

GLOBAL SANITATION FUND - OUTCOME SURVEY BRIEF

Global Sanitation Fund Tanzania Programme (Usafi wa Mazingira Tanzania (UMATA) Programme)

June 2018

OBJECTIVE

In June 2018, an independent programme outcome survey was conducted to measure key sanitation and hygiene indicators triggered through the Usafi wa Mazingira Tanzania (UMATA) Programme (The global Sanitation Fund (GSF) Programme in Tanzania). Since 2012, implemented by Plan International Tanzania (PIT) in support of the Government of Tanzania (GoT).

The specific objectives of the survey were:

- To provide statistically reliable data on key sanitation and hygiene outcomes of the UMATA programme in households and public facilities
- To measure whether Open Defecation Free (ODF) status has been sustained among previously verified communities
- To assess the programme integration of equity and non-discrimination and the needs of marginal and vulnerable households or populations
- To describe emerging indicators of programmatic effect, including behavioural norms, habits, and satisfaction with available sanitation services

The UMATA Programme is implemented through 6 sub-grantees in three rural districts of Dodoma region, namely, Kongwa, Chamwino and Bahi districts.

The survey is intended to provide consistent and representative estimates of key indicators in the Programme area for use in assessing programme effectiveness.

METHODS/SAMPLING

The survey uses a cross-sectional design, with a multi-stage cluster sampling approach¹. The sampling frame included all villages and sub-villages in which UMATA Programme is implemented, irrespective of ODF status. Because the effects of the intervention are expected to reach community-wide, including into extra-household settings, data collection also include assessment of schools and health facilities in all selected communities.

The sample size estimation was developed in order to allow sufficient power to provide reliable point estimate for key outcomes of interest for each of the top-level administrative sub-units (state, region, district, etc.) within the Programme. A most conservative expected rate, i.e., 50% was assumed for outcome prevalence.

CONTEXT



The UMATA Programme is a sanitation & hygiene Programme implemented by Plan International Tanzania in support of the Government of Tanzania through Programme Coordinating Mechanism (PCM). It aims to contribute to the overall objective of the National Sanitation Campaign through supporting communities to attain and sustain open defecation free (ODF) status, and households and institutions to gain increased access to and use of improved sanitation facilities, coupled with changed sanitation and hygiene behaviours at scale. UMATA is implemented through 6 sub-grantees in three rural districts of Dodoma region. UMATA uses community-led total sanitation (CLTS) approach in creating demand and triggering sanitation and hygiene behaviour change. National ODF Criteria: 1. All households have and use latrines. 2. 50% or more of the households have and use improved latrines and other sanitation/hygiene facilities i.e. HWFs, refuse pits and utensil racks. 3. Local institutions e.g. schools, health facilities, have improved and properly managed sanitation and hygiene facilities. 4. No visible traces of OD in all open spaces in the community e.g. farmlands, bushes, water points, valleys, along rivers, around water sources. 5. Clear commitment by the community to continue striving to attain full ODF status

Table 1: sample allocation based on the multi-stage sampling strategy in the outcome survey, 2018

Strata	Total	Selected	Method
Primary Sampling Unit	73 Sub-villages	50 Sub-villages	PPS (Probability proportional to size)
Households	1427 households	20 households/Sub-village	Simple random
Structured Observation	250 observations	5 observations/Sub-village	Simple random
Health/school Facilities	Any present	Any present	Purposive

¹ WSSCC GSF Outcome Survey Protocol and Analysis guide (<https://rebrand.ly/09wqau>)

KEY FINDINGS

Access to WaSH services: Overall, households in the survey area have very poor water access, about 18% get water from a safely managed source. In post-intervention area, an important part of the households (87%) use improved latrine facilities that are not shared with other households, 16% share improved latrine facilities, and about 10% use unimproved latrine facilities. 3% of the households still defecate in the open. On handwashing facility, 60% of households had no service, about 21% had limited handwashing facility (without soap or water), and about 19% had handwashing facility on premises with soap and water (JMP basic level).

WaSH and socio-demographics: GSF intervention does make an impact on the accessibility and behaviours of water, latrine and handwashing facility (with/without soap). Overall data shows that in many cases, the lower wealth quintiles had higher open defecation rate and have the least access to well managed water source and latrine. The Bahi district has generally higher level of sufferings in all aspects of sanitation and hygiene. Despite the Programme hard work on Equality and Non-Discrimination (EQND), Household wealth remains strongly correlated with most WaSH indicators. Wealthiest households were more likely to have basic or safely managed drinking water, basic sanitation facilities, basic hygiene facilities and appropriate MHM facilities and materials; Education also seemed to be important in sanitation-related decisions.

