
**Research-inspired Policy and Practice Learning in Ethiopia and the Nile region**

# Policy and institutional factors affecting formulation and implementation of Sanitation and Hygiene strategy

## A case study from the Southern Nations Region ('SNNPR') of Ethiopia

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**Research-inspired Policy and Practice Learning in Ethiopia and the Nile region** (RiPPLE) is a five-year research programme consortium funded by the UK's Department for International Development (DFID). It aims to advance evidence-based learning on water supply and sanitation (WSS) focusing specifically on issues of planning, financing, delivery and sustainability and the links between sector improvements and pro-poor economic growth.

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Responsibility for the opinions presented in this report rests exclusively with the author, and should not be attributed to the regional Bureau of Health, the regional government of SNNPR or any of other persons consulted (as listed in Annex 1). Any feedback on this report would be gratefully appreciated by the author at betty_terefe2002@yahoo.com.

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# List of acronyms and amharic names

| | |
|---|---|
| ADB | African Development Bank |
| Alaba | A special *woreda* in SNNPR, one of the study *woredas* |
| AWD | Acute Watery Diarrhoea |
| BoE | Bureau of Education |
| BoFED | Bureau of Finance and Economic Development |
| BoH | Bureau of Health |
| BoWR | Bureau of Water Resources |
| Cell | government, sub-*Kebele* level structures encompassing 20 households, used to mobilize community resources and communicate government messages |
| CHPs | Community Health Promoters |
| DA | Extension Development Agent |
| DFID | UK Department for International Development |
| ESHE | 'Essential Services for Health in Ethiopia' |
| FGD | Focus Group Discussion |
| GoFDRE | Government of Federal Democratic Republic of Ethiopia |
| HEP | 'Health Extension Package' or 'Health Extension Program' |
| HEWs | Health Extension Workers |
| *Kebele* | Lowest level of government administrative structures |
| M&E | Monitor and Evaluation |
| MDGs | Millennium Development Goals |
| Mirab Abaya | A *woreda* in Gamo Gofa zone of SNNPR |
| MoARD | Ministry of Agriculture and Rural Development |
| PHAST | 'Participatory Hygiene and Sanitation Transformation' |
| S&H | sanitation and hygiene |
| TPL | Traditional Pit Latrine |
| USAID | United States |
| WaSH | Water Sanitation and Hygiene |
| WaSh Cos | Water Sanitation and Hygiene Committees |
| WatSan | water and sanitation |
| *Woreda* | District, an intermediate level of government administrative structure |
| WSS | Water Supply and Sanitation |
| Zone | Government administrative structure between Region and *Woreda* |

# Executive summary

Since 2002, the SNNPR government, one of the 11 regional states of Ethiopia, trialled a new approach of broad based, low-cost, high-impact public health interventions aimed at improving basic health status of the region, including access to sanitation and hygiene (S&H) services. Four years since the initiation of the new approach, the Bureau of Health (BoH) reported a substantial growth in access to sanitation facilities in the region, from 16% in 2002 to 90% in 2006. The reported success gained wide attention considering S&H is given a low policy priority in many developing countries and because the region's policy was home grown and without major donor support.

RiPPLE conducted a case study on the SNNPR government's S&H approach and implementation experience in order to identify promising scalable practices and use lessons from SNNPR as a basis for developing similar programmes with the rest of the country and the Nile region, more generally. The case study includes three components – a technical study; a 'Knowledge, Attitude and Practice' study, and; an analysis of the policy and institutional factors affecting the uptake and implementation of the approach – the latter one being the focus of this working paper.

The findings of the study indicate that the S&H policy was formulated and packaged by the BoH in a politically attractive manner, which helped it to obtain the endorsement of the regional cabinet. The approach was well-aligned with an existing body of national health policy frameworks. It promised a financially and administratively feasible approach by incorporating low cost strategies and using existing government structures for communication and implementation. Technical feasibility was guaranteed by encouraging the use of local resources and simple technology.

S&H was promoted as one component of a package to improve basic health education in the region with accompanying messages related to basic health rights, citizens' participation in health decision making and accountability of health institutions to clients. This added to the political attractiveness of the document when it was communicated to regional cabinet and higher level politicians. The political attractiveness was enhanced as it coincided with the run up to the 2005 election. The S&H policy won the support of the cabinet members and key politicians.

The S&H policy was also formulated in flexible ways, which proved important from an implementation perspective, as it allowed new initiatives which were successfully piloted to be continuously incorporated into the programme. This was also strengthened by the existing leadership of the Regional BoH during the implementation period.

In the implementation of the policy, the combination of political will with S&H outreach through frontline health workers/ professionals proved crucial to its success. The political campaigns, through strong communication ('ignition') documents developed by BoH, helped to popularize the policy and build political support. The promotion through health front-line workers – health extension workers (HEWs) and community health promoters (CHPs) – was effective for outreach to households including providing technical support.

The implementation of the approach had some weaker aspects. The cross-sectoral collaboration adopted by the BoH – communication and promotion of S&H messages though political officials and sectors beyond just health – which was widely used in the beginning of implementation (in the period from 2003-2005), was not effective in improving access to S&H facilities. This was due to the fact that it failed to give technical support to households. Quota systems for S&H targets, introduced in order to create accountability, resulted in diverting attention away from changes in S&H behaviors of

households. The overall manner of policy implementation focused on simply increasing numbers of latrines constructed without assessing utilisation and changes in S&H behavior of households.

However, the BoH's more recent mode of implementation (from 2005 onwards) aims to address the above weaknesses by moving away from a cross-government campaign to improve basic health towards a professionalised health extension programme delivering, through health sector workers, a standard package of basic health messages including S&H.

# 1 Introduction

## 1.1 Background

Since September 2002 the Bureau of Health (BoH) of the Southern Nations, Nationalities and Peoples Region (SNNPR) trialled a new approach to basic health care. The approach focuses on a small number of 'broad-based, low-cost and high-impact' public health interventions aimed at improving the basic health status in the region. The approach was 'household-centred', reaching households via community health promoters (CHPs) and health extension workers (HEWs). An important element of the approach was the construction of basic latrines and hygiene promotion. This was aimed at reducing incidences of bacterial diseases caused by direct contact with human faeces, for instance through non-washing of hands after toileting, and related water-borne diseases.

Within four years, the SNNPR BoH reported substantial percentage increases in latrine coverage. The efforts of the BoH from 2003 onwards, without major donor assistance programmes, have attracted considerable attention in Ethiopia and beyond, as they were reported as an important sanitation success story (WSP, 2007). Thus, the SNNPR case represents an interesting case study as improvement in hygiene and sanitation remained a low policy priority for many developing countries. Accordingly, the BoH sought the services of 'RiPPLE' to examine the policy and institutional factors that contribute to (or militate against) the success of the sanitation and hygiene (S&H) approach adopted by BoH in SNNPR from late 2002 onwards (called below the 'post–2003' approach). This was aimed at providing BoH in SNNPR with an overview of the progress made thus far with regards to the BoH approach, and more importantly, to draw key lessons from the findings. This report forms one of the three components of the SNNPR sanitation case study, with the other components being the technical and socio-cultural studies.

## 1.2 Research hypothesis (for the Case Study as a whole)

The central aim for this study was to examine whether or not, 'a broad based low cost technology and household focused approach to S&H promotion with supportive political and institutional environment has led to improved S&H coverage in SNNPR'.

## 1.3 Research objectives (for the Case Study as a whole)

The research objectives for the case study were defined as follows:

- To assess conditions and factors contributing to, or hindering, the success of the BoH approach of the Regional Bureau of Health of SNNPR in improving household S&H practices in rural communities;
- To learn from the contributing (and hindering) conditions and factors for most promising practices potentially to be scaled up/out in the SNNPR;
- To share these assessments/research findings with other regions and the federal level in Ethiopia, and more widely in the Nile region.

## 1.4 Research hypotheses for policy component of the study

The research hypothesis for this policy study was defined as follows: 'The success of the Sanitation policy implementation in SNNPR is attributed to the effective construction and 'messaging' of the

policy content, to the support of key figures and politicians from within the region during its implementation and to the set-up of effective institutions and sectoral integration within the regional government'.

## 1.5 Objectives of the policy study

The research objectives for this policy study were defined as follows:

**General**

- To assess policy and institutional factors that contributed to the uptake and relative success of the S&H policy implementation in SNNPR.

**Specific**

- To assess how policy content contributed to or affected the uptake and implementation of the sanitation policy (including formulation and communication of the content);
- To assess how major actors and stakeholders' influence affected the implementation of the sanitation policy;
- To assess how the policy context in SNNPR affected the implementation of the sanitation policy;
- To study the way in which policy communication and implementation contributed to the success (or limitation) of the policy implementation.

## 1.6 Research questions

> The overall research question for this policy study is: 'What were the content-, process-, actor-related and contextual factors that worked for, and against, the formulation and implementation of the post–2003 Bureau of Health policy for S&H in SNNPR, for latrine construction and hygiene promotion from regional to *Kebele* level?'

The Principal Research Questions are set out in Annex 1.

## 1.7 Research methodology

### 1.7.1 Research tools/methods

This paper examines the interrelations between actors, structures and context that lead to the S&H policy/strategies. Secondly, the paper examines the implementation process of the BoH approach in SNNPR. The analytical framework was adapted from previous work of ODI Research Fellow, Dr. Kent Buse (Buse K. et al (2007) based on Hill M. and Hupe P. (2002)) – see further in Annex 2.

A number of rapid research methods were used. Stakeholder analysis was carried out to map out the key actors, their positions and levels of influence. The study also carried out: (i) focus group discussions (FGD) to triangulate information about political dynamics; and (ii) in-depth semi-structured interviews with key stakeholders at the relevant administrative levels.

Key stakeholders identified were, namely:

- **Region level**; Health Bureau (BoH); Education Bureau (BoE); Water Bureau (BoWR); Finance Bureau (BoFED); Information and Agriculture Bureaus; and regional council;

- ***Woreda* level**; Health Officers; Education Officers, officers for 'Water Desk', and Finance and Economic Desk; *Woreda* cabinet head;
- ***Kebele*/PA level**; Health Extension Workers; Community Health Promoters, and other officers mentioned at *Woreda* level.

Semi-structured interviews were conducted with health, education and water bureau representatives at region and *Woreda* levels and finance and economic office, *Woreda* cabinet head and rural development office at *Woreda* levels. Health extension workers were also interviewed at *Kebele* level. FGDs were conducted with community health promoters at *Kebele* level.

