


Getting Africa to meet the sanitation MDG

Lessons from Rwanda

Nitin Jain

July 2011





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I. Introduction

According to the 2010 Joint Monitoring Program (JMP) update household access to sanitation facilities has increased faster in rural Rwanda than in any other country in Sub-Saharan Africa. Almost four million people gained access to improved sanitation between 1990 and 2008. 54% of the population currently has access to improved sanitation, up from a baseline of 23% in 1990.¹ Most of this progress has been with households upgrading ‘unimproved’ latrines to improved hygienic ones. While the greatest gains have been in rural areas, improvements in urban sanitation are notable as coverage has increased despite tremendous growth in the urban population.

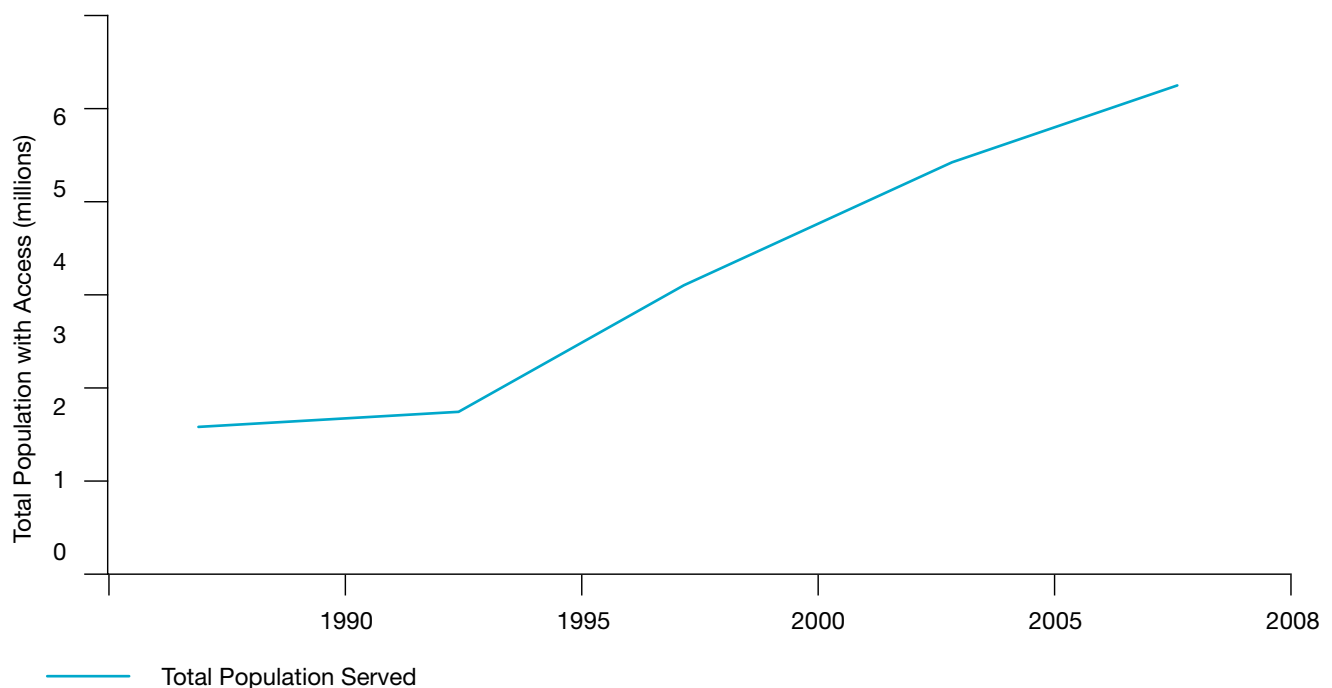
Understanding this progress requires understanding the evolution of the sector through interrelated drivers

including cultural factors, the post-genocide reconstruction process, progress in related sectors, and specific sector initiatives. The evolution of the sector can be described through four basic phases of development:

- **Historical Context: Traditional and cultural factors.** Many traditional and cultural aspects have helped more recent improvements in sanitation. Open defecation, estimated at just 8% in 1992, was low historically due in part to colonial laws and regulations. Furthermore, a common language and several traditional customs helped drive progress in more recent years.
- **1995 - 2000: Focus on reconstruction and reconciliation.** Almost 1.5 million people gained access in the years immediately after the war. The government, donors, NGO’s, and communities focused extensively on housing reconstruction programs, which included latrine construction, and other

¹ While JMP numbers differ from government figures, both sets of data show a similar scale of progress. This report uses JMP for consistency.