Access to Handwashing Facilities

Regarding the access to handwashing facilities, about 60% of the households in the intervention area has no handwashing facility; 21% limited handwashing facility and 19% has basic service (washing facility with soap and water.)

In general, among the communities covered by the Programme wealth did not seem to influence access to handwashing facilities (Figure 2). Owning improved latrines vs unimproved seems not a factor of influence on the quality of the handwashing facility too. Additionally, about 57% of households with no handwashing facility no handwashing service had no formal education. On the other hand, 53% of the respondents who had access to basic handwashing facilities had university or college-level education

Figure 2: Access to handwashing facilities

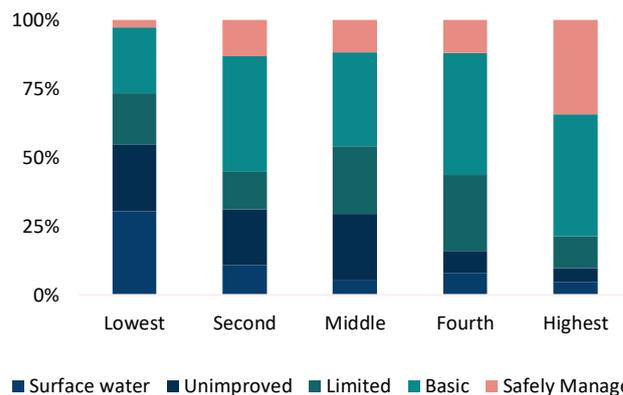


Access to Water

In the zone of intervention, access to water remains a challenge with about 18% of the households getting water from a safely managed source, about 38% with basic access and 13% with no access at all. Household water sources are distributed as following: ~3% within own house, ~15% within own compound, ~81% elsewhere).

In the Programme area, 54% of households were using improved sources of water while 46% were using unimproved water sources. The most common type of improved water sources includes public tap (~31%) and the protected public well (~16%).

Figure 1: Access to water by wealth quintile



Access to Sanitation Facilities

87% of households use improved latrine facilities with 70% having access to safely managed services. 16% use improved latrine facilities shared between two or more households, 10% use unimproved latrine facilities. About 3% of the households defecate in the open (Figure 3). Most households which practice open defecation are in the lowest, second and middle wealth quintiles and open defecation is almost eradicated in the two highest quintiles. The same way, the education of the household head is a strong factor: the more educated the better the access. Eventually, sanitation access is spread almost identically across the JMP service levels in the 3 districts of Kongwa, Chamwino and Bahi. Results also show that people under 25 years old practice more open defecation.

Figure 3: Access to sanitation facilities



Social norms – hygiene and sanitation

Sanitation: About 99% of the respondents agree with the statement that everyone should use a toilet. 50% of respondents stated that none of their neighbors regularly defecate in the open. 90% of respondents stated that their neighbors use a toilet. 99% of respondents said if everyone in their community used a toilet, they would mostly and use a toilet. Irrespective of gender, 62% of respondents reported that they would most likely tell a person who moved into their community to use a toilet if they were found practicing open defecation or inform them that it is not a custom to do so.

Hygiene: About 97% of respondents agreed to the statement that everyone should wash their hands with soap and water after defecation and 96% for before eating. Structured observation shows that overall 78% of respondents/members of households do not wash their hands after defecation, after faecal contact, before preparing food, after respiratory fluid contact, before breastfeeding, before eating and other events of potential pathogen transmission, while 19% of respondents wash their hands with water only and 34% of respondents wash their hands with water and soap. There is no strong evidence of better-established social norms in previously declared ODF communities.

Sustainability of ODF

ODF sustainability was assessed by comparing the ODF status in the survey against the declared ODF status. Overall, 74% of households in previously ODF declared villages have sustained access to Safely managed sanitation and 85% have still access to an improved sanitation facility. Basic handwashing access is also higher in ODF villages and is nearly the double compared to non-ODF villages.

ODF verification in villages previously declared ODF using the national ODF verification criteria finds no universal coverage of basic sanitation at household level. 45% of villages had no observed human feces around households or compounds. All these villages were in Kongwa district (57%) and Bahi district (55.6%). 5.0% of villages (all of which were in Kongwa district) had no sign of open defecation.

Satisfaction

On the criteria of preserving their privacy and feeling of security during the day, women have shared very high levels of satisfaction in all districts. People with limited mobility/vision and people over 65-year-old show poor satisfaction with respectively 40% and 56% of them being not satisfied at all.