# 2 Post–2003 sanitation and hygiene development in SNNPR

## 2.1 Pre–2003 sanitation and hygiene situation in SNNPR

Before 2003, SNNPR had one of the lowest S&H coverage levels in the country. For instance, latrine coverage was at 16% (BoH health ignition doc. No.8, 2006). The region's budget allocated to health was also the lowest in the country, only 0.4% of the budget was earmarked for S&H activities (Shiferaw, T/Mariam, 2003). S&H education coverage was hampered, partly by a lack of appropriate strategies for community education and mobilization (Shiferaw T/Mariam, 2003). The only way to reach people with S&H education was when they sought health services at health institutions. S&H communication was mainly conducted by volunteer community health agents, who were trained for three months. One volunteer was expected to reach 5,000 people in a *Kebele*.

Further, the approach to the provision of S&H services was service-driven. This led to an expectation, among households, for government incentives to improve S&H practices in rural communities. Consequently, household demand for S&H services was low (interview with BoH, 2007).

Table 2.1 gives a time-line of events and major developments on S&H at the national and regional level since 2000. The sections from 2.2–2.6 will provide commentary on the events listed in the table.

## 2.2 Triggering of a new S&H strategy (2003)

The post 2003 regional strategy of S&H was composed of a package of basic health development elements. The BoH new strategy was shaped by both internal and external factors. Internal factors centred on internal assessment and reviews made within the BoH in 2003. These reviews were critical of the insufficient attention paid to S&H issues in regional government's plans and budget, despite the emphasis made in national health policy. BoH reviews also decried the limited effectiveness of S&H education. Yet, a significant proportion of the disease burden in the region could be linked to poor S&H practices (Shiferaw T/Mariam, 2003), as were five main causes of morbidity (Interview with BoH, 2007). From the BoH reviews and assessments, it was suggested that there is need to develop a comprehensive community basic health education strategy that should reach people at village level.

To overcome funding problems on S&H, it was proposed that water and sanitation (WatSan) education must be combined with other public health education programs. The introduction of cost sharing between users and government/ service providers in service delivery was also suggested. Consequently, the suggestions led to the inclusion of WatSan indicators, as part of the standard *Woreda* development progress indicators (Shiferaw, 2003; Interview with BoH, 2007). Subsequently, a comprehensive document was developed, in 2003, for basic community health education, and became the first amongst a series of health 'ignition' documents (Interview with BoH, 2007).

Table 2.1: Timeline of activities in SNNPR and at the national level

| Time | National | Regional level |
|---|---|---|
| 1993 | Ethiopian National Health Policy | |
| 2000 | Public Health Proclamation<br>National Environmental Health Policy (draft), highlights latrine coverage & promotion and use of low-cost solutions | |
| 2001 | | CHP initiative supported by ESHE starts in late 2001 as a pilot project in 4 woredas; |
| 2003 | | • Assessment Report on health problems associated with WaSH written by Dr. Shiferaw in BoH<br>• A Region level review in BoH linked five top diseases in the region with poor community basic health awareness of which poor S&H practice has a major share<br>• Drafting of a comprehensive document for community basic health education and promotion which became the first health revitalization document<br>• Evaluation of the ESHE Pilot Project in 4 woredas – which was found to be a success<br>• Agreement reached to implement the CHP approach at scale by ESHE in its 20 operational woredas and by the BoH to the whole region<br>• Contractual performance agreement on basic health targets including latrine coverage started within the BoH line offices and woreda council<br>• UNICEF reviews integration of WASH in SNNPR with support from DFID.<br>• Regional Public Health Proclamation |
| 2004 | Health extension program was started | • BoH scales up the CHP approach throughout the region |
| 2005 | • National on site sanitation strategy developed<br>• National MoU signed between MoH, MoE, MoWR<br>• National WASH movement starts<br>• Health extension workers were deployed/started giving service | • MoU between UNICEF, BoFED, Water, Health and Education Bureaus is signed to collaborate on UNICEF supported projects<br>• First HEWs employed in the region<br>• Implementation of World Bank supported WaSH movement started<br>• PHAST approach introduced by UNICEF and training given to a large group of HEWs, teachers and sanitarians |
| 2006 | National Hygiene and On-Site Sanitation Protocol developed | • Regulation following the Regional Public Health Proclamation<br>• Regional MoU signed between Bureau of health, Bureau of Education and Bureau of Water Resources<br>• WaSH steering committee formed at region level<br>• 8th Ignition document discussing Water S&H |

External factors which led to the new BoH strategy are associated with the role USAID played in funding and promoting basic health, hygiene and sanitation practices in Ethiopia. Since 2001, USAID funded a project entitled, 'Essential Services for Health in Ethiopia' (ESHE), which promoted community basic health awareness. ESHE relied on volunteers selected from CHPs, who were then trained to communicate messages on simple doable actions on five key health basic health themes.

These health practices were, namely, sanitation (basic pit latrine construction, hand washing and safe water storage), immunization, family planning, malaria prevention and HIV AIDS. The ESHE project was piloted in four *Woredas* in the region including Mirab Abaya and Alaba. These two *Woredas* constitute the case studies for this study.

One year after implementation, the ESHE pilot project was viewed as a success. The S&H component, in particular, has been noted to be an 'instant win', with an easy 'buy-in'. From the package of basic health interventions promoted in the pilot *Woredas,* it was noted that it was easier to convince households to construct latrines and improve their S&H practices. This was observed to have led to higher latrine coverage during the pilot year (Interview with ESHE, 2007).

Following the evaluation, and in the process of looking for a new strategy to promote community basic health education and preparing its first health 'revitalisation' document, BoH decided to scale up the CHP approach region-wide. In the second half of 2003, ESHE approach was also scaled-up from 4 to 20 *Woredas* in the region (Interview with ESHE, 2007).

Thus, at the end of 2003, a new S&H approach/strategy was in development, informed by the SNNPR BoH internal reviews and assessments, as well as informed by experiences of the CHP initiative introduced by ESHE. The new BoH strategy marked a shift in approach, from a service-driven to a demand-driven approach. Emphasis was placed on raising awareness of communities on S&H. Once households were convinced of the importance of S&H facilities, it was expected that they would construct latrines on their own, using locally available materials. Hardware subsidies were abandoned. Households were expected to start from simple traditional pit latrines and upgrade them as their awareness of S&H, and economic status grew. Provision of construction materials, like slabs with reduced prices, was planned at a later stage, once demand had grown (Interview with BoH, 2007).

The mode of S&H education also changed. Active and direct house-to-house S&H education was promoted to reach people outside health service providing 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 of 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 their respective communities (Interview with BoH, 2007).

A multi-sectoral approach to basic health development was also outlined. All sectors were required to collaborate in communicating messages on basic health, including S&H, using their staff and organisational structures at community level. In the health sector, the *woreda* health office coordinated community health agents, CHPs and HEWs, working in health posts at *Kebele* and community level. These various health personnel located at different levels of health service structure were to raise awareness of S&H issues. In the education sector, teachers were used to pass S&H messages to students in schools. Similarly, teachers were also to promote S&H messages among adults during community gatherings. In the agricultural sector, *Woreda* agriculture and rural development offices coordinated 'Extension Agents' working at *Kebele* level to increase latrine construction and communicate S&H messages. *Kebele* chairperson supported community based health workers and passed S&H messages themselves to households through 'cell- structures'. At *woreda* level, the *woreda* council coordinated the activities of different sectors on the communication of S&H information (Interview with BoH, 2007) (See Figure 2.1).

## 2.3 Strategy design: Community mobilisation through health revitalisation documents and 'Cascading down' advocacy

At the onset, the implementation of the S&H strategy fell under a broader programme aimed at improving basic health services in the region. The broad programme was initiated, in 2003, by the regional BoH. Health 'revitalisation' documents were produced to engage government and non governmental organisations. The documents were intended to raise awareness, build consensus and mobilise support for basic health improvement initiatives. In other words, their principal function was to communicate ways of improving basic health services, sanitation and hygiene in local areas. The programme also included community on discussions of basic health.

Further, revitalisation documents also addressed various issues, such as basic health education and awareness, citizens' rights, accountability of health service institutions; and issues with political significance. Institutional issues covered by the revitalisation documents entailed, inter alia, financing and management of the sector, ongoing civil service reform[1], and performance in implementation of five year strategies. Box 2.1 below provides a summary of the main focus of the various revitalisation documents.

### Box 2.1: Main focus of BoH revitalisation and ignition documents

Health Revitalization Doc No.1, (Date N.A, probably around early 2003) – Discussed the prevention directed Nation Health Policy; prevention and control of diseases like TB, Malaria, HIV AIDS, personal hygiene and environmental health, Immunization and family planning; activities of health posts and centres; harmful traditional practices and community participation to improve basic health.

Health Revitalization Doc No.2, (Date N.A, probably around late 2003) – Discussed the National health policy strategy direction and implementation; the quality of service level in government owned health service providing institutions, evaluation of their human resources and financial management; decentralized health service delivery and citizens' participation; civil service reforms in the health sector.

Health Revitalization Doc No.3,(Date N.A, probably around early 2004) – Discussed revitalization of health service providing professionals; igniting a community movement for health development; civil service reform program; improving the governance and provision of health services.

Health Revitalization Doc No.4, (Aug, 2004) – Discussed expanding health posts and health centres; implementation of the HEP; civil service reform implementation; improving M&E systems.

Health Revitalization Doc No.6, (Sep, 2005) – Discussed progress made in the implementation of the first and second five-year strategies; targets in the third five-year health strategy; gaps seen in the health sector strategy implementation; achieving MDGs.

Water, Hygiene and Sanitation Ignition Doc No.8, (Nov, 2006) – Discussed the regional S&H situation; progress made in improving S&H, Gaps seen in implementation and future directions.

It is apparent from Box 2.1 above that S&H promotion occupied an important place in the revitalisation documents. The first health revitalisation document raised awareness about S&H along with other basic health issues. It recalled the regional Public Health Proclamation (described further

[1] The civil service reforms discussed in the health ignition documents were part of a National Civil Service reform which aim to improve government service delivery by promoting transparency, accountability to citizens/ users, reducing bureaucracy and improving leadership through participatory planning and result based management. It also aims to improve the human resource management in civil service, employing a merit system and measures to improve the ethics of civil servants/ health professionals as well as efficient management of resources.

in section 2.7 below) and reiterated that the failure to construct sanitation facilities and facilities for disposal of hazardous solid and liquid waste would be punishable by law.

The 8th health ignition document, compiled in 2006, also reviewed the progress made on S&H since the initiation of the strategy in 2003. Gaps in the implementation of the health strategy were identified. More importantly, the 8th Health Ignition Document set a future direction for the strategy. This will be discussed in detail in the forthcoming sections.

