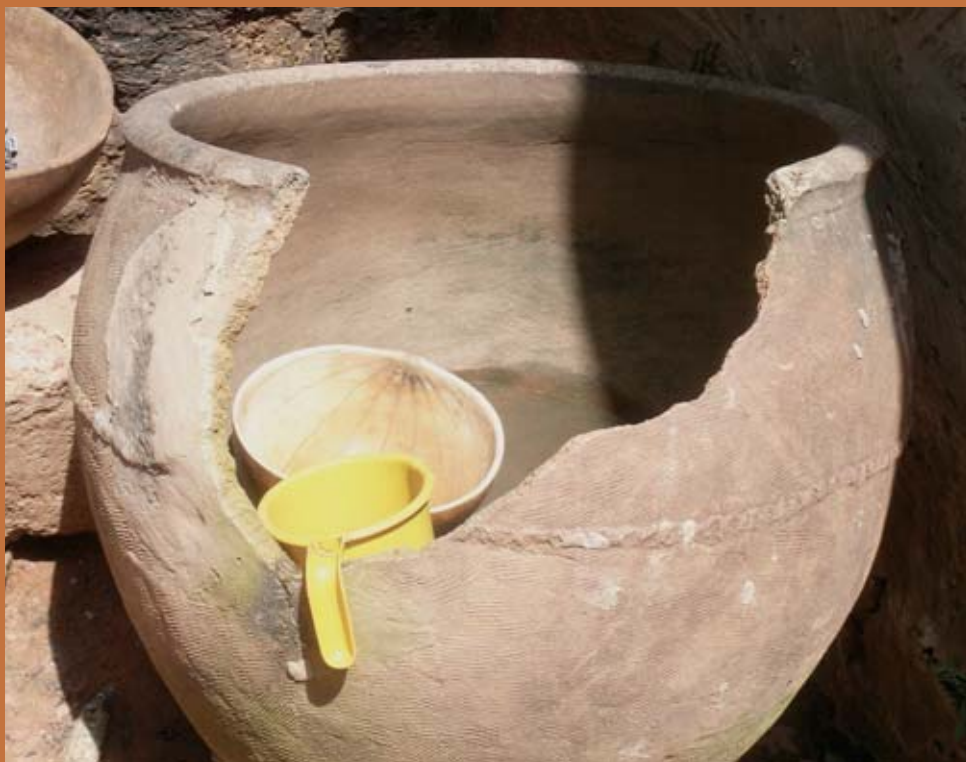


Sanitation and hygiene in developing countries: identifying and responding to barriers

A case study from Burkina Faso



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February 2007

This report will also be available in French, via the Tearfund website:

<http://tilz.tearfund.org/Research/Water+and+Sanitation>

This case study is part of a project investigating barriers to sanitation and hygiene promotion in three francophone countries in sub-Saharan Africa: Madagascar, Burkina Faso and the Democratic Republic of Congo. A description of the project is set out in Section 1.3 of this document.

As well as country case study reports, see also the Briefing Paper synthesising and commenting on the results of the studies in the three countries – on the ODI website www.odi.org.uk/wpp/Publications.html

A Tearfund synthesis paper is also available:

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Tearfund is an evangelical Christian relief and development agency working with local partners to bring help and hope to communities in over 70 countries around the world. Many of its partners work on water, sanitation and hygiene promotion projects. Through its advocacy work, Tearfund hopes to raise awareness of the current global water and sanitation crisis among its supporters and policy-makers; it also hopes to build the capacity of its partners to advocate on water issues on behalf of poor communities.

Overseas Development Institute (ODI)

The mission of the Water Policy Programme (WPP) at ODI is to contribute to poverty reduction and social development through research and advice on water policy and programmes.

L'Alliance Chrétienne pour la Coopération Économique et le développement Sociale (ACCEDES)

'Christian Alliance for Economic Cooperation and Social Development' – Accedes was founded in 1995 with the aim of supporting economic cooperation and social development in Burkina Faso. Based in the regional capital Bobo-Dioulasso, the second largest town in Burkina Faso, Accedes today operates in 14 different provinces. This Christian organisation is one of Tearfund's local partners in Burkina Faso. Accedes works on food security, education, micro-finance, environmental protection and health.

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Abbreviations¹

ACCEDES	Christian Alliance for Economic Cooperation and Social Development – <i>L'Alliance Chrétienne pour la Coopération Économique et le développement Sociale</i>
ADB	African Development Bank
AFD	French Development Agency
ARI	Acute respiratory infection
BPD	Building Partnerships for Development
CCAEPa	Coordination Group for Water Supply and Sanitation
CCEPA	NGO Coordination Group on Drinking Water and Sanitation
CLTS	Community-led total sanitation
CNE	National Water Council
CREPA	Regional Centre for Drinking Water and Sanitation
CRESA	Regional Centre for Health and Sanitation Education
CSPS	Centre for Health and Social Promotion
CVT	Village Development Council
CT	Local and Regional Government areas – <i>Collectivité Territoriale</i>
CTE	Technical Water Committee
CVT	Village Development Council
DANIDA	Danish International Development Agency
DGACV	General Directorate for the Improvement of Living Conditions
DRC	Democratic Republic of Congo
DGRE	General Directorate for Water Resources
DPHES	Directorate for Public Hygiene and Health Education
GNI	Gross National Income
GNP	Gross National Product
GOBF	Government of Burkina Faso
INERA	Environmental and Agricultural Research Institute
MAHRH	Ministry of Agriculture, Water Resources and Fisheries
MATD	Ministry of Territorial Administration and Decentralisation
MDG	Millennium Development Goal
MECV	Ministry of Environment and Living Conditions
MEE	Ministry of Water and the Environment

¹ Some of the acronyms are abbreviations for French words but have directly been translated into English here.

MITH	Ministry of Infrastructure, Transport and Habitat
MS	Ministry of Health
NGO	Non-governmental organisation
ODI	Overseas Development Institute
ONEA	National Office for Water and Sanitation
PEA	Water and Sanitation Programme – <i>Programme d’Approvisionnement en Eau Potable et Assainissement</i>
PNGT	National Programme for Territorial Management
PRS	Poverty Reduction Strategy
PRSP	Poverty Reduction Strategy Paper
SIECA	Service for Information, Education, Communication and Sanitation
THA	Health and Sanitation Technician
UN	United Nations
VIP	Ventilated improved pit (latrine)
WASH	Water, sanitation and hygiene
WB	World Bank
WDI	World Development Indicators
WSS	Water supply and sanitation
WSSCC	Water Supply and Sanitation Collaborative Council

1 Introduction

1.1 Rationale

Many people believe that simply providing a fresh, clean water supply will substantially reduce water-borne illnesses. What most people do not know is that safe hygiene practices and access to sanitation are crucial for combating the main health threats to children under five, in particular diarrhoea. Approximately 88 per cent of all diarrhoea infections worldwide are attributed to unsafe water supply, the lack of safe hygiene practices and basic sanitation infrastructure (Evans 2005). And the scale of the problem is immense: today, nearly twice as many people lack access to sanitation compared with water supply (UN 2005).

In recent years, sanitation has risen up the international policy agenda. In 2002, sanitation was included in the Millennium Development Goals (MDGs), and specifically within MDG 7, Target 10, which sets the aim of halving '*by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation*'. Yet, at national level in most developing countries, hygiene and sanitation do not yet receive much attention, despite important health implications. The aim of this report is to explore the underlying reasons for this apparent paradox.

1.2 Defining sanitation and hygiene

The first thing that comes to mind when talking about sanitation is a latrine. The term 'sanitation', however, commonly covers a much broader area of activities. Box 1 lists the broad elements that most professionals would classify as sanitation, according to Evans (2005). Elements particularly studied in this project are shown in *italics*.

Box 1
Broad elements
encompassing
sanitation,
hygiene and water
management

Source: Evans (2005)

Sanitation	<ul style="list-style-type: none"> • <i>Safe collection, storage, treatment and disposal/re-use/recycling of human excreta (faeces and urine)</i> • Management/re-use/recycling of solid waste (rubbish) • Collection and management of industrial waste products • Management of hazardous wastes (including hospital wastes, chemical/radio-active and other dangerous substances)
Hygiene	<ul style="list-style-type: none"> • <i>Safe water storage</i> • <i>Safe hand-washing practices</i> • Safe treatment of foodstuffs
Water management	<ul style="list-style-type: none"> • Drainage and disposal/re-use/recycling of household waste water (also referred to as 'grey water') • Drainage of storm water • Treatment and disposal/re-use/recycling of sewage effluents

The range of activities in Box 1 is wide. The result is that a typical view of the ‘sanitation and hygiene sector’ extends from investment in large and costly items of infrastructure such as trunk sewers, via simple ‘on-site’ latrines for individual households, to provision of ‘soft’ items, e.g. support for women’s groups seeking to change defecation practices in their community.

In Box 1 the usual order of presentation for ‘WASH’ as promoted by the Water Supply and Sanitation Collaborative Council (WSSCC) – water, sanitation and hygiene – has been adjusted. The key feature of the WASH approach is that it promotes the three components in combination, in policies and practice.

Not all elements in Box 1 have the same impact on reducing under-five child mortality. This Burkina Faso case study has paid particular attention to safe disposal of human excreta and safe hygiene practices, which are elements of basic sanitation and hygiene lacking in many poor areas in Africa and other developing countries (listed in *italics*).

‘Solid waste disposal’ (of rubbish/garbage, not faeces) is also included in Box 1, as is disposal of waste from hospitals/clinics. Less attention is, however, paid to both those aspects during this project.

Improved hygiene is also a factor in reducing acute respiratory infections (ARIs). Studies tracing the routes of faecal-oral contamination in households suggests that hands are the microbe ‘superhighway’. They carry faecal germs from toilets or defecation sites to utensils, water and food. While washing hands at critical times is accepted as an effective intervention against diarrhoeal disease, evidence is also now growing for its effectiveness against respiratory infections (Cairncross 2003) such as tuberculosis (including transmission of germs from mouth to hand to mouth, e.g. via sneezing).

Improving sanitation in line with Millennium Development Goal (MDG) Target 10, alongside improved water supply, may directly contribute to progress towards MDG Targets 4 and 6 shown in Box 2. Improving sanitation will also contribute, indirectly, to other MDGs such as Target 3 on education and Target 8 on maternal health, also shown in Box 2.

Box 2
Sanitation and
hygiene-related
targets under
the MDGs

MDGs	Targets
7 Environmental sustainability	Target 10 Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.
4 Reduced child mortality	Target 4 Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.
6 Combating disease	Target 8 Have halted, by 2015, and begun to reverse, the incidence of malaria and other major diseases.
3 Achieving universal primary education	Target 3 Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.
5 Improving maternal health	Target 8 Reduce by three-quarters the maternal mortality ratio.

Diarrhoeal diseases and parasites reduce attendance and attention at school in a number of ways: girls often stay away from school unless there are female-only latrines; time spent collecting water may take precedence over school attendance and this burden falls on girls, as does looking after sick family members. Teachers may be unwilling to live in areas without adequate water and sanitation. Women bear the brunt of poor health and the security risks from lack of private sanitation or washing facilities, and the burden of carrying water. A hygienic environment will be more conducive to maternal health: a healthy pregnancy and hygienic labour practices reduce the risk of maternal illness.

1.3 Objectives, methodology and scope

This report is based on a project commissioned by Tearfund with two objectives.