FIGURE 1: ACCESS TO SANITATION



policies and initiatives targeting rehabilitation and reconciliation. While sanitation and hygiene promotion were not always the central goal of these efforts, housing reconstruction had an immediate impact and many initiatives and reforms in this period helped lay important groundwork for the later years.

- **2000-2005: Consolidating the sanitation strategy.** As significant economic and social improvements continued to be made, the government started shifting its focus from short term measures to recover from the war and genocide to long term development plans and strategies. An important aspect was the government's strategy of formalizing traditional customs into administrative frameworks. National programs laid the groundwork for the current hygiene promotion campaign.

- **2005 - present: Accelerating progress:** Recent years have seen a greater shift within the government of taking stock and accelerating results. Ambitious targets have been set through national policies and are implemented at the community level through a strong decentralized model of governance, supported with rigorous systems of accountability that draw on traditional practices.

The analysis in the report is structured around these four phases of development, and seeks to identify factors, including the enabling policies, institutions, sector initiatives, and cultural aspects that help explain how Rwanda has made progress towards the sanitation MDG. While it is clear that the specific context that characterizes Rwanda is unique, the report will share some conclusions from Rwanda's experience for other countries to consider.



II. Historical Context: Traditional and Cultural Factors

Rwanda is a small landlocked country of over 10 million people. With almost 400 people per square kilometer, Rwanda is one of the most densely populated countries in the world, comparing with countries such as India.² The country has few natural resources and the economy is based mostly on subsistence agriculture. Coffee and tea are the major cash crops for export, accounting for almost 40% of total exports in 2009, though tourism is becoming a significant engine of growth within the economy.

With almost 400 people per square kilometer, Rwanda is one of the most densely populated countries in the world

Rwanda's current economic challenges are the outcome of several factors in the past. The economic structure reflects a failure to increase productivity despite a growing work force. Poor governance and a variety of external factors played an important role in the economic stagnation in this period. Although agricultural production per capita and crop yields had been in steady decline since the mid-1980s, high coffee prices masked failures of poor economic policy. Severe structural problems soon became very evident when international coffee prices fell. Per capita income fell sharply from \$380 in 1988 to \$250 in 1993.³

² NISR, National Population projection 2007-2022.

³ World Bank Project Implementation Document. Rwanda 1997

⁴ MINALOC

⁵ UNHCR. "The Rwandan Genocide and its Aftermath"

⁶ Turning Vision 2020 into Reality: From Recovery to Sustainable Human Development. National Human Development Report, Rwanda 2007

⁷ Demographic and Health Survey, 1992; JMR 2008.

TABLE 1: QUICK FACTS

Population	10.2 million
GNI/Capita*	US\$490
Under-five mortality rate	111 per 1000
Malnutrition prevalence	(% children < 5)
Weight for age	18%
Height for age	52%
Access to Water	65%
Urban	77%
Rural	62%
Access to Sanitation	54%
Urban	50%
Rural	55%

Data Sources: World Development Indicators, 2011.

*Current US Dollars

The war and genocide of 1994 exacerbated the situation, further impoverishing the country and leaving behind immense challenges. By the end of 1994, the human toll of the crisis in Rwanda was in the millions, with an estimated 1 million victims of the genocide, two million refugees outside Rwanda, and some 1.5 million people internally displaced. The war and genocide left 85,000 child-headed households and a high proportion of households headed by women (34% in 1996).⁴ Out of a population of seven million, over half had been directly affected.⁵

In addition to the physical and mental effects, the extended years of war had a significant economic impact on the country. Some estimates suggest the damage caused by the conflict between 1990-1993 cost the country up to \$100 million a year.⁶ Most of the country faced a serious lack of infrastructure as a result of destruction during the war and the movement of people into areas that were previously sparsely populated. While social services were restored fairly rapidly

after the war, the capacity to govern and manage the country remained severely handicapped. In 1995, only 21% of core civil servants had completed secondary education.