The ignition documents outlined a multi-sector strategy to support the movement for basic health. There was consensus that health staff alone would not be able to reach all rural households with the necessary health messages. In view of this, it emerged that putting the health strategy into effect 'on the ground' would require collaboration with other sectors. Suggestions were, therefore, made to mobilise staff from other government sectors, and existing local government structures at community level, like *Kebele*s and Cells, to communicate messages on basic health and sanitation.

## 2.4 Launch of the new S&H strategy

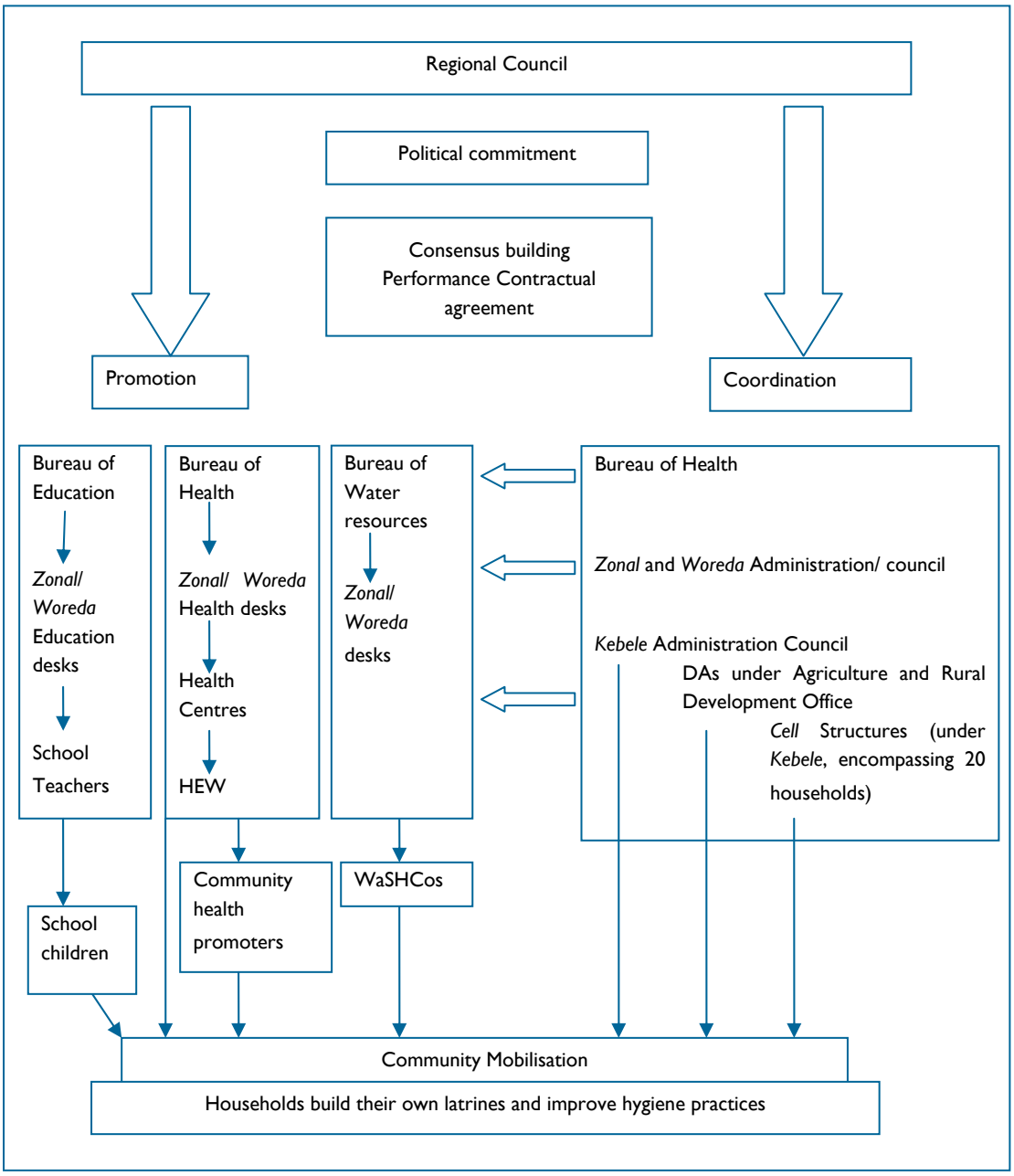
The core proposal of integrating S&H component within a wider basic health education package, that emphasised prevention of diseases, and communicating the information through the different levels of government (i.e. regional, *woreda* and *Kebele)* in SNNPR, was presented to the Regional Cabinet by Dr Schiferaw, the Head of BoH at the time. Essentially, the proposal was based on revitalisation and ignition documents and called for 'cascading advocacy'. The system of 'cascading' advocacy is illustrated in Figure 2.1. The BoH proposal was approved by the Regional Cabinet. Refer to section 3 for a detailed discussion for the reasons that led to the adoption of the proposal.

What is important to note at this juncture is that, the health revitalization documents were first discussed internally in BoH, at Zone, *Woreda* and *Kebele* levels. The health sector led the discussions and the advocacy to build a consensus. Other sector staff and NGOs participated in the discussions at each level. At *Woreda* level, the *Woreda* Council took particular responsibility with the health office to communicate the messages contained in the revitalization documents down to *Kebele* level. *Woreda* Councils also coordinated other sectors encouraging them to communicate the S&H messages to local communities. At *Kebele* level, the *Kebele* council played an important role in communicating and raising awareness on S&H issues within their respective communities. Workshops and public gatherings were used at all levels to discuss the revitalisation documents.

Other sectors also took responsibility in 'cascading' the revitalization documents down to community level. These mainly included the Agriculture and Rural Development office, via its Extension Development Agents (DAs), and the Education Office, through the use of school teachers (Interview with agriculture and rural development and education offices in Mirab Abaya and Alaba, 2007).

In 2003, the signing of contractual agreements on performance levels commenced. Within the line offices of the health administration, agreements were signed between BoH, Zonal and *Woreda* health offices, health centres and health posts. The agreements set performance targets for coverage of latrines and other basic health services. The *Woreda* councils signed agreements with the Zonal or regional health office to take the responsibility for increasing coverage levels of basic health and sanitation services. The Agriculture and Rural Development office also started assigning quotas on the number of latrines that were to be constructed per year to its *Woreda* offices (Interview with BoH; Alaba *Woreda* health office; Alaba *Woreda* Agriculture and Rural Development office, 2007).

Figure 2.1: Different levels and actors involved in 'cascading' advocacy on S&H




## 2.5 S&H Promotion via 'Community Health Promoters'

Starting from 2003, the CHP approach, introduced by ESHE, was adopted by the BoH. In essence, the CHP approach sought to promote community basic health awareness using voluntary health promoters (VHPs) selected from the community. VHPs were also referred to as CHPs.[2] Selection of VHPs was conducted by the community in which VHPs were to serve. Criteria used for selection was based on the following factors: a 50% of VHPs must be women; openness to change; and ability to communicate S&H messages in a considerate and respectful way. One health promoter is selected

[2] The terms voluntary health promoters (VHPs) and community health promoters (CHPs) is used interchangeably in this report.

to serve 50-60 households. The health promoters received training for a time ranging from two to seven days. A refresher course is held once per year.

The region-wide application of CHPs 'at scale' (as compared with a staged scaling-up) was begun despite reservations from some within the BoH and its partner NGOs as well as donors including USAID/ESHE. The reservations of some emanated from lack of optimism about the ability to see quick results through the disease-prevention directed S&H approach; also there were some doubts as to the ability of the approach to make an impact on disease burden of the region. Others, especially donors and NGOs, were not enthusiastic about the association of the CHP approach with the government campaigning through the health revitalization documents, which they saw as being largely politically-driven, in the run up to the 2005 election.

The CHP approach received support from the Regional Office of the BoH (Interview with ESHE, 2007), and then applied across the SNNPR region. This was in parallel with community mobilization campaigns, and discussions on the health revitalization documents. The region-wide application of CHPs was carried out despite reservations from some members of BoH, partner NGOs and donors such as USAID/ESHE. The reservations emanated partly from the perceived inability of the S&H approach to result in significant prevention of diseases within a short period of time. Donors and NGOs failed to appear enthusiastic about the region-wide scale up by the government, raising concerns about quality of implementation when the approach was replicated at a larger scale and at once. They preferred a stage by stage approach of implementation. Some NGOs were also of the opinion that the BoH's 'movement for basic health' was being used by the ruling political party to garner political support in the run-up to the 2005 election to the extent that the link between the CHP approach and the health revitalisation documents was increasingly viewed as politically-driven.

Despite their reservations, NGOs played a key role in the training and deploying of CHPs. The CHPs worked in close collaboration with *Kebele* Chairpersons and HEWs. CHPs were supervised by HEWs who held review meetings twice a month. The CHPs also signed contractual agreements setting out the basic health targets which they were required to reach in collaboration with the HEWs.

## 2.6 S&H promotion in Health Extension Program

Since 2004, the S&H strategy promotion in SNNPR was subsumed in the implementation of the national Health Extension Package/Programme (HEP). The characteristics of the HEP are outlined in Box 2.2.

### Box 2.2: Characteristics of the Health Extension Programme

The Health Extension Package is a national level health strategy that is aimed at improving access and equity in the prevention of diseases. HEP also seeks to promote essential interventions through community/*Kebele*-based health services. It was implemented in 2004 in SNNPR, and in Ethiopia, in general. Initially, the first pilot health extension workers started their service in 2004 and the program was extended nationally from 2005 onwards. HEP has 16 primary health extension packages, of which 7 deal with environmental health hygiene and sanitation. Health extension workers (HEW) were recruited from each locality and trained for a year to implement the 16 primary health extension packages in rural *Kebele*s. Initially, one health extension worker was recruited from each *Kebele* and their numbers are being raised to two for each *Kebele* in 2007/08 (HEP implementation guideline, 2004).

The HEP was significant in that it served to institutionalise the movement for improvement of basic health, including S&H, which was initiated in 2003. The deployment of trained HEWs in each *Kebele* raised the level of communication on S&H education, including construction of latrines.

HEWs started work with a baseline survey on existing status of basic health services and latrine coverage in each household. In addition, HEWs prepared action plans and prioritized their work in response to survey results. They reached households in S&H education by selecting and training model households, conducting house to house visits, organising community conversation dialogues and encouraging people to obtain health services from health posts.

The HEWs worked in collaboration with the *Kebele* chairperson and other *Kebele* cabinet members. In some areas, the *Kebele* leaders linked latrine construction with safety net programs[3] to the extent that households included in the program also built latrines as part of program activities. *Kebele* chairpersons and cabinet members also linked HEWs with Cell[4] leaders at sub Kebele level. The HEWs benefited immensely from the collaboration of *Kebele* chairpersons and Cell leaders, and used such linkages to influence households on access to health services (Interview with HEWs in Alaba and Mirab Abaya, 2007).