Figure 4: Female caregiver/disabled/elderly people's satisfaction with sanitation facilities in following dimensions

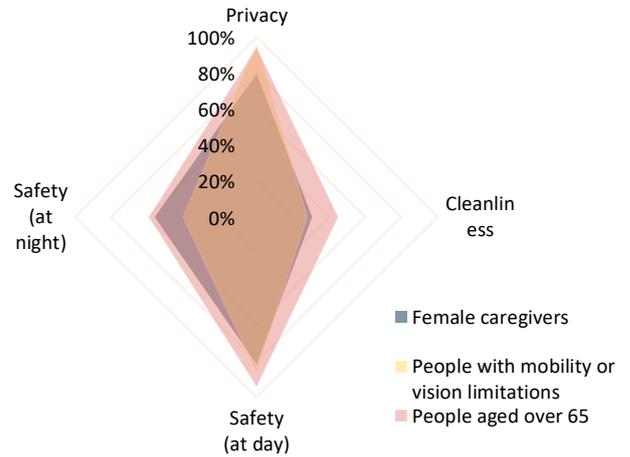


Figure 5: Access to sanitation facilities between communities ODF and non-ODF

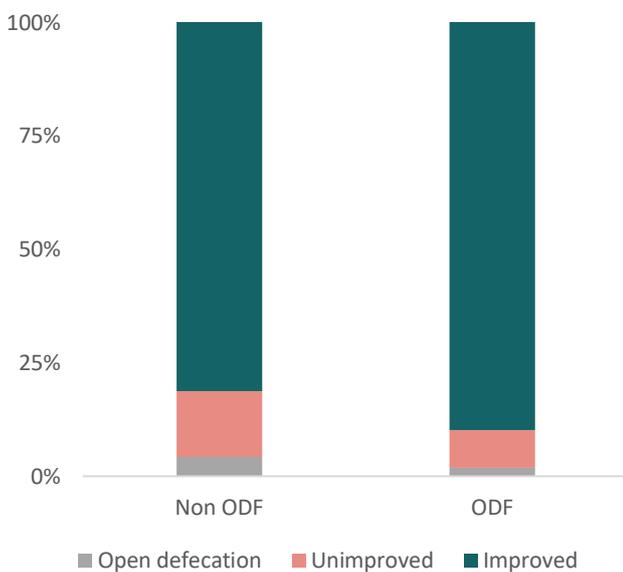
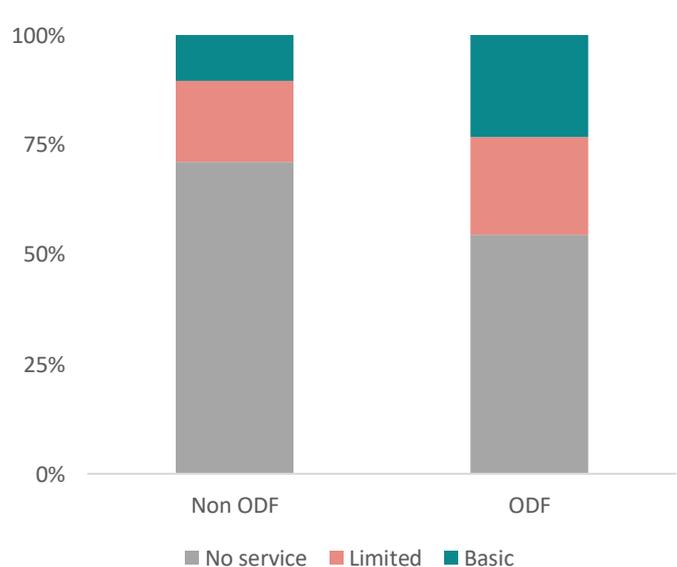


Figure 6: Access to handwashing facilities between communities ODF and non-ODF

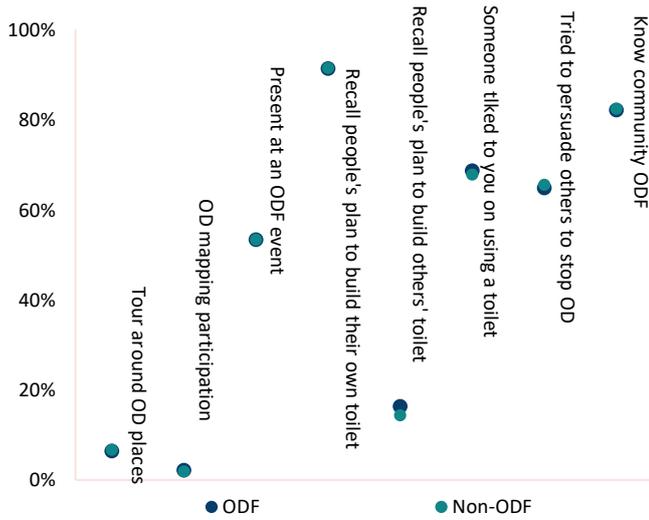


Exposure to Programme Activities

Nearly 80% of the respondents in ODF-certified and non-ODF-certified sub-villages recall participation in one or two programme activities, which confirms high intensity of exposure to programme activities. 78% of respondents stated that they were involved in decision on the kind of toilet the household would build, and 81% stated that they were involved in deciding where the toilet should be located.