Low open defecation

Despite these entrenched economic issues, there have also been several positive factors within Rwanda's historical context that have contributed to improvements in sanitation coverage. A survey in 1992 estimated just 8% of rural households resorted to open defecation⁷. This has improved further to an estimated 2% in 2008. Furthermore, basic hygienic practices such as handwashing have also been common throughout the country. There are various political, social and cultural factors that may help to explain this. Colonial rules and regulations played an important role by establishing public hygiene laws as far back as 1926. A decree from 1959, for example, enforced the construction of latrines in every house, shop, and establishment (See Box 1). The motive was inclined

BOX 1: RWANDA HYGIENE LAW

Order No. 74/345: Public Hygiene in Towns Enforced in Rwanda by ERO no 700/176 of 14 September, 1959

All houses, shops, workshops, construction sites or any other establishments shall have clean toilet facilities. A house shall be construed to mean one family per house. In towns and urban districts and in areas close to factories, construction sites, counters, workshops, managers shall build latrines for their servants or employees on the basis of at least one water closet seat for fifteen people in establishments near factories, construction sites and counters employing less than 60 people; at least one seat for 20 people in town establishments employing 60 to 200 people; at least one seat for 30 people close town establishments employing over 200 people; at least one seat for 50 people in temporary or mobile construction sites.

Latrines shall be built according to the relevant regulations. Night soil shall be removed and buried or discharged in an appropriate manner as

determined by the local territorial authority. When there is water supply, latrines shall be connected to a flushing system linked to septic tanks or sedimentation tanks of a waste treatment plant or public sewage system under a combined sewerage. Latrines, septic tanks and sewers shall be built after approval by the technical departments of the Public Hygiene Department. Septic tanks shall be waterproof and installed outside buildings. They shall be easily accessible and covered with an airproof lid that can be opened. They shall be composed of digestion and settlement tanks.

Order No. 71/18: Public Hygiene and Sanitation Enforced in Rwanda by ERO no 71/106 of 20 July, 1949

The disposal of excreta is prohibited on roads and public places in urban areas and towns outside areas planned by public departments for this purpose. Non compliance with this Order shall result in 7 days of labour bondage and a fine of 200 Francs or either penalty.

more towards cleanliness of the environment than personal hygiene, but these laws initiated the first steps towards the very low open defecation rates in the country.

Traditional factors

Traditional factors are often seen to impede improvements in sanitation. In contrast, Rwandan society also has a number of traditional institutions and social structures that the government has called upon to strengthen the reconciliation process and to support reconstruction on a large scale with limited resources.

By returning to these traditions after the war, Rwanda's leaders were able to draw on social capital to help solve the severe socio-economic problems, reform agriculture and the economy and, most importantly, foster good governance (See Box 2). In more recent years many of these have been formalized into the administrative system, making it easier for national policies and targets to be implemented within a decentralized structure.

A common language of Kinyarwanda has also helped in the dissemination of information and the implementation of national policies and strategies at the local level. Interestingly, the local word for feces in Kinyarwanda, *amazirantoki*, translates to “do not touch” or “untouchable”. This pervades day to day interactions where one would not even refer to ‘needing to use the toilet’. These sentiments of privacy may have also formed strong motives for households to build latrines.

BOX 2: TRADITIONAL CUSTOMS FORMALIZED INTO ADMINISTRATIVE SYSTEMS

- **Imihigo:** a practice where people publicly committed themselves to the achievement of a given task. Breaking this commitment was considered a great dishonor for the individual and the community. Following the government's strategy to decentralize decision making, *Imihigo* was resurrected in 2006-2007 in the form of contracts between the President and district mayors.
- **Gacaca:** the tradition of communal resolution of disputes. This has been adapted to deal with the resolution of disputes about land and was a supporting factor in Rwanda's land reform.
- **Ubudehe:** the tradition of mutual assistance or local collective action especially in farming, used to encourage community support for poorer households without the ability to finance improved sanitation facilities;
- **Umuganda:** a traditional cultural practice pre-dating the colonial years that has used in various forms to mobilize labor, usually for work on public projects;
- **Umusanzu:** the tradition of support for the needy and contribution to the achievement of a common goal.