HEWs held bi-weekly review meetings with CHPs to assess progress in *Kebeles*. They also submitted reports, held review and reflection meetings at *Woreda* level with the *Woreda* health officers. These meetings were held once a month. Also, HEWs signed minimum performance level agreements with the *Woreda* health officer, defining targets for the coverage of health issues, particularly latrine coverage (Interview with HEWs in Alaba and Mirab Abaya, 2007).

## 2.7 Institutionalisation of the strategy

The implementation of the HEP marked the beginning of institutionalization of the movement to improve S&H in SNNPR. This had already been launched as a policy – because of the emphasis given to S&H in the HEP.

In parallel, other regional and national developments in the health sector also contributed to the institutionalization process. The five different developments and processes are cited below.

### 2.7.1 Regional public health proclamation and regulation

In 2004, a public health proclamation was issued in SNNPR which stipulated that the disposal of solid and liquid waste in a hazardous manner by households and organisations would be subject to punishment. The proclamation went on to state that, legal actions would be taken against households and organisations not possessing sanitation facilities (Regional Health Proclamation, 2004). A public

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[3] Productive safety net program is part of the government food security program that tries to address basic food needs of chronically food insecure households in food insecure *woredas* through multi-year financed safety net systems that help to prevent household asset depletion and create assets at community level. The program has labour intensive public works component where targeted households get paid to contribute labour to implement basic public work activities such as; improving land productivity and soil fertility restoration, improving market infrastructure, improving schools an health facilities, improving access to drinking and irrigation water etc. Activities involve, also, building water supply schemes like springs and shallow wells and latrine construction.
The planning and implementation of the program involves institutions like Ministry of Agriculture and Rural Development, Federal Food Security Coordination Bureau, Disaster Prevention and Preparedness Agency, Ministry of Finance and Economic Development and their line offices at region and *Woreda* levels. At *Kebele* level the *Kebele* council/cabinet identifies and approves safety net beneficiaries and activities for safety net purposes (Productive Safety Net Program Implementation Manual, Version 2; GoFEDRE, MoARD; March 2006).

[4] A 'cell' is a collection of 20 households that are located at sub *Kebele* level, which is partly organised to communicate government policies downwards as well as mobilising community resources.

health regulation was also issued in 2006 which outlined the establishment of coordinating organs at Region, Zone, *Woreda* and *Kebele* levels. The proclamation was not supported by by-laws. To this end, and from an enforcement perspective, there was no uniform application of sanctions on non complying households. At *Kebele* level, officials frequently used threats of fine and imprisonment to households which did not have sanitation facilities (Interview with CHPs and HEW in Alaba and Mirab Abaya, 2007). However, only in few cases did *Kebele* officials actually fined households without sanitation facilities (ibid.). Consequently, there existed an uneven application of sanctions, and a weak system for legal enforcement to support household construction of sanitation facilities.

### 2.7.2 MoU between BoH, BoWR and BoE

Another development in 2006 was the signing of a Memorandum of Understanding (MoU) between the BoH, BoWR and BoE. The MoU declared that planning of WatSan services and hygiene education was to be undertaken in an integrated manner in communities, health institutions and schools. The MoU was also expected to resolve the long-standing competition between water and health sectors over the delivery of rural water supply and sanitation. Added to this, the MoU was aimed at clarifying roles and responsibilities between the concerned bureaus.

However, officials interviewed for this study observed that the implementation of the MoU and integration of sectors has been achieved only to a limited extent. Staff from the three sectors at *Woreda* level, reported a lack of awareness of the MoU and the different logistics and budgets available to the sectors. It appears that each sector has its different priorities. As such, there exists a lack of detailed guidelines for integration and a coordinating body. This state of affairs was seen as problematic. Interviewees reported that some integration does take place where NGOs and donors followed an integrated approach in allocating budget to the different bureaus. UNICEF and the World Bank-financed WaSH program were cited as cases in point (Interview with Water, Education and Health offices in Mirab Abaya and Alaba, 2007).

### 2.7.3 World Bank-financed WaSH program

The WaSH program which started in 2005 in SNNPR, which was initially financed by the World Bank, has been vital in the institutionalisation process for integrated delivery of S&H services between BoH, BoWR and BoE. The integration of services added value to S&H education to the extent that integration of services is becoming common by donors in the sector. The WaSH approach to S&H, as interpreted in SNNPR, is similar to the BoH strategy, focusing on promoting a no-hardware subsidy approach to household latrine construction. Similarly, the WaSH program pays particular attention to software aspects of community education and raising awareness. The WaSH approach supports construction of demonstration latrines in schools and health institutions – which is also part of the national S&H strategy. It proposes to organize and use the WaSH committees (WaSH Cos), the organized community institutions to manage rural water supply services and to train communities on S&H.[5]

However, the impact of the WaSH program is likely to be limited due to its limited coverage. Out of 105 *Woredas* in the region, the WaSH program was implemented in 36 *Woredas* financed by the World Bank, and in 24 *woredas* financed by the African Development Bank (ADB). In each *Woreda*,

[5] The household survey results in this study indicate the added value of the WaSH program over the Regional S&H strategy. Households from the three sample *Kebeles* in *Mirab Abaya*, where the WaSH program is being implemented show a slightly better awareness and practice on S&H compared to households in *Alaba. (see 'Report of Technological and Socio-Cultural factors affecting implementation of S&H strategy'; RiPPLE, February 2008.*

the program was implemented in few selected *Kebele*s. In Mirab Abaya the program was implemented in 6 *Kebele*s of the *Woreda* out of the 25. And within the six *Kebele*s, only one third of the population is served. An official also pointed out that, only 20% of the population in the *Woreda* was covered by the program (Interview with Mirab Abaya Health office, 2007).

### 2.7.4 Introduction of the PHAST approach

Another development on S&H has been the incorporation of the Participatory Hygiene and Sanitation Transformation ('PHAST') approach into the regional S&H strategy. This was aimed at strengthening the hygiene education component. The development emanated from the reviews made in 2005 by UNICEF and BoH, on the strategy implementation. The reviews indicated that although there was a strong political commitment to improved education, and that 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).

### 2.7.5 SNNPR experience feeds into National Strategy and Protocol

The post–2003 approach of the BoH in SNNPR, and the experiences of promoting S&H in that region, have subsequently become incorporated into the national sector strategies. The 'National Onsite S&H strategy of 2005' states that, the pillars outlined to achieve 100% coverage and ingredients identified for achieving that have drawn on the experiences in SNNPR and other (localised) success stories in other regions of Ethiopia. The SNNPR experience was applauded as providing an approach for increasing coverage substantially without major external assistance, through strong political leadership and utilization of local resources. The political commitment seen in allocation of budget to S&H, inter-sectoral collaboration and the 'cascading' advocacy employing elected leaders and civil servants, as well as the system of accountability created, were taken as important learning points (National on Site Sanitation and Hygiene strategy, 2005).

Informed by the SNNPR experience, the first pillar of the National Strategy, designed to establish an enabling framework, listed minimum performance contractual agreements and inter-sectoral collaboration – using other sectors' structures and staff from region down to *Kebele* level. The use of CHPs and HEWs in combination as a system of S&H promotion was also outlined under the second pillar of the strategy.

Similarly, the SNNPR experience has informed the development of the National On-Site Hygiene and Sanitation Protocol issued in 2006. The second among the eight steps outlined in the Protocol to improve S&H is 'cascading advocacy' and consensus building among politicians and technocrats from region to village and household level. The Protocol suggested that, regions should prepare cascading advocacy packages in the style of the SNNPR ignition documents. The SNNPR ignition documents were commended for linking improved hygiene and sanitation with poverty reduction and the achievement of the MDGs. The Protocol also adopted performance related contracts used in SNNPR and suggested that other regions could use similar agreements to develop an accountability from Region down to *Kebele* level. As in the SNNPR strategy, the Protocol supported households starting with minimum standard basic latrines so that all households could have options for up-grading (National On Site Sanitation and Hygiene Protocol, 2006).

# 3 Factors affecting formulation and implementation of the policy

This section addresses the research question posed by this study, namely: what were the content-, process-, actor-related and contextual factors which contributed, positively and negatively, to the formulation and implementation of the post–2003 BoH policy for S&H in SNNPR? Particular attention is paid to latrine construction and hygiene promotion from regional to *Kebele* level.

## 3.1 The policy content

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 SNNPR BoH was nowhere described in detail in accordance with the conventional manner of documenting a policy strategy. The health 'ignition' and 'revitalisation' documents prepared by the BoH and the verbal statements made by its representatives refer to the following key elements:

- 'Low cost': increasing coverage using local resources, without relying heavily on external support. This included removing hardware subsidies to latrine construction and encouraging construction of latrines from locally available materials;
- 'Broad-based' and 'household-centred': shifting from a service driven to a demand driven approach across the region. This required more focus on S&H education reaching people at village level. It included changing the features of S&H education from health institution-centred to household-centred, and using interactive dialogue based methods of communication.

The manner of formulating the BoH policy in general terms allowed flexibility: the BoH approach continually evolved, incorporating within it new initiatives that came from the region and national level as they were piloted and considered successful. The adoption of the ESHE pilot using health promoters selected from the community, the CHPs, within the BoH policy, is a case in point .

At the same time, the S&H policy, as outlined by the SNNPR BoH, did not conflict with the existing policies at a federal level, the Ethiopia National Health Policy of 1993. The1993 policy had identified environmental health as one priority area. The S&H strategies proposed in 2003 by the SNNPR BoH, for instance, the use of informal community structures for S&H education, were in line with the national health policy strategies, to the extent that they applied to promotion of S&H. Thus the BoH could argue that, its new S&H approach found a strong base in existing policy documents and fitted within the existing policy. The BoH approach was, in other words, sufficiently aligned with the federal policy as to be implemented at regional level.

When communicated to the regional cabinet, 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 bureau heads and other high-level politicians at regional level. Such an approach was aimed at winning their backing and endorsement of the BoH approach. As noted above, the S&H strategy was incorporated as part of a range of basic health improvement interventions and the messages accompanying the policy, relating to rights to basic health, participation in health service decision making, accountability of health service providing institutions to the people, seemed to have added to the attractiveness of the package. In addition, the timing of

communication of the policy coincided with elections. This will be discussed in the forthcoming section.

The health ignition documents reflected political considerations. They read more as communication rather than technical documents. As communication documents, the health ignition documents were aimed at inspiring, persuading and mobilizing politicians, civil servants and other actors around the importance of improving health service delivery. The communication objective was further strengthened by the use of Amharic, expressing the S&H message in layman's terms, rather than technocratic jargon.