Overall, 43% of the households have participated in at least in 1 programme activity. There is no obvious sex difference in exposure to programme activities.

Figure 7: Comparison in level of activity exposure between non-ODF and ODF communities



Menstrual Hygiene Management (MHM)

Questions were included to assess perception and stigma about MHM to serve as a baseline for GSF to go forward.

- **Appropriate materials with private place to wash and change:** 95% said they had pads, cloth or cotton available to manage menstrual period. 91% use appropriate menstrual hygiene materials with private place to change and wash at home. 93% said there is adequate water to clean reusable material and 87% have place to dry the reusable material under sunlight. 94% feel comfortable and 86% said they are affordable with the material available. 99% of them confirm having private place to change and wash at home during the period. 98% has enough water and 93% have enough lighting and 99% are easy to access. 96% feel safe while using the place and 96% have enough privacy.
- **MHM related awareness and stigma:** Overall, 70% of respondents were not aware of the first time when they got their menstruation period, 22% were aware and out of them 86% were prepared to manage the first period while 8% declared they do not remember. 94% of women and girls often feel ashamed about menstruation while 57% feel ashamed during menstrual period.
- **Exclusion of activities during menstruation:** Still around 30% of them did not participate in social activities, school or work due to menstruation in the last 12 months. This absence prevails regardless of age or education level.

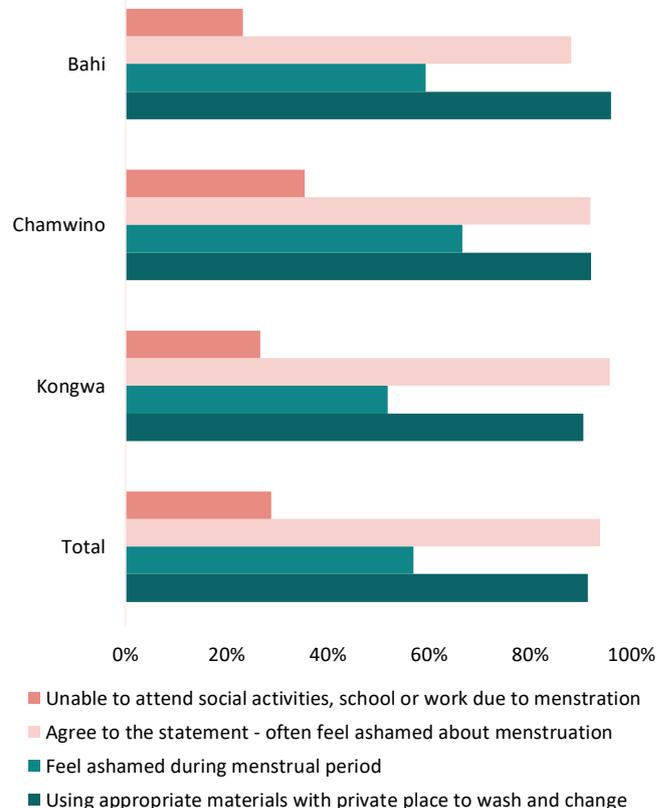
Equity and non-discrimination

Most households (92%) have a toilet facility that household members usually use. On average, 87% of respondents report that all people (boys, girls, men and women) can use the household latrine. They further report that 84% of people with visual/mobility limitation and only 34% of people over age 65 can use household latrine. The low use of household latrine by people over age 65 may be due to mobility and self-care limitations.

84% of people with disabilities respondents stated that they can use latrine every time they need to, 43% are using bucket that is emptied into a latrine, and 14% are defecating in the open space while no one is using another family's toilet or defecating on the floor for someone to pick it to put to the latrine. 87% of respondents are comfortable to use the latrine and 65% of respondents can use latrine without help from any other person while 10% use latrines that has adoptions to help respondents.