III. 1995-2000: Reconstruction and Reconciliation

The challenge in the years immediately after the genocide was to stabilize the precarious condition of the country through reconstruction and reconciliation, reintegration of the survivors and returning refugees, and rebuilding social structures. Recognizing that acute poverty only exacerbated the difficult circumstances, the government's priority in the aftermath of the war was to tackle poverty by putting in place national policies and building the institutional frameworks necessary to transform the rural economy. Structural reforms at this stage prioritized reforms in agriculture, health, and education. While sanitation and hygiene promotion were not always central to these efforts, many initiatives and reforms in this period helped lay important groundwork for the later years.

Housing reconstruction and villagization

The reconstruction process, which included the construction of improved latrines in new housing, had a very significant impact on sanitation coverage, with almost 1.5 million people gaining access between 1995 and 2000. Villagization, or *umudugudu*, was a cornerstone of the government's efforts to deliver basic services for the thousands of returning families and to confront the demands of land scarcity. The approach dated back to the Arusha Protocol of 1993 under which refugees away for more than ten years would not claim their original property but be assisted to settle in villages by the government. The government saw *umudugudu* as a way to provide security for scattered families and improve services including schools, health centers, water, and roads at a lower cost. Developing detailed plans with specific technical requirements helped attract donor funding. Supported by relief agencies, an estimated 300,000 houses, most of which included latrines, were constructed under the program by 2004.⁸

Even with these efforts, many poor people still lived in temporary shelter without adequate sanitation. In order to support these families, the government initiated a community action program based on a traditional practice of '*Ubudehe*'. The program was used to involve communities in participatory planning and funding of priority projects across the country. The program encouraged communities to work together to help poorer families construct permanent housing that met basic sanitary standards.

Land reform

Given the complexity of reintegrating returning refugees with the number of families that died in 1994, ownership of housing and land was a pressing issue for the government to tackle. Historically, land belonged to the state and

The reconstruction process, which included the construction of improved latrines in new housing, had a very significant impact on sanitation coverage, with almost 1.5 million people gaining access between 1995 and 2000

⁸ IRIN, "RWANDA: Government implements low-cost housing for returnees", 2004. (<http://www.irinnews.org/report.aspx?reportid=51581>)

citizens were essentially given the right to develop it for their living. Following the war, the government changed this approach and, in 1996, started developing a new land law to give full ownership to all landowners. A key element of the reform was to extend property rights to women, who constituted more than 60 percent of the surviving population. Securing property rights was recognized as an important aspect of economic reconstruction because title to land improved people's ability to borrow money and created incentives to invest their own money in better housing.

Linkages with health sector reform: Community health workers

Like most other services in 1994, the health sector in Rwanda was in disarray. As basic capacity was a severe constraint, the government established institutes such as the Kigali Health Institute to train a cadre of skilled doctors and nurses and tapped into community level health workers to extend services to households. Setting up these training institutes was an important factor in building local capacity within the health sector, and may have contributed to important policy decisions in the next phase that emphasized a shift from curative to preventative approaches to improving health.

Community health workers evolved from volunteer health workers that were recruited to provide support for traumatized individuals in the wake of the genocide. Their role was gradually expanded to include basic preventive services including sensitizing community members on child health, family planning, nutrition, hygiene, and various diseases at monthly village meetings. Under the program, each village elected a male and a female volunteer to act as community health workers for the general population. Their role was further formalized in the 2005 National Community Health Policy and in subsequent reforms. Though not government employees, the 45,000 community health workers have become more formally recognized. They are overseen by the Ministry of Health (MINISANTE) through a cadre of around 450 health officers who have targets for improving sanitation included in their performance contracts. This combined network of health offices and community health

workers, backed by closely monitored performance targets, is now driving a scale of promotion that is a significant factor in motivating households to maintain and upgrade their latrines.

Shifting from emergency relief to a development path: Vision 2020

Vision 2020 articulated the government's goals in transforming Rwanda's economy and, for the first time, placed access to improved sanitation at the center of Rwanda's development plans. The Government developed Vision 2020 between 1998 and 1999 through consultative meetings with citizens throughout the country, laying the framework for all the sector policies and strategies that would emerge between 2001 and 2005. Through it, the government outlined a path to transform Rwanda into a middle-income nation in which Rwandans are healthier, educated and more prosperous by 2020. This would be achieved by promoting macroeconomic stability and wealth creation to reduce aid dependency, transforming from an agrarian to a knowledge-based economy, creating a productive middle class and fostering entrepreneurship.