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 a two-day training session for CHPs. Implementation mainly relied on household's own resource: in technical terms, the policy of promoting the construction of basic-pit latrines using local materials. This did not pose insurmountable technological problems. The traditional pit latrine (TPL) was a technology that could be made available in rural communities.

The BoH approach was also administratively feasible in that, it relied, essentially, on existing government administrative structures and human resources, mainly, staff of sector offices at *Kebele* level and on the *Kebele* chairmen themselves. An additional element was the CHPs, one deployed for every fifty household. The use of existing government administrative structures otherwise ruled out the need to set up new administrative structures for the programme. Also, the approach included a multi-sector strategy to communicate S&H messages and to mobilise people.

In summary, the following are seen to have been the important features of the BoH policy, in terms of its content, which contributed to its successful launch:

- the BoH policy was formulated in such a way as to be **politically attractive**: the way S&H was packaged with other basic health components and linked to wider sector issues, along with the timing of production of the documents, enhanced the appeal to regional politicians and particularly helped it to be endorsed by the regional cabinet;
- the BoH approach was **policy-aligned**: in harmony with existing policy documents: the 1993 health policy, and the 2000 public health proclamation;
- the key elements of the policy were expressed in brief and general terms which allowed for **flexibility** in their development;
- because the approach was low-cost, it was **financially feasible**;
- by using very largely existing government structures, the design of the approach increased its **administrative feasibility**;
- the approach was technically feasible, making sanitation simple and affordable for households (Refer also to the technical study report).

## 3.2 The policy context

### 3.2.1 Triggering events and international flow of ideas and finance

A number of contextual factors combined to support the launch and implementation of the S&H policy. The Head of the BoH and his team of senior BoH colleagues drew upon these favourable

contextual factors to their advantage as will be illustrated on the forthcoming section on the role of key actors.

A key first step to placing the new policy on the agenda was the assessment report written by the BoH in 2003. This document identified a mis-match between policy and practice pertaining to the promotion of S&H. The paper indicated that the importance given to S&H in policy documents was not reflected in the budget allocation and activities of the health sector. Also, in 2003, the internal review of BoH linked poor S&H status with increased disease burden, highlighting that major causes of morbidity are actually preventable, if community awareness is increased.

As well as bringing these issues to attention (both revelations were not new), the BoH assessment paper and review proposed strategies by way of response. The assessment paper suggested integrating WatSan education with other public health programs, strengthening S&H education to reach people at village level, and community mobilisation using simple hygiene messages. The review emphasised the need to develop a good strategy for community health education and promotion. These suggestions were incorporated in the newly developed S&H approach for the region.

A second contextual feature was the timing of the development and communication of the first ignition documents in the late 2003 and 2004. This coincided with rallies for the 2005 national election. Undoubtedly, the political campaigns contributed to the endorsement of the policy by the regional cabinet. Put differently, S&H issues formed part of the issues raised during political campaigns, thus lending political support to S&H issues. The way the S&H approach was packaged was in line with the political need of the ruling party to solicit public support: by igniting a movement for improved basic health service delivery.

Thirdly, there was an increasing recognition of the success of the piloting of the CHP approach introduced by ESHE, and especially the S&H component of the approach, which provided the tool required for achieving 'outreach' of the BoH approach. The CHP approach was thus opportunistically adopted by the Head of the BoH and his team.

The ESHE pilot was introduced in 2001, and that could have influenced the BoH in its writing of both the assessment and internal review reports. This assertion hinges on the fact that some of the forward actions suggested in the assessment report reflected the CHP strategy.

Once the S&H policy was launched, several factors helped to keep S&H issue on the political agenda of the regional government. These include, inter alia:-

- the initiation in 2004 of the national HEP, which reinforced the focus on environmental health. To reiterate, 7 of its 16 extension packages were dedicated to environmental health issues. Further, the push made by UNICEF and other donors at the national level towards sector integration on S&H delivery led to signing of a MoU relating to inter-sectoral collaboration in implementation of WatSan services. Such developments highlighted the need for cross-governmental action.
- the implementation of WaSH programs in selected *Kebele*s, supported by the World Bank and ADB and the formation of steering committees from various sector offices for WaSH implementation, backed by the civil society, the WaSH movement, in particular, has kept S&H on the government agenda. This has also provided an additional lever for multi-sector collaboration;

- the recurrent outbreak of acute watery diarrhoea (AWD). Following the outbreak of the AWD epidemic, there was some inter-sectoral collaboration in an effort to contain it. For example, the epidemic led the BoWR to employ more Sanitarians. The AWD outbreak also saw the revival of WaSH steering committees that involved the health, water, education and finance sectors as well as major donors on S&H.

## 3.3 The policy process and key actors

### 3.3.1 Agenda setting and formulation

The presence of political leadership with the Head of the BoH to champion the new policy approach was crucial in bringing all the different factors together. Dr. Schiferaw combined technical knowledge of preventative health, based on his background as a health professional, with political and communication skills. He also had good leadership skills and the ability to motivate those working under him, according to his former staff in BoH. During the implementation phase, he played a role in coordinating other sectors within the cabinet on S&H promotion and within the health bureau.

The Head of the BoH was supported by senior officials in the BoH Department of Disease Prevention and Control, who discussed and helped develop the S&H strategy and contributed to preparation of the health revitalisation and ignition documents. Also, discussions on health revitalisation and ignition documents were conducted more widely within the health sector and with other sectors and civil society organisations. The discussions were particularly geared towards communicating the strategies, rather than consultations on the content of the strategy itself.

As noted above, the S&H strategy as proposed by the BoH needed the support of the regional cabinet for it to be approved and then implemented. The Head of the BoH was a member of the cabinet as well as being a member of the ruling party. He initiated the strategy, brought it to the cabinet's attention. The cabinet endorsed the health ignition documents after discussing them. Dr Schiferaw obtained the general agreement among cabinet members. As discussed above, the manner in which the S&H policy was formulated contributed to its successful implementation and general acceptance. Central to this was the fact that the S&H policy had few policy elements, which were expressed in general terms and politically-attractive terms. In addition, the S&H was packaged as part of a basic health education program for all citizens.

The approval of the cabinet comprising heads of bureaus 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) for implementation. This was coupled by the cabinet's regional public health regulation issued in 2006.

In a country with a high aid dependency, the BoH policy was striking for being regionally-inspired and internationally supported, rather than driven by donors. The flow of ideas and finance from international sources, such as the CHP approach (an experience taken by USAID from Madagascar) and, later, PHAST including the financial and technical support by UNICEF for the training of a large number of 'frontline' health workers. In addition, international NGOs which financially supported the implementation of the S&H approach, through the training CHPs, were not central in driving the S&H approach.

The donors have, however, provided crucial funding for the S&H policy. In other words, despite the BoH approach being relatively 'low-cost', the implementation of the BoH approach was made successful by the presence of external sources of finance.

It is important to note, however, that donor representatives were also cautious about the approach outlined in the health ignition documents. They were concerned that adopting the 'broad-based' approach of the BoH, that is, implementing the S&H as an approach region-wide, was rather ambitious. As such, donors were not optimistic that the campaign-type community mobilisation and 'movement for basic health' would have 'high impact' results as forecast by the BoH. They also had reservations about the issues with which the basic health messages were being packaged in the ignition document which they perceived as being politically driven.

### 3.3.2 Process of implementation

#### *3.3.2.1 Effectiveness of communication channels and mobilisation systems*

##### A. Health revitalisation documents and channels outside the health sector

The S&H communication strategy from region down to *Kebele* level, through discussions on health ignition documents, had many advantages. Using existing government administrative structures reduced the cost of communication and mobilisation, and enabled information on S&H to reach a wider number of households in rural areas. This was mainly because all sector line staff and facilities used for outreach activities were located at local and community level. The 'cascading' advocacy involved civil servants, politicians and civil society groups which was vital in popularising the strategy as well as building consensus across a wide range of actors. This raised the momentum for implementing the strategy, and later created a conducive, environment in which 'frontline' HEWs and CHPs operated. The regional political approval given to the strategy, and transmission down to *Woreda* and *Kebele* levels, meant that *Kebele* leaders supported 'frontline health staff' in different ways, such as linking HEWs with Cell leaders. In addition, *Kebele* leaders linked S&H implementation with safety net programs. Mobilisation meetings around health ignition documents held at Woreda level between *Woreda* councillors and other actors were used to persuade *Woreda* level government officials. Such meetings were supported by the Regional council. The *Woreda* government officials in turn convened meetings with *Kebele*s and applied some political push to involve *Kebele* level officials into supporting the implementation of the strategy.

Despite the opening of channels of communication for the S&H campaign, the persons consulted during the course of this study were critical of the content of the S&H message as it reached household level. They argued that the focus was more on increasing coverage and little attention was given on promoting the utilisation of sanitation and health facilities, specifically the traditional pit latrine. With reference to pit latrines, it was stated that there was a lack of technical support to households in the construction of usable latrines. Added to this, critics noted that insufficient attention was paid to promoting behavioural change. To illustrate the point above, a health extension worker in Galeto Alaba reported that, when she was employed in the *Kebele*, open pits were dug in each household as a result of orders from the *Kebele*. However, the pits were dug far away from houses and they were not used by households. It was stated that only six households in the *Kebele* actually used the latrines.

More importantly, the health worker in Galeto Alaba mentioned that none of the CHPs in the *Kebele* had constructed latrines. Similarly, a staff in Agriculture and Rural development office in Alaba, whose desk has always been involved in teaching households about S&H, including latrine construction, stated that they were assigned large quotas to raise latrine coverage in 2003. Consequently, the

Agricultural and Rural Development office focused more on fulfilling the quotas than on behavioural change or encouraging utilisation of traditional pit latrines. By extension, most of the latrines constructed during the 2003 period were not used due to the fact that they were poorly constructed or the households did not understand the need for them (rural women's desk in Alaba). A UNICEF representative in SNNPR also claimed that, during the first period of mobilisation, most of the latrines were constructed in the absence of proper supervision and many had negative experiences (Getachew, UNICEF, SNNPR).[6]

Regarding the roles of different non-health sector actors, apart from the *Kebele*, others did not come out as significant contributors at community level. *Kebele* chairpersons took the responsibility for S&H communication from *Woredas,* and thus created conducive conditions for CHPs and HEWs to implement the S&H approach. Kebele chairpersons were also responsible for relaying S&H messages. A survey of two *Woredas* indicated that 25% of the households first heard about S&H messages from the *Kebele*. The *Kebele*'s role also included convincing and enforcing sanctions on households to comply with the building of latrines. In contrast, the findings from the same survey showed that other agents like WaSHCos and DAs were not significant agents in communicating S&H messages in the survey.[7]

### B. Communication through CHPs and HEWs

The regions' S&H strategy was communicated and implemented by CHPs and HEWs. Since 2003, CHPs were continuously trained in large numbers to pass messages on simple and doable actions. From 2005 onwards, HEWs also assumed an important role in S&H strategy communication as the health extension package – a national program – gave a lot of emphasis to S&H. Both HEWs and CHPs played a major role for S&H communication at community level, followed by *Kebele*s. Respondents in the household survey in Mirab Abaya and Alaba reported that 35% heard the S&H messages from CHPs and 31% from HEWs.