- First, this project is designed to contribute to better understanding of factors which hinder or, conversely, support:
 - the development of policies on sanitation and hygiene at national level
 - the effective implementation of sanitation and hygiene programmes (delivery to those who need it).
- Secondly, Tearfund aims to build the capacity of its local partner organisations in carrying out evidence-based advocacy on sanitation issues in their respective countries. The starting point for choosing which countries to study was therefore individual Tearfund partners' interest in sanitation and hygiene policy. From among those interested, Tearfund selected three Francophone countries which were therefore less well-known to UK-based organisations, namely Madagascar, Burkina Faso and the Democratic Republic of Congo (DRC).

The research methodology is informed by the objectives above. Rapid research methodologies with a strong capacity building element have been used to allow Tearfund's local partners to participate in carrying out the study. This report therefore presents the findings from 'scoping' rather than in-depth analysis.

In Burkina Faso, the research was carried out jointly between ODI, who took the lead at national level, and Accedes, Tearfund's local partner which implemented the local-level research. The research is based on a desk study of relevant policy and materials in-country and on semi-structured interviews at national level of representatives of government, NGOs and donors, both sanitation and hygiene specialists and other development practitioners. This was complemented by an illustrative case study in the rural local government area of Bobo-Dioulasso; this included semi-structured interviews with representatives of government and NGOs, as well as focus group discussions in five villages in this local government area on barriers and supportive factors for latrine construction and adoption of safe hygiene practices. Draft research results were validated through a project seminar held in Bobo-Dioulasso to bring together the information gathered and to identify and agree the findings of the study. There was also a peer review of preliminary results by international and in-country experts.

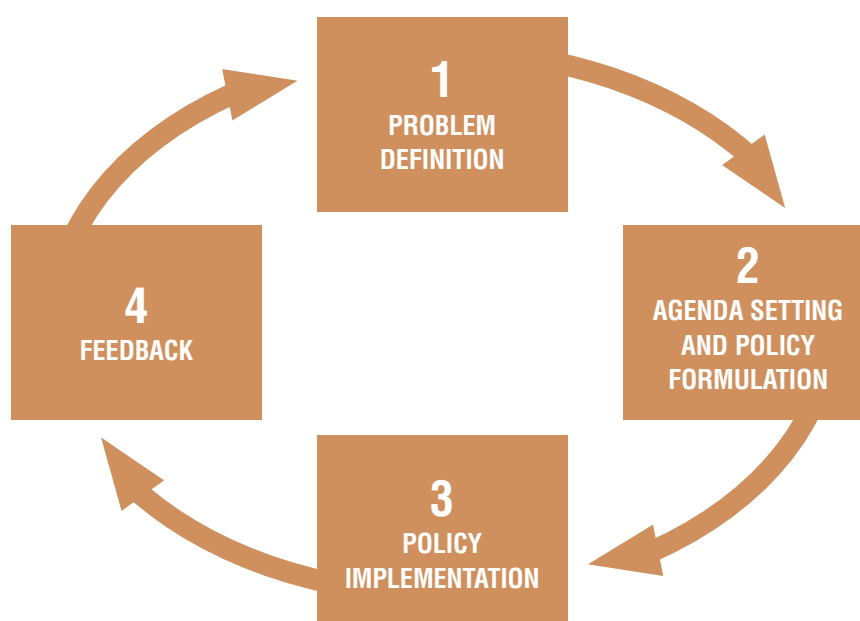
This report offers a snapshot of the sector as it is perceived by key decision-makers and experts at national level and by users and practitioners in one locality.

1.4 Approach to identifying barriers and supportive factors

There are a number of potential barriers to developing and implementing sanitation and hygiene policies – and some factors which are supportive of them.

A typical policy process broadly encompasses the four essential stages of 1 – **Problem definition**, 2 – **Agenda setting and policy formulation**, 3 – **Policy implementation** and 4 – **Feedback**, as shown in Figure 1.

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



As will be seen, barriers to development and implementation of sanitation and hygiene policies may occur during each of the first three stages. The fourth ‘Feedback’ stage was not covered by this study, although clearly monitoring and evaluation of how programmes are being implemented is an important element of the policy cycle, to feedback lessons learnt.

The studies in the three countries suggest that, once agendas have been set and policies on sanitation and hygiene formulated (stage 2), the challenges of achieving policy implementation (stage 3) are substantial. In Burkina Faso, as in many African countries, decentralisation is recent and ongoing – a process which in many locations exists, as yet, more on paper than in practice.

1.5 Structure of the report

The report is organised in the following way:

SECTION 2 is a summary of factors which international commentators consider to impede investment in sanitation and hygiene programmes in developing countries. Perceived ‘barriers’ applying at each of the first three stages in the policy process above are listed (and numbered) under the above headings: ‘Problem definition’, ‘Agenda setting and policy formulation’, and ‘Policy implementation’.

SECTION 3 sets out the results of the national scoping study, and describes the country context in Burkina Faso, as well as the structure of the country’s sanitation and hygiene sector.

SECTION 4 reviews the scope and results of the ‘local’ study carried out by Accedes.

SECTION 5 considers whether the potential barriers identified in Section 2 are present in Burkina Faso, and whether other barriers to improving sanitation and hygiene services are operative. It also considers whether there are supportive factors to promote them.

SECTION 6 concludes the report and summarises the recommendations made by local actors for future actions.

The three case studies reveal that each country is at a different stage in the policy development process. They provide insights into how the barriers and responses suggested in the international literature manifest themselves (or not) in these three sample countries – as reported to the researchers by key actors in each nation.

Differences between sanitation challenges in urban and rural contexts are exemplified by the principal focus of the local study in DRC on (two) urban localities and in Madagascar and Burkina on rural settlements.

2 Perceived barriers

Why then is sanitation proving ‘*such a hard nut to crack*’? (Evans 2005, page 16.)

In this section, we set out the factors which international commentators perceive as being the principal impediments to investment in sanitation and hygiene in developing countries. Each of the fifteen barriers listed below is described in relation to one of the first three stages of the policy development process: 1 – ‘Problem definition’, 2 – ‘Agenda setting and policy formulation’, and 3 – ‘Policy implementation’.

2.1 Problem definition

The first challenge in developing sanitation and hygiene policies is to define terminology – an integral part of the first stage of the policy process.

Box 1 showed the three components of WASH and activities commonly included under each.² But interpretations vary and it cannot just be assumed that stakeholders are using the terms ‘sanitation’ and ‘hygiene’ in the same way. Differences of interpretation which remain unnoticed and unexplored will undermine efforts to identify and agree the problems which future policies and programmes must resolve.

Jenkins and Sugden (2006) note that use of the term ‘sanitation’ is in danger of blurring the important distinction between ‘on-site’ methods of handling human waste on the one hand, and connections to sewer systems on the other.³ Experience shows that a decision relating to an on-site pit latrine for an individual household involves issues which are substantially different from those surrounding a network of sewers and household connections to them. In French, a distinction is made between *assainissement autonome* (autonomous sanitation) and *assainissement collectif* (collective sanitation).

2.2 Agenda setting and policy formulation

The second stage of the typical policy cycle is agenda setting and policy formulation. There are five key barriers which can hinder development of policy during this stage:

2.2.1 Lack of information

Problems may be caused in many developing countries by lack of recent, reliable information on the condition of existing sanitation and hygiene infrastructure, including whether or not it is actually functioning. Official statistics on sanitation coverage are often inconsistent or even hopelessly inflated. Needs and demands, particularly in more remote

² Vector control is not included in Box 1: it was little referred to by the persons interviewed.

³ While household connections to sewers are, Jenkins and Sugden (2006, page 8) note, a technical option, ‘*it is unrealistic to believe that anything but a small percentage of the world’s urban poor will be served by sewered systems in the next 20 years*’.

rural areas, are frequently unknown, making the task of setting a coherent and balanced agenda more difficult.

2.2.2 Tensions between mindsets

Mutual incomprehension between different mindsets is frequently a barrier to improving sanitation and hygiene provision. Some policy-makers argue, for example, that sanitation as a household amenity is a household responsibility, so that public agencies should concentrate their energies on public aspects of sanitation, e.g. on public networks for storm water drainage, sewerage etc, i.e. large public works projects. Health experts advise, however, that removing excreta from living spaces has major health benefits, not just for individual families, but also for their neighbours; and that many health benefits stemming from improved sanitation are shared by the community at large, rather than accruing principally to individual households. According to this view, such externalities justify the use of public funds for latrine promotion.⁴ So public institutions, both central and decentralised, have an interest in – and an obligation towards – allocating public resources for household and small community-level sanitation improvements.

The UN Task Force (UN 2005) explains the danger of transferring to developing countries a utility model current in developed countries which focuses on piped networks, sewers and other large public works, with much less interest in and attention to sanitation at the household level. A ‘utility mindset’ inclines naturally to the conclusion that sanitation is best institutionally ‘housed’ within the same (national) ministry and (regional and municipal) agency responsible for public water supply networks. Most water supply and sanitation agencies in industrial nations have very little direct interaction with the hygiene behaviour of households at all. Yet, in countries dependent on external aid, national policy-makers and practitioners who favour a household hygiene focus may encounter pressure to divert from that approach and keep in line with the utility vision of international consultants.

Another example of possible tensions between mindsets is between those who accord priority to public education campaigns designed to promote behaviour change, and those who favour a more (private) market-oriented approach. Research⁵ has suggested that low uptake of household sanitation facilities may be explained by sanitation programmes which do not sufficiently understand users and their needs, as compared with those which treat users as having a say in which products (e.g. latrines) they buy to meet their needs. The distinction lies in seeing people not as passive beneficiaries of gifts, but as active citizens and consumers.⁶ There are some indications that the latter kind of ‘social marketing’ increases demand and uptake of sanitation. Jenkins and Sugden (2006) make a case for this (page 16ff), although, as observed elsewhere, health professionals in public agencies (Newborne and Caplan 2006) may be instinctively sceptical of marketing techniques, at least those practised by private sector companies. This is despite the proven success of, for example, private soap producers

⁴ Cairncross and Curtis, (undated).

⁵ *Social Marketing for Urban Sanitation: review of evidence and inception report*, WEDC, Loughborough University, UK. Research carried out by WEDC, UK, in conjunction with the London School of Hygiene and Tropical Medicine, TREND Group, Kumasi and WaterAid Tanzania: www.lboro.ac.uk/wedc/projects/sm

⁶ Uptake of latrines could increase if they were designed to meet more of people's demands: if they offered the opportunity to sit while using it, no smell and good ventilation, and easy access for desludging (emptying); and if they were cheap to install, less dependent on water and safe for children.

in promoting sales of soap.⁷ A recent report for Building Partnerships for Development (BPD) highlights potential barriers for social marketing: where, for example, potential ‘consumers’ of sanitation products (e.g. latrines) are tenants of low-grade rented dwellings/sites, landlords have little interest or incentive to invest their own resources in sanitation, due to the perceived interim nature of their accommodation (Schaub-Jones et al 2006).

Jenkins and Sugden (2006) point out that, as regards sanitation services, there is evidence to challenge the views of those who instinctively favour public sector solutions to all ‘water sector’ problems. In developing countries the contribution of public-sponsored construction of sanitation infrastructure has been very small to date, compared with action by private households and providers to households.

2.2.3 Lack of coordination

Other commentators point to the lack of clarity in some developing countries over who – or **which** institution(s) – is responsible for which of the functions referred to in Box 1.

