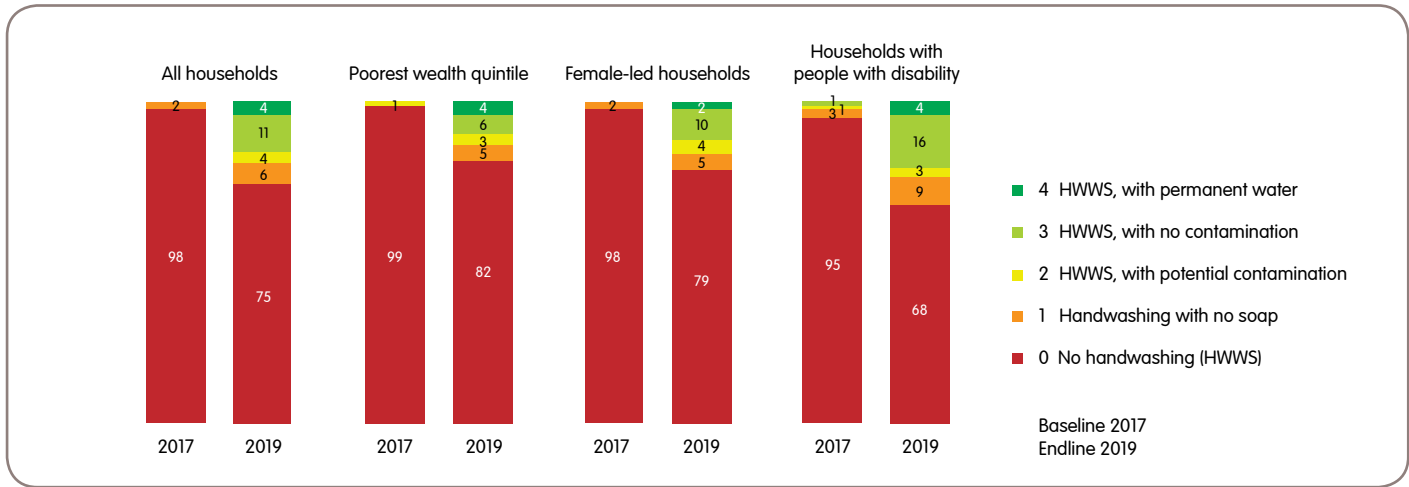
By the end of 2019, the hygienic use and maintenance of toilets increased by 32 percentage points, with 22% of households having adopted functional, clean and private toilets (level-4 toilets) compared to 6% at baseline. These results are attributed to BCC interventions and mobilisation of communities through the JSG networks, as well as experience-sharing by local leaders from neighbouring villages.

The endline results for the poorest wealth quintile show 12% of these households had functional, clean and private toilets (level 4) compared to 4% at baseline, with a 45 percentage-point increase in hygienically used and maintained toilets (levels 2–4) overall. Female-led households and those with people with disability saw increases of 30 and 37 percentage points in hygienically maintained toilets, respectively. These positive results across the vulnerable groups are attributed to the roll-out of BCC interventions at the sub-village level and collaborating with schools and faith-based institutions as agents of change in enforcing sanitation standards.

⁴ In each sub village, 10 households formed a group and elected a leader who mobilises, keeps track of and reports on the sanitation status of each household in the group.
⁵ Swahili for 'clean'. *Safi* toilets were designed by SNV through action research and are an adaptation of the easy latrine designed by International Development Enterprises (iDE) in Cambodia. They are affordable and are produced by SNV to meet the durability and safety requirements of households.

Figure 3: Percentage of households with access to a handwashing facility with soap near toilet, 2017 and 2019

Access rate: 19% (2019 endline)
0% (2017 baseline)

Note: Levels 2 through 4 are considered to indicate access to a handwashing facility with soap.

Access to a handwashing facility with soap near toilet up by 19 percentage points (fig 3)

At endline, knowledge on HWWS after defecation increased from 24% at baseline to 32% at endline, while access to HWWS (levels 2–4) increased from 0% to 19%. This equates to 197,000 people who gained access to HWWS facilities between 2017 and 2019. The increase in knowledge is attributed to the BCC interventions implemented in the districts, including *emo-demos*⁶ in health centres, promotion of handwashing through school children and mobilisation through the 10-cell JSG networks.

Access to HWWS in the poorest wealth quintile and female-led households increased to 13% (compared to 1% at baseline) and to 16% (compared to 0% at baseline), respectively. BCC messages through *emo-demos* were targeted at mothers nurturing their babies and were successful in winning the support of women. Almost all villages had been triggered with CLTS, BCC and other approaches by endline. Among the vulnerable groups, households with people with disability showed an impressive 21 percentage-point increase in access to HWWS, from 2% at baseline to 23% at endline. These improvements are attributed to hygiene promotion activities which were implemented through the local government and community health promoters. Although the increases in access to HWWS

between surveys indicate that some progress has been made, 75% of households still had no handwashing facilities at all by endline. Therefore, this remains a challenge and a priority area for future work.