BOX 3: VISION 2020

The aspirations of Vision 2020 were built around six pillars:

- good governance and a capable state;
- human resource development and a knowledge-based economy;
- a private sector-led economy;
- infrastructure development;
- productive and market-oriented agriculture; and
- regional and international economic integration.

Vision 2020 also emphasized the importance of progress on four cross-cutting issues: gender equality; natural resources; the environment; and science, technology and ICT.

IV. 2001- 2005: Consolidating the Strategy

By the early 2000's, the government was able to consolidate its vision and started shifting its focus from short-term measures to recover from the war and genocide to long-term development plans and strategies. These included critical policies and strategies for the sanitation sector. Sanitation and hygiene emerged as important interventions as stakeholders saw more evidence showing the need to shift from curative to preventative policies. Decentralization was a key reform of this period, laying down a basic institutional framework to improve sanitation coverage. Participatory Hygiene and Sanitation Transformation (PHAST) and Hygiene et Assainissement en Milieu Scolaire (HAMS) programs were initiated to promote hygiene and sanitation by influencing positive behavioral change and adoption of better practices among Rwandan communities, they also introduced concepts that later evolved and were mainstreamed under the national community health promotion program.

Decentralization was a key reform of this period, laying down a basic institutional framework to improve sanitation coverage

Placing sanitation at the center of poverty reduction strategies

While the rural water supply sector started being actively managed by the government in the sixties and an urban utility was created in 1976, the first National Sectoral Policy was only developed in 1992. It was subsequently revised four times to include emerging issues including: demand responsive approaches (1997); decentralization and reinforced participation (2004); and hygiene, sanitation, and environment (2010). Until 2010, the policies covered sanitation but, in practice, mainly targeted water supply. Financing within the sector also showed a very strong bias towards water. Donor projects always had a sanitation component but this was often ignored in implementation. Health systems were mainly focused on curative approaches to improvements in health. This started shifting as stakeholders started advocating the need to focus more on preventative measures. In response, the government started investing in effective low-cost promotional strategies to encourage household investments in improved sanitation.

In 2002, the government introduced its Poverty Reduction Strategy Paper (PRSP), developed through an extensive national consultation process, to guide national planning efforts to achieve the targets outlined for Vision 2020. The PRSP recognized that access to water and sanitation was essential to the overall strategy and vision of improving lives and reducing poverty by:

- Improving maternal and children's health;
- Improving enrolment in schools, especially for girls;
- Improving security, particularly for women;
- Reducing health expenses for households and the Government, particularly for diseases like diarrhea; and
- Increasing productivity because of better health.

This would later evolve under the second Poverty Reduction Strategy Paper, known as the Economic Development and Poverty Reduction Strategy 2008-2012 (EDPRS). Under EDPRS, the government set itself an even more ambitious goal of increasing the proportion of the population with sanitation services from 38% to 65%. EDPRS also aligned responsibility for different sectors between the different ministries, districts and other stakeholders. While the first PRSP focused on managing a transitional period of rehabilitation and reconstruction, the EDPRS focuses strongly on growth and poverty reduction.

In parallel to the PRSP, the government started drafting and revising sector strategies and, in 2004, published its first water and sanitation policy which defined guidelines for efficient use of resources and integrated new aspects such as decentralization, participatory approach, and privatization. The 2004 policy aligned government goals with MDG objectives and Rwanda's Vision 2020. It also complemented the government's 7-year program which emphasized decentralization and participatory approaches to delivering services.

Following the passage of the constitution and presidential and legislative elections in 2003, the government acted to implement institutional reforms to implement the new policy and rapidly increase the scope and quality of service delivery. In related shifts in the health sector, the government prioritized approaches that stimulated public demand for services, aligning health districts with the decentralized local government districts, and improving accountability of facilities and personnel to local government institutions. The community health worker system, while still based on volunteers, was expanded and given a larger mandate, and health facilities, personnel, and communities were incentivized to achieve results with the introduction of performance based financing.

Decentralization and donor harmonization

The government's main strategy to achieve good governance and sustainable economic development was to decentralize decision making to bring the development process closer to the people. With roots in measures to improve the functioning democracy in the late nineties, the government adopted the National Decentralization

Policy in May 2000, as a mechanism to achieve three main goals: promotion of good governance; poverty reduction; and efficient, effective and accountable delivery of services, including improved sanitation.