The most commonly adopted arrangement is that the institutional ‘home’ of sanitation is located within ministries of water. A second option can be to place sanitation within the remit of the ministry of health: a number of activities in Box 1 have a public health element, and there is a natural link therefore between hygiene and health (particularly preventative health – see further below). Another possibility might conceivably be a separate ministry for sanitation.

Since, however, the range of water, sanitation and hygiene-related activities is so wide, searching for ‘the right institutional home’ may not be fruitful. Arguably more important is establishing links between institutions, e.g. via planning processes which bring together departments from several responsible ministries. The above BPD report calls for tasks to be shared, *‘rather than agreeing that one agency should always “lead” the process’* (Schaub-Jones et al 2006, page 26). Creating and linking **budget** lines across several responsible agencies may be an effective way of achieving coordinated policies. National WASH platforms, placed alongside but kept distinct from government, can help support joint planning by several agencies responsible for sanitation and hygiene, without joint **implementation** being necessary or appropriate, due to e.g. differing time-scales and skills requirements.

2.2.4 Lack of political and budgetary priority, lack of demand

A limiting factor commonly evoked is lack of funds for investment. Both water and sanitation have been losing out to other sectoral interests in the competition for scarce public funds. For example, in a 2003–2004 survey of Poverty Reduction Strategy Papers (PRSPs) and budget allocations in three countries in sub-Saharan Africa (ODI 2002; ODI 2004a), other ‘social’ sectors, such as education and health, attracted much larger budgetary allocations than water, and sanitation was especially under-funded. It prompts the question as to whether the political will exists to increase budget priority of sanitation.

⁷ The objection is that soap sales do not reach the poorest groups.

Advocates of increased support for sanitation need to address the fact that, in many instances, household and community expressed demand for sanitation facilities is lower than for other forms of support, including drinking water supply. Sanitation and hygiene specialists note that, for example, *'toilet acquisition may not be a priority item of expenditure, especially for the poor'* (Cairncross and Curtis, undated, page 1). Allocation of public funds to sanitation facilities in households which have not made them a priority may run the risk that, after installation, those facilities will not be used.

2.2.5 Donors' agendas

In aid-dependent developing countries, donor priorities will tend to be influential in setting sectoral agendas, and if pursued individually they will undermine efforts to promote collaborative planning.

2.3 Policy implementation

The third stage of the typical policy process is policy implementation. International commentators point to the following barriers which commonly need to be overcome in developing countries.

2.3.1 Lack of human and technical capacity

In many developing countries a lack of capacity in terms of human resources inhibits development, particularly at a decentralised level. The multi-faceted nature of WASH means that a wide range of different disciplines and skills is required to improve sanitation and hygiene provision. While the water sector has tended to be *'dominated by engineers who feel comfortable with technical problems and tend to lean towards technical solutions'* (Jenkins and Sugden 2006, page 7), household sanitation *'requires softer, people-based skills and takes engineers into areas where they feel uncomfortable and unfamiliar'* (page 8). Promoting behaviour change at household level is an area *'where most countries have few skills... and limited capacity. Most public agencies are unfamiliar with or ill-suited for this role'* (Evans 2005, page 25).

2.3.2 Low capacity to absorb funds

In a sector where spending has historically been low, a question arises about the rate at which flows of finance may be increased, at least funds channelled through state (public) bodies. It cannot simply be assumed that more resources will rapidly translate into improved outcomes. All development interventions need to be designed taking into account constraints in *'absorptive capacity'* (ODI 2005). As well as funds being available, it is important that they *'be used in the right way'* (Tearfund 2005, page 23).

2.3.3 Lack of service providers

The reality in many locations in Africa is that there is limited choice of sanitation and hygiene providers, whether agencies of local government, community associations, NGOs or private suppliers.

In cities in some developing countries, empirical studies have highlighted the activities of small **private** suppliers (e.g. Collingnon and Vézina, undated; WSP 2005). In relation to sanitation, these include, for example, bricklayers (or ‘masons’) for latrine construction and people to empty pits manually. There are still some doubts as to slum populations’ willingness to pay, but the significance of the role of small private providers in meeting the needs of poor populations is now more widely recognised, where they are able to offer the right product for the right price.⁸

What is ‘affordable’ is very context-specific, and among poor communities affordability may be a persuasive limiting factor on uptake of new sanitation facilities, such as latrines. *‘The decision to install home sanitation for the first time can be a big one and often involves changing [other] household-related infrastructure’* (Jenkins and Sugden 2006, page 13).

2.3.4 Methods/technology ill-suited to context

Suitable sanitation services/facilities will vary according to context: there will be differences between urban and rural contexts, large and small towns, planned and unplanned settlements – as well as between different ethnic and social settings (e.g. communities with more or less collective organisation and identity).⁹ Since different products embody different technology choices, technology options which prove inappropriate will constitute practical barriers. There is broad consensus in the literature that the right choice of technology is an important determinant of take-up and use of sanitation facilities.

2.3.5 Lack of access to credit

Access to credit is also noted as something which is commonly lacking in sub-Saharan African countries,¹⁰ particularly micro-credit for small service providers, whether community-based or private (WSP 2003). Loans available are often only for income-generating activities, rather than for improving community and household infrastructure (both sanitation and water facilities). And credit such as is available may not be at affordable interest rates or offer repayment periods long enough for poor borrowers.

2.3.6 Lack of strong messages

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

⁸ Recognising that, for very poor populations, availability of a public subsidy (in whatever form) may be essential.

⁹ See for example Jenkins and Sugden (2006) for a summary of differences in urban and rural excreta management (page 22).

¹⁰ There are a few exceptions where the microfinance sector is reported as being more developed, e.g. Benin and Kenya (WSP 2003, page 14).

e.g. open defecation' (WSSCC, undated, page 26).¹¹ *'If the campaign is focused only on the building of latrines ... there will always be people who are not reached, people who defecate in the open and who continue to pollute the water sources and spread disease. High levels of latrine coverage, therefore, are simply not good enough. At the very least ... this movement should be marching under the banner "No Open Defecation"'* (page 8).

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

2.3.7 Lack of arrangements for cleaning and maintenance

A key aspect of the financial viability of shared and communal sanitation facilities is payment for maintenance – cleaning and pit-emptying. Sustained demand for use of latrines will depend on their being clean and without smell. If the rota or other system for cleaning breaks down, the facility will become unpleasant to use. The BPD report (Schaub-Jones et al 2006, page 7) suggests for communal facilities that *'engaging a caretaker is strongly recommended, preferably a local person paid from usage receipts, rather than a public employee. To cover this expense, as well as [other] maintenance and emptying costs, a fee for use is charged.'*

2.3.8 Complexities of behaviour change

However compelling the 'societal' reasons may be for investing in sanitation – reduced disease burden, reduced public health costs, increased school attendance for girls, greater economic productivity etc – the 'private' motivations of individuals for better sanitation at home may be different. As commentators have pointed out, an individual is likely to be prompted to improve his/her sanitation facilities by a mix of motives, including some which are **not** linked to a concern for health – see Box 3 overleaf.

'... Old-fashioned didactic approaches based on education about germ theory and threat of disease have been the norm,' states one commentator (WSP 2002). But, although discouraging poor hygiene practices and encouraging good hygiene practices is important, it will not be enough: just because people know about disease and the cause of disease it does not necessarily follow that they will do something about it. The regular daily conduct of individuals and their habits will be based, at least in part, on reasoned decisions as to how

¹¹ WSSCC is here citing the words of Surjya Kanta Mishra, Minister for Health and Family Development in West Bengal, India, a former doctor and local government leader, who apparently helped launch a well-known pilot project in Medinipur and thereafter promoted a 'total sanitation' campaign in West Bengal.

Box 3

Why might an individual/household choose to use a latrine, instead of opting for open defecation?

Source: WSP and WaterAid (2000)

- **PRIVACY** Lack of privacy during open defecation is a major issue for women. A household latrine means that women do not have to wait for certain times of day, e.g. dawn or dusk, to relieve themselves.
- **CONVENIENCE** Latrines can be constructed next to the house, which is closer than traditional open defecation areas. Latrines can also be built with bath extension, increasing their utility for women.
- **SAFETY** Encounters with snakes, insects, vehicles and vegetation are common. Examples include the death of a 12-year-old girl from snakebite and a 48-year-old man killed by a bus while defecating by the roadside.
- **STATUS/PRESTIGE** A household latrine is a symbol of progress and material wealth. WaterAid-India has anecdotal evidence from its project areas to show that if the poorest households can be motivated to construct household latrines, the more affluent households follow suit.
- **COST SAVINGS** The recurring cost to treat consistent poor health is a considerable drain on household resources. A latrine is a one-off cost that is offset, in the longer term, by the cost savings on health bills.
- **INCOME GENERATION** A latrine can be built with a bath extension and the waste water from bathing can be used to generate income from kitchen gardens. In one village, several women used the extra income to pay off the latrine construction loan to the village self-help group.

they organise their daily lives, within the limits of time or resources. Where open defecation offers people adequate privacy, convenience and safety, they may not wish to change their 'bad' habits ('bad' when viewed from a broader public health perspective).

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

2.3.9 'Cultural' factors

Indeed, beyond individual motivations, further potential barriers referred to in the international literature are cultural factors which make the intended beneficiaries of sanitation and hygiene promotion projects reticent or resistant to new facilities. Cultural difference arises from gender: variations in the perspectives of women and men on sanitation facilities are noted by many commentators. The views of adults and children vary too. Household circumstances are also diverse. Different ethnic groups may have varying beliefs and customs, while attitudes to sanitation and hygiene may vary substantially between urban and rural contexts.

3 Burkina Faso survey – national level

In this section, the country context in Burkina Faso is described, and an overview given of the sanitation and hygiene sector. The sector overview is based on interviews conducted by ODI and Accedes in the capital, Ouagadougou.

3.1 Burkina Faso

Burkina Faso is a small, francophone, landlocked country in West Africa (274,200 km²), with a population of around 13.6 million inhabitants, according to the last estimate in 2004 (PNUD 2004 in WA BF 2005a). Nearly 80 per cent of all Burkinabes lived in rural areas in 2005 (GoBF 2006a).

The country forms part of the Sahel zone, which is characterised by an arid climate and a fragile environment. Annual rainfall ranges between 600 mm and over 900 mm and is subject to a high variation between years (WA BF 2005a). Agriculture, which represents between 30 and 40 per cent of the GNP, is an important income source of the predominantly rural population. Most rural dwellers make a living through subsistence agriculture and are thus vulnerable to frequently occurring droughts and other natural disasters. Food insecurity is a common phenomenon in Burkina Faso. Cotton accounts for approximately 50 per cent of total exports, which makes the country vulnerable to external shocks (GoBF/UN 2003).

Burkina Faso features among the highly indebted poor countries¹² and in fact, with its GNI of US \$400 per capita, it was one of the poorest countries in the world in 2005 (WB 2005). In the Human Development Index, Burkina Faso is ranked at 174 out of 177 countries in total (UNDP 2006). In 2004, 46 per cent of the population lived below the poverty line of a dollar per day. In reality, poverty in Burkina Faso means that the average life expectancy remains below 50 years (WB 2005), that 192 out of 1,000 children born died before reaching their fifth birthday (UNICEF 2006), and that only 22 per cent of all Burkinabes above the age of 15 are literate today (GoBF 2006).

Poverty across the country has been rising rather than declining despite donors' investments over the last few years (GoBF/UN 2005). In the rural water sector alone, bilateral and multilateral donors accounted for 89 per cent of all investments in the last recorded period from 1996 to 2000 (PEA 2005). Burkina Faso is thus highly dependent on outside assistance for any development interventions it plans to undertake.