CHPs and HEWs were central to the success of the strategy in various ways. Firstly, the CHPs significantly raised the number of community level communicators from the previous one community health agent for 2000 households in a *Kebele* to between12 and 28 CHPS. In other words, there was one CHP for about 50 households. This made it easier for CHPs to reach a wide number of households within a community.

Secondly, CHPs were selected members of the community, and thus had easy access to households where there were already accepted. Thus, it was easy for CHPs to communicate S&H message. Related to this is the fact that the message was also easily accepted by members of their respective communities. This was in stark contrast to community health agents, who passed on the S&H messages to people who would have visited health institutions. Thirdly, the training of CHPs for S&H

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[6] The assertion that the first channel of communication and mobilization campaigns, especially those that used channels outside the health sector, although, have done a lot to popularize the strategy and raise political support, they were not significant in leading to construction of latrines utilized by households is supported by findings of household survey results. Increased latrine construction by households for the first time is witnessed particularly at the later stages around 2005 when HEWs were deployed. In the early stages of mobilization campaign between 2003-2005, the rate of construction of latrines by households was low.*(see 'Report of Technological and Socio-Cultural factors affecting implementation of S&H strategy'; RiPPLE, February 2008).*

[7] Household survey results showed some association between agents of S&H communicators and households' trend of utilizing the first latrines they constructed. The percentage of households who constructed latrines failed to use them after receiving S&H messages from *Kebele*s and DAs is higher than percentage of households who received S&H messages from CHPs and HEWs, constructed latrines and failed to use them. *(see 'Report of Technological and Socio-Cultural factors affecting implementation of S&H strategy'; RiPPLE, February 2008).*

message communication was least expensive as they are not paid. More importantly, their work is subsidized. The public recognition of CHPs was viewed as an incentive for their motivation.

With reference to the health extension workers, they were viewed as the main 'frontline' health workers. The HEWs were instrumental in institutionalising the campaign type of community mobilisation for the S&H approach. HEWs were also important in bringing technical input into the S&H strategy implementation. In addition, they contributed in improving S&H education and message communication. HEWs supervised the construction of latrines, gave technical advise, and corrected quality problems raised during the first phase of the S&H strategy implementation.

With regards to the latter, a health extension worker interviewed for this study, in Galeto Alaba, noted that;

> "*In this Kebele, pits constructed in the first campaigns for latrine construction, were far from the houses – more than the prescribed 6 meters distance. They were also open pits which were not usable or used. They served as mosquito breeding ground and there was, high malaria prevalence in the Kebele. The first thing I did when I started work was to order those pits to be filled. Afterwards I raised the awareness of people on how to build proper latrines*"

HEWs were successful in communicating the S&H strategy, and in increasing latrine coverage. This was attributed to different factors. These include large numbers of HEWs per *kebele*. More concretely, HEWs were supported by between 12 and 25 S&H communicators (12–25 CHPs) in one *Kebele*, which reached and extended supportive supervision to wider households in a *Kebele*. The consultation workshops and discussions on the strategy via health ignition document discussions created political support and built momentum that provided a favourable environment for HEWs to communicate S&H messages to households. The *Kebele* cabinet organised different community education programs together with the HEWs. *Kebele* chairpersons often linked safety net programs with latrine construction, organising households encompassed in safety net programs to build latrines. The HEWs also often relied on the authority of *Kebele* chairpersons and influence of Cell leaders to convince households to build latrines.

Therefore, the achievements of HEWs in the S&H communication was due to the combination of the HEP strategy with the CHP approach, and more importantly, to mass mobilisation and consensus building campaigns.

#### *3.3.2.2 Response of implementing staff*

The S&H strategy implementation has involved several actors from Region down to *Woreda* and *Kebele* levels. At the regional level, the disease prevention and control team in BoH led some consultation and discussion forums on the S&H strategy and ignition documents with other government sector offices and NGOs. BoH also led the cascading down of the ignition document into different Zones and *Woredas*. In addition, BoH was responsible for the monitoring and evaluation of the implementation of the strategy.

Other sector offices like Bureau of Water Resources (BoWR), Bureau of Education (BoE), Bureau of Agriculture and Rural Development (BoARD) shared ideas on the health ignition documents. The aforementioned organisations communicated S&H message through their line offices at *Woreda* and *Kebele* level. BoARD used Development Agents at *Kebele* level, while BoWR utilised community based institutions managing water supply systems (WaSH Cos) through its office at *Woreda* level.

Teachers constituted the chief means of communicating S&H messages to communities, within the BoE framework.

At the beginning of the S&H strategy implementation some sectors like Agriculture and Rural Development played active roles, assigning large quotas for latrine coverage to their *Woreda* offices and DAs. Other sectors including the *Woreda* council have also taken active roles in campaigning and advocacy at community level. However, the role of other sectors was significantly reduced after 2005i.e after the end of the national elections period, which could reflect reduced pressure from the regional cabinet to implement the strategy. To explain their reduced role, some officials from the Agriculture and Rural Development offices in Alaba and Mirab Abaya, stated that they held a mandate analysis around 2005 and identified that S&H communication was/ is not their mandate (Interview with Agriculture and Rural Development offices in Alaba and Mirab Abaya, 2007).

Within the health sector, HEWs supported by CHPs are the 'frontline' implementers. For HEWs, S&H is one major component of their work in the HEP. All the HEWs interviewed in the survey were highly committed. They adopt different methods to ensure uptake of S&H by households. They network with local actors, NGOs and *Kebele*s to give incentives like slabs to households or sanction non-complying ones.

CHPs, on the other hand, are community volunteers who do not get monetary benefits for their activities on S&H strategy implementation. However, although some complain that they should be compensated for time spent, most CHPs were happy to continue teaching the community without being compensated. Almost all the CHPs interviewed in this study claimed that they are the primary beneficiaries of what they are doing through their awareness about family planning, immunisation and personal hygiene. They were also happy to see the changes others are making in their community (interview with CHPs in Alaba and Mirab Abaya; ESHE).

The main complaint of HEW and CHPs was often related to the non-consistent nature of incentives given to 'frontline' implementers. HEWs signed performance agreement contracts with the health centres and *Woreda* health office on coverage levels of latrines and other basic health interventions. Public recognition of HEWs with best performance and good coverage reports were viewed as the main motivating factors.

However, the recognition system has not been consistent and this has discouraged some HEW (HEW at Galeto, Alaba). Similarly, CHPs complain about the lack of consistency in recognizing their effort or contribution to S&H implementation. During the initial period of 2003 and 2004, CHPs were publicly recognised for their efforts and were awarded certificates in public festivals and gatherings prepared by BoH. However, the practice had stopped.

Considering the key role of HEW and CHPs in S&H strategy implementation, it would be important to find ways to motivate the 'frontline implementers' to continue performing better.

#### *3.3.2.3 Response of those affected by the policy*

As described in the accompanying reports of the technical and socio-cultural components of this S&H case study, survey results from 399 households and observation data from 78 households show that more than 80% of households have constructed latrines in their homes. Fairly more than half have also adopted safe hygiene practices. This is a significant achievement compared to the 16% latrine coverage in 2003, before the implementation of the new S&H strategy in SNNPR.

There are not any formally adopted systems of rewards and sanction for households to improve S&H practices. However, in the health extension program implemented since 2005, public recognition and graduation certificates are given to households who have implemented the 16 HEPs, including the improvement in S&H practice. Threats of fines and imprisonment, which were more often not carried out, were used as sanctions against households not complying with public health regulations. The public health proclamation and regulation, although permitting some sort of sanctions, does not clearly state the type of punishment that can be carried out.

The reasons for households' non-compliance with the policy varied. Some households reported that they lacked construction material such as wood, while others cited flooding, and caving-in of latrines. For other households, changing old habits was rather difficult, and they stuck to habits which undermined the objectives of the S&H programme. Water shortage was also cited as a reason for the failure to practice hand washing (Interview with HEWs and CHPs in Mirab Abaya and Alaba, 2007).

The system of sanctions could be argued to have a mixed effect on good hygiene practices. Rather than constructing latrines for use in keeping with good hygiene practices, most households did so as a consequence of their fear of sanctions. Put differently, the construction of latrines was premised on a fear of sanctions rather than an adherence to good hygiene and sanitation practices. Consequently, this led to low utilisation of latrines, and low levels of behavioural change. This was most likely in instances where latrine construction was carried out without any technical support from the appropriate authorities. This appeared to be the case in the early campaigns of 2003 and 2004, where households dug open pits in their compounds because orders were given by local officials to construct latrines (HEW in Galeto, Alaba; Rural women's development desk, Alaba).

In contrast to the above, fear of sanctions did not emerge as a key factor in the construction of latrines post 2003. Findings from the technical and socio-cultural studies indicated that 3% of the 399 households surveyed, reported that they constructed their latrines to avoid sanctions. On the other hand, the greatest majority (97%) of the respondents noted that they built their latrines with the view to improve their hygiene and sanitation. The significant reduction in the households citing 'fear of sanctions' as the reason for the construction of latrines could be explained as being the result of general improvement in awareness of households, with the deployment and effective engagement of HEWs and CHPs, in the past two years.

#### *3.3.2.4 Development of supportive regulations systems*

##### A. Minimum performance contractual agreements and quota systems

Performance agreements were signed on S&H coverage and other basic health intervention within the health sectors starting from the year 2003. Agreements were signed between regional BoH and Zonal health offices, between *Woreda* and Zonal health offices, between health centres and *Woreda* health offices and between health posts/ HEWs and health centres. The *Woreda* health office also signed agreement with *Woreda* council. These agreements helped to create accountability within the health line offices from region to *Kebele* level.

In addition to the minimum performance agreements, quotas were assigned to different health line offices on the number of latrines that needed to be built or the coverage levels that needed to be reached annually. Other sector offices like agriculture and rural development had also started assigning quotas to its line offices at *Woreda* level. Assignment of quotas combined with signed

agreements helped to create a framework of accountability and responsibility for the various actors to increase the coverage.

However, the quotas assigned were too large to the extent that officials running the S&H programme focused more attaining their targets at the expense of educating people on the importance of actual using the latrines. As a result, behavioural changes issues were kept at the periphery of their activities (Interview with Rural Women's Development desk in Alaba, 2007). In other words, the quota system also by its very nature was directed at increasing the coverage and not changing behaviours or the utilization of latrines.