Conclusion

Access to sanitation substantially improved in all of the eight programme districts, with 79% of households having access to sanitation by endline compared to 47% at baseline. The focus and emphasis of SSH4A RP in Tanzania was not to only promote health benefits but to also educate households on the convenience, privacy and prestige of having and using their own toilets

The programme ensured that processes were institutionalised in two ways: firstly, by working to build the capacity of local government authorities (LGAs) to develop and implement area/district-wide sanitation plans; and secondly, by working to change norms within communities through BCC messages. With LGA staff presence up to the sub-village levels, LGAs are best suited to roll out and implement sanitation plans. The SSH4A programme strengthened capacity of government institutions in the areas of demand creation, supply chains, governance, planning, monitoring and evaluation, and communication to enable these institutions to manage their

⁶‘Emotional demonstrations’ (*emo-demos*) are used in behaviour-centred design to trigger behaviour changes (such as HWWS) by creating disgust and shame.



plans. In particular, the programme ensured that monitoring, enforcement and reporting was done by local stakeholders through the JSG or the 10-cell sanitation network, thus helping to ensure sustainable results. However, gains made by the programme could be heightened if the government were to intervene and support sanitation and hygiene programmes by allocating more resources. LGAs could also mobilise resources from local taxes, for example.

To eliminate OD, LGAs will have to pay greater attention to implementing strategies that directly target groups in the 'last mile'. These categories include poor households headed by single mothers, poor households without family members to provide financial support, households that live in remote areas far from information and local administrative centres and households living in difficult terrains (e.g., with swampy, flooding, rocky and collapsing soils). Defiant households (youth and the rich) that have the socio-economic resources to build toilets but prefer to practise OD should also be targeted by LGAs.

The endline results show that community norms can be changed since 100% of people had knowledge on hygiene by the end of 2019. Hygiene recall increased by 61 percentage points between surveys in the programme districts – an increase that is attributed to the BCC interventions and strong mobilisation through the 10-cell JSG networks. However, the challenge lies in translating this knowledge into households practising HWWS. Although the endline results show increased access to HWWS in programme districts between 2017 and 2019, HWWS rates remain low overall with 81% of households still with no access to HWWS by endline. The increased access to, at least, level-2 HWWS is attributed to the establishment of sanitation networks, easy access to water in some parts of the districts and strong local leadership. But the local government needs to embed targeted BCC messages within ongoing campaigns such as the *Nyumba Ni Choo*⁷ and scale up efforts in the whole district.

Finally, application of a market-based approach helped increase access to toilets. The programme kick started markets by investing in and building the capacity of the private sector including local

⁷ 'Nyumba Ni Choo', means a house is not complete if it has no toilet.

business enterprises to sell and market toilets. Currently, over 56 local business entrepreneurs are selling improved toilets so the programme envisions this trend to continue. It is recommended that more local business entrepreneurs are

trained and receive coaching to scale up production, and that these businesses receive LGA support to produce and sell different toilet options, such as *Safi* toilets and wooden pedestal stools.

Sustainable Sanitation And Hygiene For All Results Programme (SSH4A RP)

SSH4A RP is a pioneering results-based financed programme implemented in select countries in Africa and Asia. The programme contributed to ending open defecation; increased use of safely managed, functional and private toilets; and increased access to handwashing with soap facilities. SSH4A RP in Tanzania is a collaborative initiative with the Government of Tanzania. It received generous funding from UKAID of the Government of the United Kingdom.

SNV

SNV is a not-for-profit international development organisation that makes a lasting difference in the lives of people living in poverty by helping them raise incomes and access basic services. Focusing on three sectors – Agriculture, Energy and Water, Sanitation and Hygiene (WASH) – SNV has a long-term, local presence in over 25 countries in Asia, Africa and Latin America.

This SSH4A RP endline brief was prepared by Anne Mutta and Jackson Wandera, with support from Rosenell Odondi and Anjani Abella. It was edited by Joanna Fottrell and designed by Belle Phromchanya.

Photos ©SNV
(FRONT) Government officer explains correct installation procedures of tippy taps for HWWS to community sanitation committees
(P5) Local Maasai learn how to make a cement slab for a Safi latrine



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For more information

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In collaboration with the Government of Tanzania, SNV supported local governments to lead and accelerate progress towards area-wide sanitation coverage in rural areas.¹ Between January 2017 and November 2019, the Sustainable Sanitation and Hygiene for All Results Programme (SSH4A RP) was extended to eight districts: Maswa, Misungwi, Itilima, Msalala/Kahama, Shinyanga, Arusha Rural, Monduli and Hanang. The programme reached 1,145,000 people. The endline achievements are highlighted here. From January 2017 through November 2019...