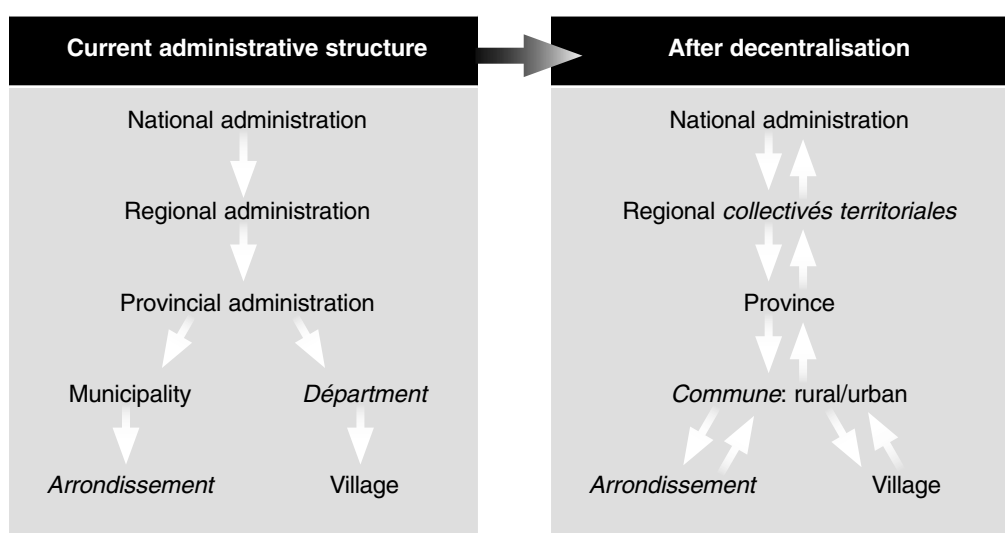
¹² See also: www.imf.org/external/np/hipc/index.asp

3.2 The political-administrative structure

In the past, Burkina Faso has been a centralised state, with an institutional structure inherited from French colonialism. Decisions were taken at the centre and then executed at the local level via the political-administrative hierarchy. The administrative structure is divided into five layers. As shown in Figure 2, the highest layer is the national administration, which is followed by the regional administration and the province. Below the province, the administration used to be split into rural *départements* and urban municipalities. *Départements* represented a number of villages, whereas the municipalities comprised several *arrondissements*.

Since the early 1990s, Burkina Faso has been undergoing a process of decentralisation. Driven by a push towards democratisation, the constitution of 1991 establishes *Collectivités Territoriales* (CTs) at regional and local level as the basic democratic and administrative entities. Throughout the 1990s, a number of laws were introduced to implement decentralisation, of which the most recent is the *Code Général des Collectivités Territoriales*,¹³ adopted in 2004. This latest development in Burkina Faso's decentralisation process is the most significant. It establishes that local governments are juridical entities, which enjoy financial autonomy. These local governments will replace both, former rural *départements* and municipalities, by so-called *communes*. These local government entities have the right to administrate themselves and to establish their own development plans according to locally set priorities including sanitation services. Both urban and rural local governments will be governed by the same rules. The first local government elections took place on 23 April 2006.¹⁴ At the village level, it is envisaged that Village Development Councils (CVTs) will be responsible for development projects in their own villages and will also form part of local government working groups (Sawadogo 2006, interviews).

Figure 2
Administrative
structure before and
after decentralisation



¹³ General code for local government areas

¹⁴ With the local elections of 2006, local governments have actually been established for the first time in most localities.

The decentralisation process envisages that there will be a 'fast-track process' for the transfer of a number of core responsibilities to local governments. These responsibilities include sanitation and hygiene promotion (Sawadogo 2006).

According to government officials, the overall transfer process from line ministries to local governments has already begun. A number of decrees have been issued to guarantee the transfer of goods and infrastructure and the transfer of financial resources. But donors currently supporting the process of decentralisation in the field remain cautious. Their experience so far has been that the Ministry of Finance finds it difficult to loosen its control over financial resources.

Another bottleneck seems to be the transfer of human resources and competencies from line ministries to local governments. On the one hand there are procedural complications but another problem is the overall lack of human resources at municipal level, which has led to serious crises in various municipalities across the country. In reality, many municipal councils, which have already decentralised responsibilities, are currently run as 'one-man shows' by the local executive (interview with MATD). The future development of the sector will depend on whether or not these local governments draw up and implement hygiene and sanitation strategies for their constituencies.

3.3 Water and sanitation coverage

In Burkina Faso, 60 per cent of the population had access to an improved water source in 2005 and 29 per cent had access to basic sanitation facilities (GoBF 2006; PEA 2005).

Table 1
Essential indicators
for Burkina Faso

Total population (2004)	13.6 million (WA BF 2005a)	
Under-five mortality rate (per 1,000)	192 (UNICEF 2006)	
Adult literacy rate	21.8% (GoBF 2006)	
Water and sanitation coverage (2005)	<i>Access to water</i>	<i>Access to sanitation</i>
<i>Urban</i>	85% (GoBF 2006)	69% (PEA – Region Afrique 2005)
<i>Rural</i>	51% (GoBF 2006)	15% (PEA – Region Afrique 2005)
<i>Total</i>	60% (GoBF 2006)	29% (PEA – Region Afrique 2005)

As shown in Table 1 above, the overall water supply coverage rate of 60 per cent translates into 51 per cent for rural and 85 per cent for urban areas. According to WA BF (2005a), these average figures need to be considered with caution as they may hide disparities between and within provinces.¹⁵ For access to sanitation, official statistics suggest a breakdown of 69 per cent for urban areas and 15 per cent for rural areas (PEA 2005). According to the latest figures from the Ministry of Agriculture, Water Resources and Fisheries (MAHRH) however, official latrine coverage remains below 1 per cent in rural areas if traditional latrines, which do not meet official standards, are left out of the equation. In Burkina Faso, only those sanitation facilities that prevent humans, animals and insects from coming in contact with human excreta are classified as improved technologies (MAHRH 2006c).¹⁶

Whatever the real figures, sanitation coverage in Burkina Faso remains dramatically low in rural areas. The high under-five mortality rate of 192 children per 1,000 life-births – equivalent to nearly a fifth of all children born – can be seen partly as a consequence of this. International statistics suggest that the majority of under-five child deaths are linked to water-borne diseases such as diarrhoea, cholera, dysentery and malaria (Evans 2005). In Burkina Faso, 56.8 per cent of all consultations at health centres for children under the age of five are linked to diarrhoea. At the same time, only 12.8 per cent of all women understand the causes of the disease (MAHRH 2006c). Box 4 illustrates how these statistics translate into real-life situations in the village of Farakoba, Burkina Faso.

Box 4

Sanitation and hygiene in Farakoba

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

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

The Water and Sanitation Programme (PEA 2005) estimates that the country would have to increase its capacity to deliver sanitation services more than six-fold to reach the Millennium Development Goals by 2015 – a mammoth task for a country with limited resources. In the remainder of this report, particular attention will be paid to basic sanitation in rural areas, where the situation is the most precarious in Burkina Faso.

¹⁵ According to WA BF (2005), coverage rates between provinces range between 39 per cent for the province of Banwa and 166 per cent for Yagoua province, according to the national guidelines that one water point should be provided for 300 persons.

¹⁶ Sanitation technologies classified as improved by the GoBF are: VIP latrines, latrines with a covered pit, latrines with a flush system, septic tanks and sewer systems (MAHRH, 2006a).

So, what exactly stands in the way of improved hygiene and sanitation in Burkina Faso and how can the status quo be improved? At which stage is the sector currently and what are the main barriers and supportive factors for its future development? For this, we need to turn to the institutional and policy context that governs the sub-sector in Burkina Faso.

3.4 The development and organisation of the sector

In Burkina Faso, sanitation and hygiene are still at an infant stage as national sectors. Although there has been a national sanitation strategy since 1996 and a legal framework since 1997, it has remained largely underdeveloped until now. This also goes for hygiene promotion: a hygiene code and policy was adopted only recently, during 2004–2005. In addition to the national sanitation strategy of 1996, the main towns of Ouagadougou have developed their specific sanitation plans in conjunction with a World Bank project restructuring urban water and wastewater management. This means that the city of Ouagadougou and, more recently, Bobo-Dioulasso are the only areas with a sanitation action plan, structure and financing mechanisms in place. The rural areas and small and medium towns, on the contrary, have been completely neglected until recently with no clear strategy, no budget and no delivery mechanisms to cater for these areas. In 2005, with institutional and financial support from DANIDA, the sector began to move. A coordination group was established between the different line ministries, donor agencies, municipalities, NGOs and other civil society organisations and a road map was established to reform the sector.

In the following paragraphs we will explore the main actors, the sector policy and legal framework and how sector policies tie in with wider nationwide policies and reform processes. At the end of this section the main barriers and opportunities, as identified by key sector stakeholders, will be summarised.

3.4.1 The main actors involved in sanitation and hygiene promotion

Sanitation and hygiene promotion is compartmentalised between different ministries in Burkina Faso. At the national level, as many as five ministries have partial responsibilities for sanitation or hygiene promotion. Three additional ministries have an impact on the sub-sector by the nature of their interventions. Because of the government's limited spending capability, outside actors i.e. donors and international and local NGOs, also play an important role in the sector. While the former have important leverage on the formulation of policies, the latter have a crucial role to play in implementing sanitation- and hygiene-related interventions. The main sector actors, their core competencies and interrelationships are described below and displayed in Figure 3.

In 1996, when the first sanitation strategy was developed, water supply was still part of the environmental sector. The Environmental Code of 1997 quotes the Ministry of the Environment as the agency responsible for waste disposal and the management of rainwater. A few years later, the competences for water supply, and with it sanitation, were moved to the agricultural sector. Since then, the competencies of the current **Ministry of Environment and Living Conditions (MECV)** with regard to sanitation have been reduced to environmental protection issues such as pollution and the management and control of

Figure 3
Ministerial
responsibilities
for sanitation and
hygiene promotion
in Burkina Faso

Ministries	Related offices / departments	Notes
MINISTRY OF AGRICULTURE, WATER RESOURCES AND FISHERIES – MAHRH	General Directorate for Drinking Water Supply – DGRE	<ul style="list-style-type: none"> • Development of juridical sanitation framework, and control of its implementation • Development of national policies for wastewater and excreta management
	National Water and Sanitation Office – ONEA	<ul style="list-style-type: none"> • Sanitation in urban areas
MINISTRY OF HEALTH – MS	Directorate for Public Hygiene and Health Education – DHPES	<ul style="list-style-type: none"> • All issues regarding public hygiene
MINISTRY OF ENVIRONMENTAL AND LIVING CONDITIONS – MECV	General Directorate for the Improvement of the Living Environment – DGACV	<ul style="list-style-type: none"> • Issues regarding environmental protection such as pollution and the management and control of solid, industrial and medical waste
MINISTRY OF TERRITORIAL ADMINISTRATION AND DECENTRALISATION – MATD	General Directorate for the Development of Local Governments – DGDCT	<ul style="list-style-type: none"> • Ensuring the implementation of the decentralisation process
MINISTRY OF BASIC EDUCATION AND LITERACY TRAINING – MEBA		<ul style="list-style-type: none"> • Hygiene and sanitation through school curriculum
MINISTRY OF INFRASTRUCTURE, TRANSPORT AND HABITAT – MITH		<ul style="list-style-type: none"> • Probably stormwater management
MINISTRY OF ECONOMY AND DEVELOPMENT – MEDEV		<ul style="list-style-type: none"> • Coordination and implementation of PRSP
MINISTRY OF FINANCE		<ul style="list-style-type: none"> • Provision of budgets for the sub-sector
Coordinating bodies		
National Coordination Group for Water Supply and Sanitation – CCP-AEPA		
Technical Water Committee – CTE		
National Water Council – CNE		

solid, industrial and medical waste (according to interviews for this study). Within MECV, the General Directorate for the Improvement of the Living Environment (DGACV) is the agency responsible for the sub-sector (GoBF 2006).