The policy drew on lessons from before the 1994 genocide, a period of poor governance characterized by highly centralized authority and lack of citizen participation in leadership and development. Following the policy, the government also set up the Common Development Fund (CDF) in 2002, with the goal of channeling 10% of the annual national revenues to support projects and programs planned and implemented at the district level.

The CDF was designed to mobilize and target donors funding. The proliferation of aid partners with different approaches, mechanisms, and agendas had mixed results. On one hand, the influx of millions of dollars contributed to reconstruction of housing and services, thereby improving health indicators including access to sanitation. The influx of external resources, however, often only reflected donor priorities leading to a disproportionate expenditure

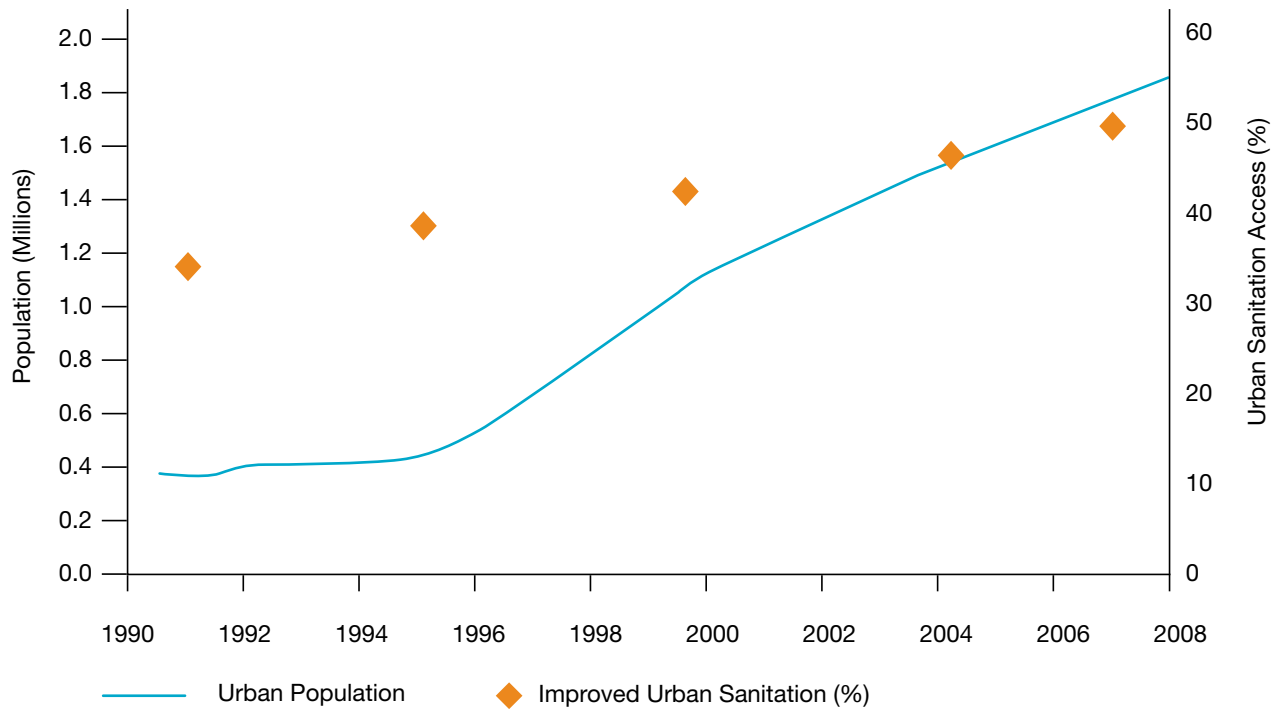
BOX 4: URBAN SANITATION

While the greatest gains have been in rural areas, improvements in urban sanitation are notable due to the tremendous growth of the urban population which has doubled every decade since 1990. Moving forward, the government has developed a supporting policy framework for urban sanitation, with national policies from MININFRA and MINISANTE, and city-level Sanitation Master Plans for Kigali town. The 2008 AfricaSan meeting helped improve coordination between the different Rwandan institutions in charge of urban sanitation, based on an understanding that no one institution can successfully address sanitation alone, especially in the urban context. Action plans addressing the subsector target focus on adapted on-site sanitation, as there is no significant investment program planned to develop public sewerage systems.

of funding on too many sanitation models that were not designed and distributed according to the local context. These donor-driven programs were focused on constructing facilities, and ignored building local capacity and sanitation promotion programs. Furthermore, funding

converged on a handful of districts leaving other areas behind. In order to bring some measure of control, the government started assigning different donors and NGO's different districts and required that their approaches aligned with national strategies.