### B. Sectoral collaboration

When the multi-sector approach to S&H strategy was developed, and highlighted in the health ignition documents and public health regulation, it initially reflected the World Bank financed WaSH program. The multi-sector collaboration was effectively used during the initial phases of community mobilization campaigns. However, the multi-sector approach has declined after the introduction of the institutionalization process, and partly due to the scaled implementation of the HEPs in 2005. Further, the reduced collaboration between departments has also been due to different departments increasingly paying attention to their core activities. The department of Agriculture and Rural Development is a case in point as reported by an official in Alaba and Mirab Abaya.

Nonetheless, some collaboration occurred during periods of crisis, like AWD in 2007 in Alaba, or when a new health ignition document was being developed, or in donor funded projects such as the World Bank supported WaSH. With regards to the latter, a steering committee was formed from all the main sectors at *Woreda* level to implement the project (Alaba Education office). Thus, the collaboration was significant and contributed to initial strengthening of community mobilization and consensus-building. However, this was weak after 2005 partly because of the institutionalization processes which had started within the health sector.

### C. Prioritisation of S&H in government plan and budget

The focus of government on S&H in the SNNPR was reflected in the allocation of more human resources to S&H activities and the prioritization of S&H activities in sector plans and campaign activities on S&H since 2003.

In the health and water sectors, attention given to S&H was reflected by the employment of staff to support the S&H service delivery. The health sector office significantly increased the number of its frontline health workers. Regionally, the number of HEW was raised from 1,000 in 2003 to 4,000 in 2007 while the number of CHPs increased from 2,000 to 10,000 during the same period (Interview with BoH, 2007). In each *Kebele*, there was one HEW with plans to increase their number to two. In the study areas of Mirab Abaya, there were 25 HEW in 24 *Kebele*s, supported by 335 CHPs with a group of 15–20 CHPS working in each *Kebele* (Interview with Mirab Abaya health office, 2007). Both HEWs and CHPs carried out S&H activities as a major component of their work.

Also, in BoWR, more attention was given to water quality, sanitation and hygiene as evidenced by attempts to integrate S&H services. This was underlined by recurrent outbreaks of AWD. The bureau has made structural changes to raise the number of sanitarians to two in each Zone and one in each *Woreda*. At the region level, the water quality team experts' number was raised to five. At the time of the study, however, only 50% of these new positions were filled (Interview with BoWR, water quality team, 2007).

In the health sector, prioritizing S&H in *Woreda* health plans were also noted. BoH had, for the first time, allocated budget to S&H from the national treasury in 2003 (26% of the regional health annual budget). However, budget limitations for S&H activities were apparent. S&H still received little funding. Within the health office, money allocated to disease prevention and control, and environmental health, barely covered salaries. The health office staff in the two *Woredas* tried to make up for the under-funding of S&H by delivering S&H education in combination with other basic health programs such as malaria prevention (Interview with Health office in Alaba and Mirab Abaya, 2007).

Despite the increase in number of sanitarians, activities in BoWR were curtailed by lack of funds for equipments and operation costs. Sanitarians relied exclusively on donor support to undertake any activity (BoWR, water quality team, 2007). In both Mirab Abaya and Alaba, despite the fact that sanitarians at *Woreda* level have been hired some 6 months, they were inactive due to a lack of funds to purchase water quality testing materials, and to meet other operational costs (Water desks in Alaba and Mirab Abaya, 2007). The lack of funds at *Woreda* levels was partly due to the fact that, starting from 2005 *Woredas* had severe budget cuts mainly due to the reduction in financial assistance to government in the wake of the post election political crisis. Hence, most *Woreda* sector offices had limited financial resources which were insufficient to cover operational costs, after staff salaries were paid out. Most of the budget support for S&H has come from grants and loans.

Table 3.1: Budget share of BoH from the region and allocation to environmental health costs in SNNPR

| Year | Percentage for health bureau out of total Region budget (including grants and loans) | Percentage for health out of Region budget from central treasury and own revenue | Percentage for environmental health out of total health budget | percentage of costs for environmental health and sanitation programs, without grants from central treasury |
|---|---|---|---|---|
| 2003 | 13.68 | 1.37 | 16.24 | 26.34 |
| 2004 | 16.09 | none | 8.21 (fully from loan) | none |
| 2005 | 8.01 | 2.25 | 1.08% to S&H related costs fully from grant money | none |

Source: SNNPR BoFED

Table 3.2: Health bureau share from *Woreda* budget and costs for environmental health in Alaba woreda

| Year | Percentage for health office out of total *Woreda* budget (including grants and loans) | Percentage for health out of *Woreda* budget from central treasury (excluding grant and loans) | Percentage of S&H out of total health budget |
|---|---|---|---|
| 2003 | 9.47 | 2.39 | 9.33 (fully covered by grant) |
| 2004 | 11.63 | 16.06 | 10.02 (fully covered by grant) |
| 2005 | 7.04 | 6.42 | |

Source: Alaba Office of Finance and Economic Development

### D. Monitoring and Evaluation (M&E) System

The strategy implementation, along with other basic health interventions, had multiple layers of review and supervision. Bi-weekly meetings of CHPs with HEWs in the *Kebele*s, monthly meetings between HEWs and *Woreda* health office at woreda level, bi-annual meetings in the region and quarterly field monitoring and supervision by regional and Zonal environmental health experts, were carried out. The multiple layers of monitoring and supervision involved is one of the strengths of the M&E system. The review and reflection meetings helped to reveal problems and gaps in implementation, which provided a basis for improvement.

The review meetings at regional level identified important gaps, such as the need to increase technical input in the construction of latrines and the need to popularize the MoU signed between the 3 sector bureaus. Although, it was not clear what action was taken to improve the gaps, apart from identifying gaps, and making verbal commitments, during meetings, to address them.

One of the weaknesses of the M&E system at *Woreda* level was the reliance on supervision that focused on latrine coverage only at the expense of encouraging behavioural change and good hygiene practice. There is, therefore, a need to improve the M&E system.

#### *3.3.2.5 Ongoing modification based on implementation experience*

The multiple layers of M&E of the implementation process has led to the development of new ignition documents that relied on information from reviews and reflections carried out. The new ignition documents identified gaps noted in the implementation process and outlined broad actions that should be taken to mitigate the problem.

Some of the identified gaps listed in health ignition document No. 8, included:

- failure to impact on disease burden and frequent outbreak of AWDs;
- need for technical support to HEWs in the construction of latrines;
- need to pass accurate messages and to change the S&H education method;
- poor sector integration (MoU implementation).
- Implementation of some recourse measures was already started. For example, UNICEF introduced the PHAST approach, and funded the scaling up of the approach in SNNPR to strengthen the S&H education component. Other recourse measures outlined by BoH included;
- changing focus from quantity to quality, utilization and behavioural change in S&H promotion;
- focusing more on availability of sanitation facilities in institutions, schools and health services.

What specific actions were planned and what was actually undertaken to implement those recourse measures is not yet identified. However, the practice of identifying gaps from implementation experiences and planning recourse measures was an encouraging step. And also with the support of other actors some activities are in progress, which are in line with the recourse measures suggested.

In summary, it can be concluded that;

- Combining three communication systems for the S&H strategy was vital for its success. The mobilization campaigns and consensus building popularized the strategy, and created political support for the approach. In addition, the CHP approach had strategic communicators, while the HEP program had trained 'frontline' workers, who provided technical support.
- Rewards for HEW and community volunteers (CHPs) in non-monetary terms should continue to keep 'frontline' implementers motivated;
- Most supportive laws and regulations developed set a system of minimum performance agreement and quota systems and public health proclamation and regulations. Sectoral collaboration was also important at the initial stage of implementation.
- Some initiatives have been set up to modify the strategy, learning from the experiences of implementation. Identification of implementation gaps and broadly outlining alternative measures was taken as a start. However, this needs to be built up and turned into concrete actions for alternative measures; and
- A key weakness of the implementation was the exclusive focus on coverage and insufficient attention paid to behavioural change, utilization of S&H facilities and hygiene practice.

# 4 Conclusion

The SNNPR BoH S&H strategy was developed and implemented by combining a politically supported region wide approach to improve basic health with the adoption of different public health promotion models intended to bring professionalism and institutionalize the approach. Political support from different levels of government was equally important for the development and adoption of different tools employed in outreach to households.

Looking at the S&H strategy formulation and implementation from the perspective of the policy content, the key to success was in developing a strategy expressed in general terms, feasible in appearance, in harmony with existing body of policy and packaging it well to make it politically attractive which resonated with the values and needs of the ruling party. By using general terms like 'broad-based', 'low-cost' and 'high-impact', and not clearly outlining and documenting from the start how this would be achieved, the policy content allowed flexibility in the approach which made it possible to adopt different models as they developed. Advocating reliance on local resources to improve sanitation coverage, using existing administrative structures to communicate S&H messages and adopting simple technology promised a feasible strategy, which was also politically attractive. The packaging of the S&H strategy with other public health interventions, linked to governance issues with political significance, in health revitalization documents, as part of a broader movement to improve basic health services, combined with the timing, near to the 2005 national election, helped to give it more attention from the Regional Cabinet and to win the approval needed to get other sectors to collaborate for the implementation.

The context in which the strategy was developed and implemented had also much to contribute to the successful formulation and implementation. At the national level, the HEP, with a lot of emphasis on S&H, was developed, and the consequent deployment of HEWs, provided a strong community outreach tool. Moves towards sector integration in WSS service delivery culminated in the signing of agreements between BoH, BoWR and BoE and the national WaSH program. In combination, this contributed to putting S&H on the agendas of different government bureaus. A national civil society WaSH movement linked with a global civil society movement contributed to putting S&H on the public agenda. A recurrent outbreak of AWD meant that sanitation issues remained of chief concern.

Donors did not drive the policy process, but were available to finance S&H programmes, and there were strong actors supporting the region's BoH such as ESHE and UNICEF. Donors brought different models used in other countries like PHAST, CHP, which provided tools for implementation of the policy. They also supplied finance, especially for software aspects of training, even if the strategy did not rely heavily on external funding for hardware aspects.

The presence of strong individual actors, such as the Head of BoH and other senior civil servants in the BoH team, was an important factor in the successful implementation of S&H activities and programmes. The Head of BoH helped to bring the political and institutional streams together and practical solutions to identified problems.