The **Ministry of Agriculture, Water Resources and Fisheries** (MAHRH) inherited responsibilities for water matters from the environmental sector at the beginning of the millennium. This includes all aspects of sanitation related to water supply, namely wastewater and excreta management (according to an interview with DGRE). Within MAHRH, the General Directorate for Water Resources (DGRE) is in charge of taking these issues forward. When it comes to implementing wastewater and excreta management, institutional responsibilities are divided into an urban sub-section under the auspices of the semi-autonomous National Office for Water and Sanitation (ONEA) and a rural sub-section headed by DGRE.¹⁷ As described above, sanitation coverage in the main urban centres, the development of which has been supported by the World Bank over the last ten years, is substantially better than in rural areas.

One additional element of the sanitation sector is the development and management of storm drains. In Burkina Faso, this area should theoretically fall within the remit of the **Ministry of Infrastructure, Transport and Habitat** (MITH). This notwithstanding, stormwater management is not explicitly mentioned in the mission of MITH, which also does not have the adequate human resources to deal with this area (GoBF 2006). This aspect of sanitation was still to be clarified in August 2006.

Apart from infrastructure development and management, promoting safe hygiene behaviour and encouraging people to adopt sanitation facilities are crucial elements of the sub-sector. In Burkina Faso, the Ministry of Health (MS) holds overall responsibility for hygiene promotion – a field which is still in its infancy. The national hygiene strategy and implementation guidelines were adopted in 2004, followed by a Public Hygiene Code in 2005. Within the ministry, the General Directorate for Public Hygiene and Health Education (DPHES) presides over these activities and also ensures the coordination of all public hygiene-related activities. The responsibilities of MS are theoretically complemented by the **Ministry of Basic Education and Literacy Training** (MEBA), which is in charge of raising awareness of hygiene and sanitation as part of the school curriculum in Burkina Faso (GoBF 2006).

Outside the sector, a number of other ministries have an important impact on the implementation of sanitation and hygiene promotion policies:

- The **Ministry of Territorial Administration and Decentralisation** (MATD) has been created in order to facilitate the ongoing decentralisation process in Burkina Faso, which will be described in more detail below. MATD's task is to organise the transfer of responsibilities, personnel and financial resources from the central line ministries to local governments and to support the latter in setting up local development plans, which will include the provision of sanitation services and hygiene promotion activities. Although the ministry is not directly involved in sector policies, the success of the decentralisation process, managed by MATD, will be crucial for improvements in implementing sanitation- and hygiene-related policies in the rural local governments of Burkina Faso.

¹⁷ After the completion of the field visit in October 2006, a sanitation directorate was established under DGRE (personal communication with WaterAid Burkina Faso).

- The **Ministry of Economy and Planning** (MEDEV) is responsible for coordinating all activities to reduce poverty in Burkina Faso. Through the Burkinabes Poverty Reduction Strategy Paper, MEDEV prioritises particular sectors for poverty reduction. As such, the ministry has, in theory, an important impact on sector budget lines.
- Finally, the **Ministry of Finance**, with its role of providing budgets, controls the governmental financial flows to the sub-sector.

A number of coordinating bodies have been created with a view to achieving coordination between the different ministries. The **Coordination Group for Water Supply and Sanitation** (CCEAPA) was set up to facilitate interaction between all stakeholders concerned with water supply and sanitation, to get sector reforms agreed and underway. The CCEAPA is open to all actors including the private sector, civil society organisations and donors. Formed in 2005, it has developed a road map towards a sector-wide approach for WSS under the leadership of MAHRH (GoBF 2006). Since it was set up in mid-2005, it has met several times to discuss the development of the sector and, for example, to discuss the reviewed sanitation strategy. It is, however, not clear how inclusive the process is in reality. The NGO Wateraid has, for example, not been invited to discuss the reviewed strategy since February 2006. As far as sectoral leadership is concerned, it remains to be seen how seriously MAHRH will take its leadership role in the future.

The **Technical Water Committee** (CTE) is an inter-ministerial body that needs to be consulted on all important decisions with regard to water resources management, including, for example, the revision of the national sanitation strategy (GoBF 2006).

The **National Water Council** (CNE) is another body with a wide membership across central and decentralised government bodies, user organisations and scientific bodies. It needs to be consulted for all major decisions regarding water supply and sanitation, and also has a legislative function. It can propose various initiatives that might lead to better WSS management (GoBF 2006).

The two main **donors** providing support to sanitation and hygiene promotion are DANIDA and UNICEF. DANIDA provides support to the water and sanitation sector. Its institutional and financial support is directed towards MAHRH, the ministry responsible for water supply. The medium- to long-term goal of DANIDA is to establish a sector-wide approach for both water supply and sanitation by strengthening MAHRH as the lead agency for the sector. UNICEF prioritises hygiene promotion. Its support is focused on DHPES, the directorate for hygiene promotion and health education under the Ministry of Health. A number of other donors including the World Bank, the African Development Bank, the German Development agencies, the European Union and the French Development Agency (AFD) provide support to the sub-sector. But recent sector studies by GoBF (2005) and WaterAid (2005a) indicate that their activities have so far mainly focused on urban and peri-urban areas. DGRE is currently in discussion with some of these donors about supporting the implementation of a revised sanitation strategy.

In Burkina Faso, a number of **non-governmental organisations** (NGOs) are active in the water sector but their total number is unknown. At the national level, 26 organisations formed a water and sanitation network in 2004. The mission of the NGO Coordination Group for Water supply and Sanitation (CCEPA) is to improve coordination across sector

NGOs and to carry out lobbying at the national level. According to member organisations in the network, CCEPA is still in its infancy concerning the development of a common lobbying approach for sanitation. This opinion is echoed by donor organisations that consider the network's voice on sanitation- and hygiene-related issues to still be weak.

The **private sector** also appears to be weak in the area of sanitation and hygiene promotion. ONEA supports private entrepreneurs in producing latrine components such as slabs (according to an interview with ONEA). Apart from that, the government does not know the capacity of the private sector and the private sector seems to have been largely ignored as a potential partner for increasing sanitation coverage and for activities around hygiene promotion in the past (according to interviews for this study).

3.4.2 The legal, policy and budgetary framework

Both legal frameworks and policy strategies are a necessary precondition for making strategic progress on sanitation and hygiene promotion. In Burkina Faso, the legal framework for sanitation continues to be governed by the Environmental Code of 1997, while the national sanitation strategy, which sets the policy framework, is currently under review by the CCEAPA. The legal and policy framework for hygiene promotion was reformed in 2004–2005. The sanitation sector is also governed by the wider poverty reduction framework for Burkina Faso and by the sectoral budgetary allocations accompanying the PRSP. This section sets out the main elements of the sector at national level.

The legal framework

The main legal text referring to sanitation is the Environmental Code of 1997¹⁸ which, in its Article no. 5, paragraph 14, defines sanitation as the management of:

- solid, liquid or gas-like waste from households, public and private institutions, industries, small manufacturers and agriculture
- rainwater
- plant and animal waste.

According to the recent review of the sanitation sub-sector by GoBF (2005), this makes sanitation a cross-cutting issue and explains why there is no specific 'sanitation law' in Burkina Faso. Instead, there are a number of laws in different sectors, which make reference to sanitation. These laws are listed in Box 5 below.

Articles 5 and 58 of the Environmental Code set out that the ministry in charge of the environment is also in charge of developing a national sanitation strategy. However, since the code was published in 1997, ministerial responsibilities have been restructured in Burkina Faso with the above-mentioned consequence that water has been allocated to the agricultural ministry. The draft revised sanitation strategy takes account of these changes by giving each line ministry the lead in developing the legislative framework and national policy for the particular aspects that fall within their sector. This means, for example, that MAHRH is responsible for all aspects of wastewater and excreta management, MECV is in charge of issues relating to solid, liquid and gas-like waste management, and MS takes care

18 Code de L'Environnement, Law No 005/97/ADP in GoBF, 2005.

Box 5

Additional laws
with reference
to sanitation and
hygiene promotion

Source: GoBF 2005

- The **Public Health Code of 1994** provides an overall framework for wastewater and excreta management and also specifies the type of household sanitation that is obligatory in urban and rural areas.
- The **Agrarian and Ground (*foncier*) Reorganisation of 1996** sets guidelines for the protection of drinking water and divides responsibility for different aspects of its implementation between the ministries in charge of the environment, water, habitat, territorial administration and health.
- The **Orientation for Water Management Law of 2001** elaborates on the environmental code for wastewater and excreta management by covering the drainage of wastewater, as well as water treatment and purification. A decree in 2005 (decree no. 2005-187) further specifies different types of works to be undertaken to guarantee adequate water management.
- The **Local Government Code of 2004** devolves the majority of responsibilities relating to sanitation to local governments. This includes all responsibilities with regard to rainwater, wastewater and excreta management, health and hygiene promotion.
- The **Public Hygiene Code of 2005** in many ways reinforces other existing laws on sanitation. It focuses on the regulation of hygiene in public spaces i.e. streets and swimming pools and in public, industrial, food-processing and school buildings.

of hygiene and bio-medical waste. The only aspect of sanitation without a clear institutional home is the management of rainwater (GoBF 2006a). Overall, MAHRH has responsibility for taking the initiative in developing further a legislative and strategic framework for sanitation. The MECV has more of a regulatory function i.e. safeguarding evolving norms (according to an interview with DGRE).

**The policy
framework**

The first policy document on sanitation is the National Sanitation Strategy of 1996 (MEE 1996). As stated above, this strategy was developed during the restructuring of the urban sanitation sector in Burkina Faso and therefore focused primarily on urban wastewater and excreta management. As such, the sanitation strategy of 1996 had a number of important shortfalls. It did not take into account all aspects of sanitation i.e. aspects of environmental protection and it did not make an explicit connection with hygiene promotion. Furthermore, no guidance was given for improving sanitation in rural areas and new developments under decentralisation over the last few years were not taken into account (according to interviews for this study and MEE 1996).

Since the setting-up of the national sector coordination group CCEAPA in 2005, MAHRH has commissioned the preparation of a new **national sanitation strategy**. This strategy is accompanied by various sub-programmes, setting out the objectives, strategies and investment needed to reach the MDGs for Burkina Faso by 2015 (MAHRH 2006a; MAHRH 2006b). The draft national sanitation strategy was reviewed by the sector coordination group, the Technical Water Committee and the National Water Council between February and August 2006. In October 2006, it was about to be approved by the Council of Ministers (according to an interview with DGRE). The reviewed strategy identifies juridical gaps that need to be plugged and sets out the institutional framework for implementing sanitation and hygiene promotion. The socio-economic principles for sanitation envisage a demand-based approach, realised through encouraging behaviour change and participatory approaches that take into account the needs of women, children

and handicapped persons. The draft strategy sets out a priority list of appropriate technologies to be adopted for rural and urban areas that are to be verified by feasibility studies. For the implementation of the strategy, the government relies heavily on the support of NGOs and the private sector, as well as declaring its intention to strengthen inter-ministerial cooperation and to intensify capacity-building of local governments and line ministries. (GoBF 2006; Interview with DGRE). So far, it remains uncertain whether latrine construction will be subsidised in rural areas. MAHRH is currently in discussion with potential donor organisations about piloting the implementation of the revised strategy. While the ministry is in favour of providing subsidies, some donors are strictly opposed to this idea. The outcome of this debate was still uncertain in October 2006.