371,403

people gained access to sanitation



197,534

people began handwashing with soap after defecation



Access to toilets

74%

of the poorest households, up from 35%

71%

of female-led households, up from 40%

85%

of households with people with disability, up from 49%



Hygienic use and maintenance of toilets

75%

of the poorest households, up from 30%

74%

of female-led households, up from 44%

86%

of households with people with disability, up from 49%



Handwashing with soap after defecation

13%

of the poorest households, up from 1%

16%

of female-led households, up from 0%

23%

of households with people with disability, up from 2%

¹ SNV's target for SSH4A RP was to enable 163,300 people to gain access to new and improved toilets and 18,300 to practise handwashing with soap.



= 100k People



= Baseline January 2017

Sustainable Sanitation and Hygiene for All (SSH4A) is an integrated approach that supports local governments in achieving area-wide rural sanitation and hygiene. The goal is to meet the needs of the entire population: no one should be left behind.



Introducing the SSH4A components

The SSH4A approach contributes to building systems and capacities in rural areas. SSH4A integrated components include:

- ✔ **Strengthening capacity to steer and implement sanitation demand creation** of local governments and partners to generate community demand for quality sanitation services, and to take this demand to scale.
- ✔ **Strengthening capacity for sanitation supply chains and finance** to develop and deliver appropriate and affordable market-based sanitation solutions that address the needs or desires of various consumer segments.
- ✔ **Strengthening capacity for behavioural change communication (BCC) for hygiene** to institutionalise hygiene promotion and sustain positive hygiene behaviours.

- ✔ **Strengthening capacity for WASH governance** to improve sector alignment of sanitation and hygiene initiatives and to address the needs and aspirations of traditionally disadvantaged groups – girls and women, the poorest, minorities, people with disability and the elderly.

Measuring SSH4A performance: outcome indicators

Progress in sanitation and hygiene is realised incrementally and measured in small steps as people climb up the 'ladder' of access and services. The performance and appropriateness of the approach is measured by three outcome indicator ladders, adapted from the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) Joint Monitoring Programme for Water Supply, Sanitation and Hygiene.

OUTCOME INDICATOR 1.

Progress in access to a toilet

Indicator level	Description
4 Environmentally safe	Human faeces contained and not in contact with humans or animals. No flies or rodents enter or exit the toilet. Human faeces do not contaminate surface water or ground water.
3 Improved with fly management	Human faeces contained and not in contact with humans or animals. No flies or rodents enter or exit the toilet.
2 Improved (basic)	Human faeces contained and not in contact with humans or animals, with the exception of flies or rodents.
1A Unimproved	Unimproved (private) toilet. Human faeces not contained and may be in contact with humans or animals.
1B Shared	Unimproved toilet shared between two or more households. Human faeces not contained and may be in contact with humans or animals.
0 Open defecation	No toilet; open defecation.

Outcome indicator 1 measures the presence and quality of a toilet within the household.

In the DFID-funded **SSH4A Results Programme**, progress in access to a toilet (outcome indicator 1) is counted from '1A Unimproved' level. For outcome indicators 2 and 3, households that reach level 2 'Functional toilet' and 'HWWS, with potential contamination' signify an improvement, respectively.

OUTCOME INDICATOR 2.

Progress in hygienic use and maintenance of a toilet

Indicator level	Description
4 Functional, clean and private toilet	Toilet used for its intended purpose. Functional water or seal cover (not blocked). No faecal smears on premises. Walls and doors in place. Cleansing materials and water available. Privacy assured (door can be closed and locked).
3 Functional and clean toilet	Toilet used for its intended purpose. Functional water or seal cover (not blocked). No faecal smears on premises. Walls and doors in place. Cleansing materials and water available.
2 Functional toilet	Toilet used for its intended purpose. Functional water seal or cover (not blocked).
1 Toilet in use as a toilet	Toilet used for its intended purpose.
0 No toilet/toilet not in use	No toilet on premises, or toilet not used for its intended purpose.

Outcome indicator 2 measures the general cleanliness and maintenance of a toilet within the household.

OUTCOME INDICATOR 3.

Progress in access to a handwashing facility with soap near toilet

Indicator level	Description
4 HWWS, with permanent water	Handwashing with soap within accessible distance. Hands do not touch water source. Permanent water available (running water, or handwashing at well).
3 HWWS, with no contamination	Handwashing with soap within accessible distance. Water container covered properly, with no risk of contamination. Hands do not touch water source.
2 HWWS, with potential contamination	Handwashing with soap within accessible distance. Water container not covered and easily contaminated when hands touch water source.
1 Handwashing with no soap	Handwashing station within accessible distance. No soap.
0 No HWWS	No handwashing station within accessible distance.

Outcome indicator 3 is measured by proxy – the presence of a handwashing station within an accessible distance of a household's toilet – rather than the behaviour of handwashing itself. A proxy indicator is used because questions about behaviour can prompt 'socially desirable' answers that do not reflect actual practice. Accurate measurement at household level is difficult.

The use of soap is considered more essential than the availability of permanent water. A handwashing station with permanent water, but with no soap is scaled down to Level 1, below the acceptable benchmark.

For more information

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