Looking at the implementation process itself and the different channels used, there were both advantages and disadvantages. One of the earlier systems of strategy communication used, the 'cascading' down advocacy using existing government structures or the multi-sector approach, helped to popularize the strategy and build political momentum for front-line implementers. However, it was weak in terms of providing technical support to households in construction of latrines, before

the HEWs were deployed. The system was also directed to reporting coverage levels instead of working on behavioural change. Ambitious quotas were assigned to different 'front-line' offices backed by contractual agreements. While these were good to create accountability, they also had adverse impacts. For instance, focus was directed at fulfilling quotas without paying sufficient attention to utilization of latrines. The problem was exacerbated by the monitoring system which was directed at assessing coverage, and relatively weak in assessing behavioural change.

Political support from the Regional Cabinet kept other sectors involved in the S&H strategy implementation, at least initially. However, after 2005 – the period of the national election – the role of other sectors gradually faded out, although there were pockets of collaboration to improve S&H situation when AWD threats arose or where the World Bank – and ADB-financed WaSH programs were being implemented. These efforts led to more sectoral integration in WSS delivery.

The health sector channels involving HEWs and CHPs were reliable in communicating S&H messages. The CHPs were vital in communicating S&H messages partly because they were many, and were members of the communities in which they worked. Similarly, HEWs were important for S&H programme mainly due to the fact that they had technical training which was vital for S&H activies, such as the construction of latrines. The combination of CHPs and HEWs with the support of local political authorities, which was evident at regional and *woreda* levels, contributed significantly to the community outreach programme. However, a weakness in the channels of communication was the gradual reduction of rewards, and recognition, of the CHPs.

Looking at new developments in the sector after 2003, various factors contributed to the institutionalisation of the implementation strategy. Among these were initiatives for sector integration and the signing of the MoU between BoWR, BoE and BoH for integrated WSS service delivery. On the other hand, some factors undermined the institutionalisation process. For instance, little popularization and awareness about the existence of the MoU at *Woreda* level and non-functioning of coordinating bodies contributed to the MoU's limited impact

The continuous review and reflection on the implementation of the strategy incorporated in the multiple layers of M&E system proved to be a useful feature in the strategy. The reflection provided the opportunity to make modifications based on experiences of implementation.

Finally, the S&H strategy within the political domain, required putting of S&H activities and programmes firmly on the regional government's agenda. This was achieved by developing a politically attractive policy content which did not generate strong opposition, and incorporated S&H in a broader programme for basic health. Development of strong communication tools to inspire, persuade and mobilise politicians, civil servants and other actors in health revitalization/ignition documents was a key factor in successfully promoting S&H activities and programmes. At the institutional level, the system of contractual agreements created within the health sector with *Woreda* Councils, can be viewed as a further achievement. Meanwhile, for the purposes of community outreach, the opportunistic adoption of models introduced by different actors and associated leveraging of donors' fund for software aspects was also a key factor in the success of S&H activities and programmes. The combined use of 'front-line' health implementers with local political support provided by *Kebele*s enabled S&H activities and programmes to be extended to communities, through community outreach programmes.

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# Annex 1: Principal research questions

### Actors

- Who are the key internal (sector) and external (wider government and non-governmental) actors who drove the S&H approach in SNNPR from the regional to the HH level?
- What are the positions and levels of influence of the different key actors? What determines their positions, their commitment and levels of influence (Interests, Incentives, financial resources, hierarchies)?

### Content

- What are the contents and characteristics of the S&H policy?
- How did the policy content contribute to or affect the uptake and implementation of the sanitation & hygiene policy?

### Context (situational, structural, cultural and exogenous factors)

- What social networks were there to support the implementation process (e.g. the relation between the administrative and political parts of government and between government and non-governmental actors)? What networks worked against it? What role did outside actors play during the process?
- What windows of opportunity; in available funding, new evidence, political support, etc; were there that helped actors drive the sanitation agenda?
- What external factors affected the policy implementation?

### Process/ Implementation ('roll-out')

- How is the policy expressed and embedded in formal rules (laws, regulations, performance targets, public sector funding, M&E systems, etc)?
- How was the policy rolled out (which aspects of content were emphasized, geographical sequencing, roles of actors etc)?
- How were the S&H messages transferred from the regional to *Woreda* to *Kebele* level?
- Were any policy alternatives considered and did implementers or those affected by the policy have any possibility of feeding back?
- Did any reflection of the policy process take place at any time (e.g. were amendments made such as creating incentives for health workers)?
- Were there any blocks in the system (implementation capacity, financial resources, skills, knowledge, technical, etc.)?

# Annex 2: Information on analytical framework

Buse (Buse K. et al (2007) and (forthcoming), and Hill and Hupe (2002) specify seven factors that influence policy implementation:

- policy characteristics (content);
- nature of the policy formation process (e.g., the extent to which views of implementation staff and the public were considered in the specification of policy alternatives);
- layers of the policy transfer (different administrative levels & other involved in implementation);
- factors affecting responses of implementation agencies and delivery staff (e.g. incentive structures, motivation etc);
- relationships between parallel organisations tasked with implementation;
- factors affecting the responses of those affected by policy (e.g. households, public institutions);
- wider policy environment (i.e. the specific situational, structural, cultural, international contextual factors impacting on policy).

By investigating the above factors i.e. policy **content** (its goals, administrative, technical and financial features and the values to which it appeals) policy **process** (the way in which policy is made and implemented), the **actors** (i.e. those making and effected by policy including insiders and outsiders) and **contextual factors** (e.g. factors that gave momentum to the policy, the enabling governance environment, political support to the sector, internal power structures, cultural and exogenous factors) have an impact on whether and how implementation occurs.

**Actors** are conceptualized as stakeholders with individual interests and different types of assets (e.g. financial, moral, political legitimacy) determining their positions, levels of commitment and their capacity to influence policy implementation. Individual actors are also seen as part of social networks; the strength/outreach of these networks affects the scope of implementing policy changes.

Leichter (1979) in Buse (forthcoming) categorizes different contextual factors as follows:

- **Situational factors**: factors that gave the momentum to the implementation of the sanitation policy in the form of a window of opportunity e.g. cholera outbreak or an ongoing reform in the sector, political support, external funding made available etc;
- **Structural factors**: factors that determine interactions in society and may have evolved over a period of time. They are likely not to change but impact on policy change and could also be called the formal rules of the game. For example, structural factors include the openness, closeness of the formal political system, salary structures and public sector funding or the presence of motivated and committed health officials, or the existence of a governance environment that enables civil servants to effectively implement a policy, such as support of the key officials to S&H policy, availability of data on acute need woredas and use of it in decision to chose pilot intervention areas. But structural factors can also refer to wider factors such as demography or availability of skills or technology;
- **Cultural factors**: factors that originate in informal rules of the game. For example, kin-relationships, respect for age or strong hierarchies and power structures can impact on how

well new ideas can be floated and implemented. Also, the cultural appropriateness of the sanitation policy could play an important role for its acceptance and adoption or trust given to the main implementers of the policy;

- **Exogenous factors**: factors external to the immediate policy process but still have an impact on it. This impact can come, for example, through the influence of donors who have sanitation high on their agenda, the availability of external finance, or trends of change or focus in the broader global environmental health/ sanitation sector.

NB: due to the limitations on the time/resources available for this case study, the researchers carrying out this policy analysis will investigate 'Exogenous Factors' only to a limited extent.

# Annex 3: List of persons consulted

### Regional Government Bureaus

- SNNPR Bureau of Health; Ato Demssie Dubamo (head of Disease Prevention and Control Department) and Ato Derje Mamo (team leader of the IEC/BCC in Health Bureau and Environmental Health Specialist);
- SNNPR Bureau of Water Resources; Ato Solomon (Acting head of Water Supply, Study and Design department), Ato Damenu (head of Planning Department) and Ato Eyasu (Water Quality Expert);
- SNNPR Bureau of Education; Ato Hassen Abdu Beshir (Deputy Bureau head) and Ato Kasu (Head of Planning Department);
- SNNPR Bureau of Finance and Economic Development; Ato Getachew Eskete (Head of Planning and Budget Department) and W/rt Belaynesh (Team Leader);
- SNNP Regional Council; Ato Teshome Tadesse (Chief Executive Assistant to the Vice President)

### Alaba Special *Woreda* government offices

- *Woreda* Council; Ato Mehadi Ahmed (Acting *woreda* council head and Head of Information office);
- Health Office; Ato Engdayehu Hailu (Health Services and programs desk head and acting head of health office) and Ato Abdu Shafir (Mothers and children health expert and acting Environmental Sanitation focal person);
- Water Office; Ato Salim Bargicho (Head of *woreda* water office) and Ato Tewodros Simenigus (Assistant Water Engineer);
- Agriculture and Rural Development Office; Ato Mesfin Tsegaye (Natural Resources and Land Administration Desk head and Acting office head) and W/o Birhane Dula (Rural Women Affair's Expert);
- Education Office; Ato Feleke Dalul (Acting office head);
- Finance and Economic Development office; Ato Teferi Tagese (Office head)

### Kebele-level

- Health Extension workers; Zeynya Shainagi (Amata *Kebele* HEW), Aziza Usman (Galeto *Kebele* HEW), Zeyneya Kemal (Hulegeba Koke *Kebele* HEW);
- Community health Promoters in Amata, Galeto and Hulegeba Kuke Kebebles.

### Mirab Abaya *Woreda* Government offices

- Health office; Ato Getye Shiferaw (Acting Office Head and Health Services Desk), Ato Fikade Tultula (Disease Prevention and Control Team Leader), Ato Fikade Michael Mola (Environmental Health expert);

- Water Resources Development office; Ato Habtamu Mandefrot (Assistant Engineer and acting office head), Ato Serifo Sharew (Community Mobilization Officer);
- Finance and Economic Development Office; Ato Gedyelew Daba (Head of Finance and Economic office);
- *Woreda* Council; Ato Arba Guja (deputy head of *Woreda* Information Office and acting *Woreda* Council Chairman), Ato Girma Fekede (currently Youth and Sports office and previously chairman of the *Woreda* Council);
- Agriculture and Rural Development Office; Ato Kiros Mesfin (Natural Resources Development and Land Administration Desk head).

### Kebele-level

- Health Extension Workers; W/t Zenebech Adnew (HEW in Mole *Kebele*), Tsehay Meskele (HEW in Wajifo *Kebele*);
- Community health promoters in Mole, Omolante and Wajifo *Kebele*s

### Non-Governmental organisations

- Dr. Solomon Dimamu ( Previously Regional Project Manager in ESHE, USAID);
- Ato Adane Bekele (UNICEF, WaSH Specialist and responsible for M&E in SNNPR);
- Ato Getachew, WES officer, UNICEF, SNNPR;
- Mrs Shaya, Director of UNICEF SNNPR Branch;
- Ato Ambachew Derese (Formerly Bilateral Cooperation Desk, BoFED).