For **hygiene promotion**, a national policy was developed in 2004 (MS 2004). This document provides an overall orientation regarding institutional organisation, the responsibilities of key actors, overall coordination, capacity development and a communication approach in order to implement the legal framework for hygiene promotion. The strategy focuses on inter alia hygiene promotion in rural areas and schools, and on the development and capacity-building of technical services in municipalities.

In common with all other sectors in Burkina Faso, sanitation and hygiene promotion are part of the wider framework set out in the country's **Poverty Reduction Strategy Paper** (PRSP). Burkina Faso was one of the first states to receive debt relief in 2002 after embarking on a Poverty Reduction Strategy process in the year 2000. As such it is seen as one of the more progressive countries in sub-Saharan Africa (Wegemund 2004; Mehta and Fugelsnes 2003). But the picture changes when one examines the inclusion of water and sanitation in Burkina Faso's Poverty Reduction Strategy Paper. Water and sanitation were only poorly represented in the first PRSP, falling behind other sectors in Burkina Faso. In the case of sanitation, no figures on overall coverage were provided in the PRSP (Mehta and Fugelsnes 2003). In the second PRSP – finalised in July 2004 – the fact that no separate budget line was allocated to sanitation is a strong indication that the sub-sector continues to lag behind water and other sectors, although it is listed as one of the priority areas of the latest strategy (MEDEV 2004).

Although the PRSP provides an overall framework for sanitation and hygiene, the coherence between the sub-sector and the overall PRS process was minimal in 2006, according to various stakeholder interviewed. This may be related to the lack of political priority accorded to sanitation to date and to the historical lack of coordination between sub-sector ministries.

The budgetary framework

In 2006, sanitation did not have a separate budget in Burkina Faso. Any investments in the sector had thus been limited to donor-supported projects and NGO interventions. This means that any sanitation-related activities in Burkina Faso have been carried out under donor-funded projects and programmes and have been limited to particular geographical areas until now. The General Directorate for Water Resources now plans to start a campaign to lobby the Ministry of Finance to provide a sanitation budget in the next financial year. In parallel, the line ministry also expects to receive continued support from the international community to implement the draft strategy (according to an interview with DGRE).

4 Burkina Faso survey – local study

In addition to scoping the sanitation and hygiene ‘sector’ at national level, Accedes and ODI carried out a study at district and local level. In this section the context and scope of that ‘local’ study are described, and the findings from it summarised.

4.1 Context of local study

Bobo-Dioulasso is situated in the west of Burkina Faso, 365 km from the capital Ouagadougou. The city of Bobo-Dioulasso, with its 410,000 inhabitants, is the second largest city in Burkina Faso (INSD, not dated). Bobo-Dioulasso is the capital of the Haut-Bassins region and of the Houet province (as shown in Map 1), which comprises nine local government areas (*communes*).

Map 1
Location of
Burkina Faso, and
Houet province



KEY ■ Houet province ● Capital city ● Chief town of district

The west of Burkina Faso has one major wet season lasting from May to October. However, rainfall patterns vary between years with droughts, occurring on a regular basis. This and other natural disasters such as locust swarms tend to render the already low agricultural production insufficient. This has severe consequences for the population living around Bobo-Dioulasso, whose livelihood depends predominantly on subsistence agriculture.¹⁹ Food insecurity is a chronic phenomenon around Bobo-Dioulasso, according to Accedes.

¹⁹ The main crops are millet, maize, sorghum and groundnuts. Cotton is the main cash crop in the area.

In the local government area of Bobo-Dioulasso, the soil is sandy and prone to erosion and in some areas rocky, which means that particular techniques are required for constructing toilets (PNGT 2000). There are relatively few trees and shrubs around due to the dry and hot climate. According to Accedes, the vegetation cover around Bobo-Dioulasso has been declining in recent years due to increased population pressure. This has meant that open defecation, which is normally practised in the shelter of shrubbery, has become more difficult in the area.

4.2 Action research methodology and process

The research team from Accedes consisted of three people. The team carried out the action research within a period of three weeks between the end of March and mid-April 2006. The team consulted background literature to obtain statistical information about the villages consulted. In each village, gender-separated focus group discussions of ten men and ten women were held to explore issues around hygiene practices and drivers and barriers for latrine construction. In addition, key informants such as teachers, health workers, priests and administrative representatives were consulted to triangulate the results of group discussions. Furthermore, administrative representatives at village, department, provincial and regional level were interviewed on the challenges they face with regard to implementing hygiene- and sanitation-related interventions. A list of individual interviewees is provided in Annex 2.

During the field research, obtaining official statistical information on health and sanitation at the local level proved to be difficult. Furthermore, it was difficult to interview all key people in all locations due to time constraints imposed by the rapid nature of the research.

Box 6

Profile of Accedes

Accedes (Christian Alliance for Economic Cooperation and Social Development) was founded in 1995 with the vision of supporting economic cooperation and social development in Burkina Faso. Based in the regional capital Bobo-Dioulasso, the second largest town of Burkina Faso, it is situated in the province of Houet, in the Haut-Bassins region. Accedes operates today in 14 different provinces. The Christian organisation works on food security, education, micro-finance, environmental protection and health. Accedes' interest in sanitation is linked to its interventions in health, which include providing water and promoting hygiene in 30 villages in three regions with Tearfund's support over the last two years. The organisation observed that, despite its water supply and hygiene programme, health benefits remain limited in the villages where it works because water is often not stored safely and only a fraction of the population has access to basic latrines. This was one of the reasons why Accedes, together with Tearfund, carried out a study to better understand why hygiene and sanitation practices are poor in Burkina Faso and to identify and respond to these barriers.

4.3 Scope of local study

For the local action research, five villages were chosen. Since the research is of an exploratory rather than a representative nature, the criteria for choosing the villages were proximity to Accedes offices and an existing relationship between the locations and the NGO. All five villages are located within the administrative boundaries of the rural local government area of Bobo-Dioulasso, at a distance of 12 to 30 km from the regional capital. Accedes has run water and education projects in all these rural communities. The names of the five villages are Borodougou, Farakoba, Kouentou, Santidougou and Yegueresso.

The villages each have between 1,300 and 4,200 inhabitants. All villages have a population of varied ethnic and religious backgrounds. They are composed of Bobos, the main local ethnic group, and Peulhs, Mossis, Samos and Dagaris. The religions practised in the villages are Animism, Catholicism, Protestantism and Islam.

4.4 Findings from the local study

4.4.1 Local coverage

Table 2 below summarises the situation encountered by Accedes in each of the villages studied. It demonstrates that all villages have a basic health and education infrastructure (considering Borodougou and Yegueresso as part of one settlement); three villages also have some form of agricultural infrastructure such as mills. All villages have access to improved water supply but only Santidougou meets the national water supply target of providing at least one water point per 300 persons (WA BF 2005a). As for latrine coverage, no official statistics were available from the agencies visited, either for the region, the local government area or any of the villages. According to counts of household latrines carried out by the local health workers for the research, the coverage ranges between 4.3 per cent for Kouentou and 17.9 per cent for Yegueresso, based on an average household size of 10 persons.²⁰ The majority of these latrines were traditional: a dug hole covered with wooden planks and a basic straw structure around it to ensure privacy. The field research also found that neither of the two existing local market-places had latrines and that, in one case (Kouentou), the local school did not have any sanitation facilities. The only public sanitation facilities available were attached to churches and mosques. This means that most villagers go to the bush or use plastic bags to defecate.

According to the three health workers of Farakoba, Kouentou and Santidougou villages, the main diseases occurring in the villages close to Bobo-Dioulasso are diarrhoea, stomach aches, vomiting, malaria, dysentery, bilharzias and meningitis. Farakoba, in particular, experienced a rise in dysentery in 2005, which prompted the local health centre to encourage latrine construction in the village (see also Box 4). The current plan developed by the centre is to substantially increase the number of latrines within the next five years.

²⁰ This is the estimated average household size used by GoBF (2006).

Table 2
Profile of the villages
included in local
action research

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

Village	Distance from Bobo	Inhabitants	Social infrastructure	Water supply and sanitation facilities
Borodougou	15km, non-tarmac road	1,281	1 school (4 classes)	1 borehole 1 dug well 10 latrines (7.8%)
Farakoba	12km, tarmac road	4,191	1 school (6 classes) 1 basic healthcare centre 1 pharmacy 1 agricultural centre 1 agricultural and forestry college 1 rice-processing plant INERA ²¹ research centre	2 boreholes 2 dug wells Number of latrines unknown
Kouentou	30km, national road, non-tarmac	2,317 (Pasteur: 2,028)	1 school (6 classes) 3 mills train station	2 boreholes 3 dug wells 10 latrines (4.3%)
Santidougou	13km, non-tarmac road	1,491	1 school (6 classes) 1 basic healthcare centre 1 pharmacy 1 oil press 2 mills	1 borehole 4 dug wells 16 latrines (10.7%)
Yegueresso	14km, national tarmac road	2,128	1 school (3 classes) 1 secondary school 1 dispensary 1 pharmaceutical depot	1 borehole 38 latrines (17.9%)

4.4.2 Local understanding and attitudes

The barriers and supportive factors affecting the uptake of latrines and safe hygiene practices at village level were identified in focus group discussions of 10 men and 10 women in each village, some of whom had latrines.²² The results of the discussions were triangulated by interviewing people holding key positions in the villages such as the teacher, the nurse, the pastor or imam and the village chief or administrative representative. The results of the discussions provide an insight into people's motivations and perceptions

²¹ Recherche sur l'agriculture, Institut de l'Environnement et de la recherche Agricole

²² In Santidougou, two people; in Farakoba, one person; and in Borodougou/Yegueresso, three people.

regarding hygienic behaviour and latrine adoption in the local government area of Bobo-Dioulasso. The following picture emerges:

- **LACK OF UNDERSTANDING** All focus group discussants lacked an understanding of the linkages between hygiene practices and water-related diseases. While people agreed that excreta are ‘bad’, none of them made the link between contaminated water and disease. The general reason given for diarrhoea, for example, was malaria.

SOCIO-CULTURAL FACTORS Latrines and hygiene practices were also subject to local taboos and traditions. People discussed, for example, a practice of making children drink the water that the whole family has used for washing their hands. This is said to make children stronger. With regard to latrines, there is a taboo among Peulhs that ‘two holes should not face each other’.²³ On a more general level, some of the discussants felt that entering a latrine was like entering a house – and, indeed one that was smelly and, as such, rather unpleasant to be in. Being in an enclosed space was regarded as an inappropriate environment for defecating.