90% of over 65 years old respondents can use latrine every time they need to, 38% are using bucket that is emptied into a latrine, and 13% are defecating in the open space while no one is using another family's toilet or defecating on the floor for someone to pick it to put to the latrine. 91% of over 65 years old respondents are comfortable to use the latrine and 83% of respondents can use latrine without help from any other person while 15% use latrines that has adoptions to help respondents.

Figure 8: Menstrual hygiene indicators



Schools

- **Water:** Overall, 30% of the schools have basic water services, 50% with limited and 19% has no services at all. About 46% confirm the consistency of service. However, there is still 8% of the schools with no drinking water at all. In terms of access to water, it is reported that 91% can access through clear path.
- **Sanitation:** Observations were made at 338 toilets in 36 primary schools. There is no clear ratio of student per toilet cubicle. The most found types of toilet are pit latrines without slab (48%), flush/pour-flush (38%), pit latrines with slab (10%). In terms of cleanliness, about 20% of the toilets are clean, 53% somewhat clean and 27% not clean at all. All schools have toilet facilities for students but only 6% have one designated for students with disabilities. 39% of the schools had no anal cleansing material and 42% only had water as the cleaning material. 64% of the school toilets are reported to be cleaned 2-4 times a week and 14% once per week and 22% less than once per week. All schools reported that pupils can use toilets at all time during school day. In sum, 45% of schools have basic sanitation services, 54% has limited services and 12% has no services.
- **Hand hygiene:** Observations were made at 51 handwashing stations in 36 schools. Water and soap were available only at 17% of the schools. On handwashing, 16% of surveyed schools had basic hygiene services, 8% had limited while 75% had no hygiene services.
- **Menstrual hygiene management (MHM):** Observations were made at 36 schools about menstrual hygiene management. 97% of the surveyed public schools reported that they had provided education regarding MHM yet more than half of the school (53%) had no teaching material/resources. MHM material were sighted at 25% of the schools. 50% of the schools had separate place for women to change and wash MHM aside from latrines. 30% had detergent or soaps to clean sanitary clothes and 11% had designated place for drying sanitary clothes.
- **Exposures to GSF programme:** 92% of schools made plan to stop OD in order to become ODF place. 69% of the surveyed population confirmed presence at event where school made a place to become ODF. 89% felt included in the school decision of becoming ODF or to upgrade/construct related facilities. 86% of the schools recalled having a school-wide handwashing promotion and 75% reported motivating children to wash their hands with soap and water.

Health facilities

- **Water:** The main sources of water supply at surveyed health facilities were piped water supply outside the building (39%), unprotected well (19%), protected well (12%), piped water supply inside the building (8%), public tap/standpipe (4%), and tube well/borehole (4%). 12% of surveyed health facilities reported that there was no water provided at the health facility. The JMP Water Ladder Status assessment indicated that 51%, 15% and 23% of health facilities had basic, limited and no water service status, respectively.
- **Sanitation:** Observations were made at the 93 toilets in 26 health facilities. With JMP sanitation ladder status assessment, 27%, 50.0% and 23% had basic, limited and no sanitation services, respectively. About 42% of toilets were found clean and 45% of them were not well cleaned while 13% the toilets were not clean at all. All observed toilets had intact roof that provides shelter, 89% of the toilets had closable door that locks from the inside.
- **Hand hygiene:** Observations were made at the 68 handwashing stations in 26 health facilities. With JMP Handwashing ladder, 25%, 75% and 10% of the health facilities had basic, limited and no hygiene services, respectively. More than 79% of the washing points had water and soap.

Limitations of the study

- Most data were self-reported and respondents may thus have over- or underestimated some of their statements. However, for the indicators most likely to yield extreme values (such as cost-related items), the analysis focused on median values and provided the interquartile range, the standard deviation and/or the confidence interval.
- A social desirability bias may be observed for some of the habits, social norms and use indicators. Values are to be considered carefully, with data collected from actual structured observations (more objective and representative).
- For numerous levels of disaggregation, some of the presented results may have lost some statistical power. Most of the time, when this type of situation occurred, the analysis also provided the number of observations or frequency of observations for the reader to be aware of the denominator.
- Limited availability/ cooperation or non-availability of some respondents, particularly at schools and health facilities may have affected the quality of data collected. Furthermore, some HH respondents were not present on the day of data collection. In addition, some respondents got tired, particularly women and did not allow the interviewer to complete the household census subsection.
- Data collection was conducted at the time when most public primary schools were on holiday. The team was able to inspect schools and health facilities, but were unable to observe usage of facilities, nor interact with children.

Collaborators:

University at Buffalo, Plan International Tanzania, FXBT Health, Water Supply and Sanitation Collaborative Council