- **WEAK BARGAINING POWER OF WOMEN** There was a strong notion in all discussions that the decision to invest in and to construct a latrine falls within the male domain. As such, even if a woman wanted a latrine, she would still be dependent on her husband. *‘The man takes the decision: he indicates the location, digs the hole and pays for the materials. However, men do not generally see latrines as a priority,’* according to one villager. The importance of these existing role models was underlined by the fact that in the villages of Borodougou and Kouentou, the women groups even refused to talk about the topic of latrines for this reason.
- **LACK OF RESOURCES AND EXPERTISE** Another important constraint that discussants brought up was the lack of financial resources. Several persons stated that they do not have enough money to buy soap. Others said that they do not have the resources to pay for someone to dig a hole and to buy the necessary materials such as cement or a slab. People also reported that the sandy soil in Farakoba and Borodougou made latrine construction difficult, while the discussants in Kouentou had the opposite problem: rocky and granite soils. Because technical expertise is lacking to overcome these constraints, there was a general feeling that it was not worth bothering to try.

On the other hand, the discussants also identified a number of factors that encourage the construction of latrines.

- **THE NEED FOR SAFETY AND PRIVACY** Women, in particular, raised their fears of being bitten by scorpions or snakes when defecating in the open and their need for privacy. In this context, both men and women observed that it becomes increasingly difficult to find bushes and trees close enough to their village, especially during the dry season. Consequently, they have to get up earlier and walk further to reach tree cover.
- **LATRINES AS A SYMBOL FOR MODERNITY** Some discussants associated latrines positively with urban life and as ‘a white man’s affair’²⁴ which they wanted to imitate. This was particularly the case where members of a family had migrated to the town and invested in a latrine upon their return.

²³ *‘Deux trous ne se regardent pas.’*

²⁴ *‘C’est une affaire de blancs.’* (Villager from Farakoba)

- **THE INFLUENCE OF OPINION LEADERS** In two of the five villages, opinion leaders had taken the issue of latrine construction forward. In Kouentou, the local priest, who had undergone training on how to construct latrines, had started to motivate the Christians of the village to construct latrines as part of a communal effort. In addition, both priests interviewed said that they mention the importance of hygiene and cleanliness in their sermons. In Farakoba, the local health worker had developed a plan for increasing latrine coverage after an alarming increase in cases of dysentery in the village; the discussants in Farakoba generally acknowledged the importance of latrines for health and were most convinced of the need to increase latrine coverage.

Box 7

Similar studies

Source: WA BF 2005b

The results of the study are based on focus group discussions in one particular geographical area: the rural local government area of Bobo-Dioulasso. They cannot therefore be extrapolated to other parts of the country without further verification.

This notwithstanding, it is interesting to see that a study carried out by WaterAid in Burkina Faso in 2005 on drivers and barriers for latrine construction in the local government area of Tema-Bokin, Passore province, identifies similar issues. The main barriers discovered by WaterAid's study are **poverty** (lack of financial means to buy construction material), **ignorance** (about health benefits and construction techniques) and **other factors** (such as traditional habits of defecating in the bush). The main drivers identified by the study are **improving well-being** (reduce the walking distance, ensure privacy and improve health), **safety**, and **increasing prestige**.

4.4.3 Local institutions

As explained above, Burkina Faso has embarked on a process of decentralisation. This means that the former rural départements and urban municipalities are now being reorganised into urban and rural communes functioning effectively as local government entities. This is an important change, especially in rural areas where the democratic and administrative representation of the government used to be weak and in some cases non-existent. The first local elections, which took place in April 2006, have been an initial step to establish local governments as the main entities responsible for the implementation of service delivery – including water supply, sanitation and hygiene promotion (GoBF 2006). This means that local governments are now the primary actors responsible for sanitation and hygiene promotion in their jurisdictions. As explained above, local governments are still run as 'one-man shows' in many areas, with virtually no budget or human resources at their disposal. If local governments are to draw up and implement local development plans for sanitation and hygiene promotion, there will be a need to establish working relationships between local government and the decentralised structures of different line ministries. Yet, in October 2006, it was unclear how quickly competencies, skills and financial resources would be transferred from line ministries to the newly established local governments. DGRE, for example, was of the opinion that it would take at least another five years until local governments will be able to take on their sanitation-related responsibilities (according to interviews with DGRE, MATD).

The implementation of national sanitation and hygiene policies and strategies depends on how far the line ministries support local governments in taking on their new responsibilities. With regard to latrine construction and hygiene education in rural areas, this role lies mainly with MAHRH and, to some extent, with the Ministry of Health. Furthermore, NGOs and the private sector have a crucial role to play in advocating behaviour change and supporting latrine construction, according to the draft strategy.

Compared with all other line ministries involved in hygiene promotion and sanitation, the Directorate for Public Hygiene and Health Education (DPHES) at the Ministry of Health has by far the most decentralised structures. At regional level, it works through health and sanitation education centres (CRESAs), which are led by a Hygiene and Sanitation Technician (THA). The technician oversees the health districts in each region, which differ geographically from the administrative structures of local government (MAHRH 2006c). The Haut-Bassins region, for instance, is divided into three different health districts. Each health district has a team of healthworkers responsible for information, education, communication and sanitation (SIECA), and they supervise centres for health and social promotion (CSPS) at village level. The SIECA covering the local government area of Bobo-Dioulasso is responsible for 30 CSPSs (according to an interview with SIECA). The CSPS are the most decentralised structures in the health service. They are normally represented by nurses, mid-wives and pharmacists carrying out basic health education and providing medical services for a number of villages.

The General Directorate for Water Resources (DGRE) at the Ministry of Agriculture, Water Resources and Fisheries (MAHRH) currently leads the process of formulating a new sanitation policy at national level. At decentralised level, however, the ministry's representation is non-existent with regard to sanitation. The ministry has decentralised structures at regional and provincial level, which support local technical support zones covering five to eight villages each. So far, though, these structures only provide support on issues relating to agriculture and fisheries (GoBF 2006). There is currently no expertise with regard to sanitation. Nevertheless, it is envisioned that these structures will give direct support to local governments in elaborating sanitation plans and will collaborate with local NGOs in implementing these plans (according to an interview with DGRE; MAHRH 2006a). It remains unclear how this will be organised.

The prospective implementers of sanitation projects, namely NGOs with competencies in sanitation and hygiene promotion, are still rare in the rural local government of Bobo-Dioulasso. Accedes did not find a single NGO that is currently active in rural areas. The only NGO (PASUD) involved in sanitation works in an urban area of Bobo-Dioulasso on solid waste management and hygiene education in schools.

5 Barriers to sanitation and hygiene

This section reviews to what extent the barriers to sanitation and hygiene policy development referred to in Section 2 exist in Burkina Faso. It uses the same structure as Section 2, based around the stages of the typical policy cycle, to assess which barriers are present in Burkina Faso. This section draws on both the national-level research and the information provided in the focus groups during the local study.

5.1 Problem definition

As stated in the introduction, sanitation encompasses a wide variety of activities. Evans (2005) notes in this context that it can thus be difficult – even for sector experts – to define exactly which issues do, and do not, fall within the sector. In the case of Burkina Faso, the focus group discussions revealed a blurred understanding of what sanitation means in the local context. Several discussants mixed up hygiene practices like hand washing with the use of latrines for defecating. The vagueness around hygiene and sanitation issues is also reflected in the local language: in Jula the term *nyege* refers to both shower and any type of latrine, while the Jula word for hygiene, *sanyia*, also means cleanliness, sacredness and sanctification.

The legal, policy and budgetary framework for sanitation has been rather weak in the past, particularly with regard to wastewater, excreta and solid waste management in rural areas. Now, the review of the sector is well underway. The revised strategy was about to be approved by the Council of Ministers in October 2006. The progress made in these current sector reforms is in itself a very positive development, according to national sector experts.

5.2 Agenda Setting and policy formulation

5.2.1 Lack of information

As Section 3 suggests, there is a lack of up-to-date information on sanitation and hygiene needs in Burkina Faso. Particularly in rural local government areas, official data about latrine coverage and safe hygiene behaviour tends to be non-existent or very poor. In the rural local government area of Bobo-Dioulasso, Accedes could not get hold of any official sanitation statistics. Furthermore, there is little information about NGOs working in the sector and as a result little harmonisation between the approaches used. This can lead to conflicting messages and result on progress being dependent on the preference of individual organisations.

5.2.2 Tensions between mindsets

Sector stakeholders reported that the different mindsets prevalent in the various sectors can at times prevent different ministries from reaching a common understanding of the sector. While MECV is concerned with safeguarding the environment, MAHRH conceptualises sanitation around wastewater and excreta management, a field that is dominated by infrastructure development. DPHES under the Ministry of Health is, in turn, concerned mostly with health-related issues and hygiene promotion which emphasises behaviour change.

Some sector actors still have concerns about the clarity of policy direction that the strategy gives. For example, questions around providing subsidies remained unanswered and, as of October 2006, the overall financing of the sector had not yet been secured.

Among local officials, some interviewees did not perceive sanitation as a public responsibility. Rather, the construction of latrines, for example, was regarded as a private household affair. The only representatives who said they had some responsibility for hygiene promotion and awareness-raising about latrines were health workers at different levels.

5.2.3 Lack of coordination

Responsibility for sanitation and hygiene promotion activities in Burkina Faso is fragmented between different ministries. This in itself is not untypical and it is not necessarily a problem that more than one institution bears responsibilities for sanitation and hygiene promotion. Indeed, a formal coordination platform, the CCEAPA, was established in 2005 to develop a 'road map' for water supply and sanitation, with the ultimate aim of developing a sector-wide approach. This platform includes all major sector ministries, MATD and donors, and is theoretically open to civil society and private sector stakeholders. The main question is how effective the platform will be in driving forward the implementation of sub-sector reforms.

According to the Director of Sanitation under DGRE, previous ambiguities over which sector was responsible for which part of the sub-sector have now been resolved. Historically, it has not been clear whether MAHRH or MECD had the *de jure* leadership for the further development of the sub-sector. Following the revised national sanitation strategy, the Ministry of Agriculture, Water Resources and Fisheries (MAHRH) now has overall responsibility in taking the sub-sector forward.

Yet, a question remains as to the level of genuine coordination between the different ministries. A representative from DPHES, for instance, stated that during the development of a hygiene code and strategy, some ministries kept their involvement at the lowest level. For example, they sent representatives without adequate decision-making power or technical expertise to contribute meaningfully to discussions.

Also, it would seem that the different sectoral mindsets, outlined above, can result in poor communication between different ministries. For example, ONEA, whose aim is to increase sanitation coverage through promoting behaviour change, does not collaborate with the Ministry of Basic Education on a regular basis. Despite initial attempts to 'join

up' activities, *'la mayonnaise n'a pas prise'*,²⁵ according to one official who was interviewed. Whether the recently established CCEAPA can overcome this culture of institutional non-communication remains to be seen.

5.2.4 Lack of political and budgetary priority, lack of demand

Although sanitation is listed as one of the priority areas of the Burkinabes' PRSP, the sub-sector has not received any budget allocations so far. Even within the WSS sector, sanitation lags behind water supply in Burkina Faso. The general lack of political interest in the sub-sector manifests itself, for example, in the low number of staff dedicated to the national directorate in charge: only one person was assigned to sanitation in MAHRH in August 2006. MAHRH's success or failure in making a case for the sector with the Ministry of Finance and the Ministry for Economic Development will be critical in shaping sanitation interventions during the months and years to come.

5.2.5 Donors' agendas

Only two donors, DANIDA and UNICEF, provided substantial support to sanitation and hygiene promotion in rural areas in 2006. In October, MAHRH had entered into negotiations with other donors for additional support to the sector. The provision of subsidies was a key point of discussion as donors had different agenda's from the government in this point.

5.3 Policy implementation

This study was not able to examine all of the potential barriers to policy implementation in the sector. However, evidence that some of the key barriers did exist was found, and is set out as follows:

5.3.1 Lack of human and technical capacity, lack of service providers

According to Accedes' interviews at regional, provincial, local authority and village level, neither representatives from the administration nor private NGOs are currently engaged in latrine construction in the rural local authority area of Bobo-Dioulasso. By law, sanitation now falls under the jurisdiction of local governments but most rural governments do not have any personnel dedicated to and experienced in this field.

Local governments are currently in a process of transition. They are still seriously understaffed and under-resourced. It can be assumed that in many cases, they are not even aware of their sanitation-related tasks. As regards health administration, which is the only institutional structure that currently delivers hygiene- and sanitation-related services at the local level, lack of capacity is also a common problem. Health workers often have little time or financial resources, which limits the sanitation and hygiene promotion activities they

²⁵ The collaboration has never really come together.

can carry out in practice. In the department of Bobo-Dioulasso, for example, the CSPSs stated that they are regularly overstretched with curative work, which leaves virtually no time to dedicate to preventative activities such as hygiene education. The SIECAs, who are supposed to support CSPSs in their individual health districts, do not have any budget and logistics available to them that would allow them to provide back-up support to local health workers. In the Haut-Bassins region, SIECAs were only able to carry out three inspection tours in 2006, using vehicles lent by another department (according to interviews with CRESA, SIECA and CSPS representatives).

There are also unanswered questions about how the national sanitation strategy will be implemented: How will MAHRH be able to support local governments in taking on their new responsibilities? How quickly can the private sector and civil society organisations take on their roles in boosting demand and providing services? How will this be financed and who will be capable of coordinating interventions on the ground?

5.3.2 Lack of access to credit / lack of financial resources

As noted above, some of the participants of the focus groups discussions in the local government area of Bobo-Dioulasso said that they did not have enough money for soap, or for the necessary materials to construct a latrine. It could be that these items were not considered essential, and therefore not made a high enough priority for people to spend meagre resources on. However, this part of Burkina Faso is also very prone to drought and food crises and it may be that, at least sometimes, people are living literally hand-to-mouth in many of the villages. This raises the question of whether subsidies will be necessary.

5.3.3 Complexities of behaviour change and cultural factors

As the focus groups revealed clearly, there are many cultural norms and taboos which need to be tackled in the villages if sanitation and hygiene practices are to be improved.

6 Conclusions and responses

6.1 Conclusions

In Burkina Faso, sanitation coverage is very poor. The government estimates that, in rural areas, the percentage of sanitation facilities meeting national standards is below 1 per cent – in other words, virtually non-existent.

This study has examined barriers and supporting factors towards improving the sanitation situation in Burkina Faso. In doing so, particular attention was paid to increasing latrine coverage and hygiene promotion in rural areas, which relate most closely to Accedes' areas of intervention and which are most relevant for achieving the MDGs in Burkina Faso. The particular objectives were to identify impeding and supporting factors with regard to (a) the development of national sanitation policies and (b) the effective implementation of programmes for sanitation and hygiene on the ground. The picture that emerges for Burkina Faso is the following:

- At an individual level, demand for sanitation is generally very low to non-existent and hygiene behaviour is lax. This is due to a lack of knowledge of the health benefits related to safe hygiene practices and sanitation facilities, combined with the prevalence of socio-cultural taboos that support open defecation. In addition, most households lack the financial means for latrine construction and have no access to technical expertise. Latrine adoption is thus a low-priority area. On the other hand, urban sprawl and its influence on rural areas has made people aware of the benefits of latrines, such as privacy and safety, while the growth of rural settlements and disappearance of vegetation cover makes open defecation more problematic. In two of the five villages, opinion leaders had taken the initiative to encourage latrine adoption. It thus seems that encouraging the adoption of basic sanitation practices and safe hygiene behaviour as a priority action for poor households is key, together with providing financial and/or technical support. But what can rural dwellers expect from the government in this regard?
- A national policy framework for sanitation and hygiene promotion is still emerging in Burkina Faso. While, for hygiene education, a policy and legal framework was established in 2005, the revision of the national sanitation strategy was about to be finalised in October 2006. Despite the recent progress, various issues remained unresolved in October 2006. The government's policy on providing subsidies was still unclear. The main ministries with responsibilities for sanitation were part of a coordination framework – but how effective is this coordination? MAHRH, the ministry in charge of water, was identified as the lead agency for sanitation, but how much of a priority sanitation is even within this ministry is still unclear. The ministries' genuine commitment to the current reforms will have to be measured by their actions in the coming months. Also, the sub-sector remains extremely weak as regards resources. In October 2006, sanitation did not receive a disaggregated budget and the department was poorly staffed. Similarly, donor support for sanitation, especially in rural areas, can be described as merely lukewarm and civil society organisations in Burkina Faso are slow in developing a common advocacy position on the topic.

- At the local level, local governments now bear the main responsibility for promoting hygiene. However, as noted above, the decentralisation process has been a recent innovation in Burkina Faso, and it would appear that local government does not yet have the resources or capacity to carry out many of its responsibilities. The General Directorate for Water Resources (DGRE) at the Ministry of Agriculture, Water Resources and Fisheries (MAHRH) currently leads the process of formulating a new sanitation policy at national level. At decentralised level, however, the ministry's representation is non-existent with regard to sanitation.

Although poverty was generally given as the reason for the virtual non-existence of latrines in the five villages, this appears to mask a series of different underlying problems. The root cause, in Accedes' view, is the combination of two factors. On the one hand, the five villages lack information about the links between poor hygiene and water-related diseases. Since villagers do not understand this relationship and are also wary of latrines because of various socio-cultural and economic factors, they do not make the construction of latrines a priority. Their ignorance is compounded by the widespread problem of administrations' inaction on the issue. At regional, local government and village level and across different sectors, government employees (where they are present) do not collaborate in communicating important messages about hygiene education and sanitation promotion. This is partly due to a lack of funds but also linked to a lack of clearly delineated responsibilities and inadequate representation on the ground. If the administration carried out their tasks of sensitising, informing and educating people on the ground, the results would certainly be better, according to Accedes.

The draft sanitation strategy of October 2006 foresees a direct cooperation between MAHRH, MS, local NGOs and the local private sector for increasing latrine coverage. This begs a question about the involvement of the newly formed local governments, which are supposed to play a leading role in delivering sanitation services to their local constituencies.

Given the financial, institutional and logistical constraints and the diversity of actors involved in the sector, improving sanitation in rural areas of Burkina Faso will mean exploring new avenues and new partnerships between governmental and non-governmental actors. Encouraging demand and changing behaviour is a human resource-intensive task, which clearly goes beyond the existing capacities of the government. Nevertheless, the government does have a crucial role to play:

- At national level, it is responsible for providing an enabling framework i.e. a clear policy and implementation strategy and financial resources.
- At local-government level it is in charge of providing a cooperation framework that allows different actors to join forces. This could, for example, mean establishing technical services (with the support of line ministries) that build on existing local societal structures and networks. These might include religious leaders, NGOs, traditional structures and other opinion leaders, as well as the private sector for promoting and supporting change.

6.2 Responses

The following recommendations were formulated as responses during a feedback meeting in Bobo-Dioulasso on 19 October 2006:

- The development of a national sanitation strategy and implementation plan by 2015 in rural areas is a positive step. It is important that unresolved issues such as the provision of subsidies and the development of support structures for implementation be clarified as soon as possible.
- Decentralisation is now taking shape. This offers new opportunities to improve sanitation service delivery and sanitary and hygiene services at the local level. The transfer of staff competencies, skills and financial resources should be driven forward vigorously to enable local governments to take up their responsibilities.
- Each local government should include a sanitation and hygiene promotion strategy for the urban and rural areas under its jurisdiction in its local development plan. Adequate financial resources should be made available for implementation, and progress should be reviewed on a regular basis.
- Each local government should develop a framework for harmonising the activities of different actors (civil society, NGOs, private sector) involved in hygiene promotion and sanitation.
- Religious leaders should take an active part in promoting safe hygiene behaviour and the adoption of latrines.
- Aspects of hygiene and sanitation promotion should be strengthened in formal and informal education programmes.

Annex 1

List of people consulted at national level

- **Yaya Ganou**
Director, DHPES, Ministry of Health
- **Banon Siaka**
Chief of Public Hygiene Service, DHPES, Ministry of Health
- **Felix Zabsonre**
Responsible for HH sanitation, ONEA
- **Ouedraougo Athenase**
Director, Directorate for Sanitation and Pollution Prevention,
Ministry of the Physical and Living Environment
- **Bikenga Sakimata**
Responsible for Statistics and Ecosan, Directorate of Sanitation and Pollution
Prevention, Ministry of the Physical and Living Environment
- **Josephine Ouedragou**
Director for Sanitation, DGAEP, Ministry of Agriculture, Water and Fisheries
- **Thomas Riekel**
Technical Assistant, DGAEP, Ministry of Agriculture, Water and Fisheries
- **Michel Barbier**
Technical Assistant, DGAEP, Ministry of Agriculture, Water and Fisheries
- **Jean-Martin Ki**
Director, Directorate General for the Development of Local Governments,
Ministry of Territorial Administration and Decentralisation
- **Jean-Noel Ilboudou**
Director, Sanitation Department (*Direction de la Propreté*),
City Government of Ouagadougou
- **Chrystel Ferret-Balmer**
Country Director, SDC
- **Jens Fugl**
Co-operation Adviser, Embassy of Denmark
- **Paul-Jean Remy**
Country Director, French Agency for Development (AFD)
- **Togola Soungalo**
Programme Officer, Water, Environment and Sanitation, UNICEF
- **Yéréfelo Mallé**
Country Representative, WaterAid Burkina Faso
- **Yongo Nignan**
Technical Adviser, Eau Vive

- **Osseini Ouedrago**
Technical Adviser, Eau Vive
- **Eva Kouassi Komlan**
Partnership and Learning Department, CREPA
- **Joseph Wethe**
Researcher, Water, Environment and Urban Planning,
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Annex 2

List of people consulted at local level

- Village chief, Santidougou
- Project Secretary, PASUD
- Secretary of the Haut Commissariat, Haut Commissariat
- Prefect of Bobo-Dioulasso, Préfecture
- Secretary of PASUD
- **Ibrahim Fofana**
CSPS nurse, Kouentou
- **Don Hien**
Teacher, Kouentou
- **Moussa Konate**
Leader of CSPS, Santidougou
- **Mamadou Ouattara**
Teacher, Santidougou
- **Yacouba Ouattara**
Pastor, Kouentou
- **Fatoumata Ouattara**
Wife of village chief, Farakoba
- **Ruben Sanou**
Representative of the administration, Santidougou
- **Daniel Sanou**
Pastor, Santidougou
- **Bakary Sanou**
Teacher, Kouentou

- **Tontonmassou Sanou**
Village chief, Kouentou
- **Anselme Some**
Teacher, Kouentou
- **Seydou Traore**
Teacher, Kouentou
- **Issa Toure**
CSPS nurse, Farakoba
- **Amidou Yambressin**
Technician responsible for hygiene and sanitation, Hygiene Service
- **Karim Yogo**
Chief CSPS, Borodougou
- **Raymond Yonli**
Responsible for hygiene, information, education and communication, CRESA
- **Mamadou Zongo**
Responsible for information, education, communication and sanitation, SIECA

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