FIGURE 2: URBAN POPULATION GROWTH & ACCESS TO SANITATION



V. 2005 – Present: Accelerating Progress

Since 2005, there has been a positive, results based shift within the government. The international community and the government have responded to the sanitation crisis and the momentum from AfricaSan and the eThekweni declaration has helped raise the profile of sanitation within the entire continent. Senior government officials right up to the President have actively supported key interventions in the sector. The President has often singled out hygiene and sanitation, noting that access to and use of hygienic sanitation facilities cannot be donated in form of aid. These remarks point to the changing perception that personal hygiene and wellbeing are closely linked with economic development.

Community-based health promotion

The Environmental Health Policy of 2008 and the National Water and Sanitation Policy of 2010 were developed based on evidence and knowledge from the previous decade of experience in Rwanda's government-led effort to promote sanitation. The key change was in the evolving role of the community who, as beneficiaries, were increasingly expected to view their own health and wellbeing as their most valuable asset. The Environmental Health Policy concretized the shift in the government's strategy to improve health indicators from curative to preventative approaches. In December 2009, the Environmental Health Desk of the Ministry of Health launched a Community Based Environmental Health Promotion Program (CBEHPP) to build on the community-based approaches tested under PHAST and HAMS. CBEHPP is described as "... a hygiene behavior change approach to reach all communities and empower them to identify their

personal and domestic hygiene and environmental health related problems (including access to safe drinking water and improved sanitation) and solve them". The Health Sector Strategic Plan 2009-2012 further supports this by identifying sanitation as a high-impact intervention that the government will scale up.

Further impetus for progress was provided following the re-election of the President. In 2010 he dramatically raised the profile of CBEHPP by launching the Hygiene and Sanitation Presidential Initiative (HSPI), noting that hygiene and sanitation in homes, schools, offices, restaurants, and other public places form an important foundation for development because a healthy body in a healthy environment is a prerequisite for development. His party manifesto also urged different ministries to ensure full sanitation coverage countrywide by 2017, beating the vision 2020's timeline. This level of support has had an important effect in accelerating efforts to mobilize resources and implement CBEHPP in all 30 districts.

2010 also marked the first national policy that drew together the key concepts from water and sanitation policies from different ministries into a holistic approach. The National Water and Sanitation Policy of 2010 focuses on six sanitation related fronts: household sanitation, institutional sanitation, collective sanitation, storm water drainage, solid waste management and institutional sector framework. This policy draws greater focus to urban sanitation, defining a policy framework that supports the Sanitation Master Plan for Kigali town.

BOX 5: CBEHPP APPROACH

Urban and rural sanitation are heavily dependent on household contributions, which require significant effort from Government in terms of promoting and marketing access to sanitation. This is primarily being done through the Government-Based Environmental Health Promotion Program (CBEHPP) which has adopted a community hygiene club approach supported by 45,000 community health workers. A CBEHPP road map was launched in December 2009, and Government is encouraging ‘partners’ to support the program. There are no subsidies for communities, who must try to graduate from a course which covers 20 topics including hygiene and sanitation. Training for members of the community hygiene club includes methods of constructing a tippy tap or building a lid for latrines. The facilitator signs off once they have completed all the topics and there will be a formal graduation ceremony for the village.

Progress under CBEHPP is measured through ‘7 Golden Indicators’:

1. Increased use of hygienic latrines in schools and homes from **28% to 80%**
2. Increased hand-washing with soap at critical times from **34% to 80%**
3. Improved safe drinking water access and handling in schools and homes to **80%**
4. Establishment of CHCs in every village from **0% to 100%**
5. Achieve Zero Open Defecation (ZOD) in all villages to **100%**
6. Safe disposal of children’s feces in every household **28-100%**;
7. Households with bath shelters, rubbish pits, pot-drying racks and clean yards to increase to **80%**

Strengthening decentralized service delivery

While developing policies and national commitment to improving access to sanitation has been critical to progress, the process of translating these national targets and policies into action on the ground has been Rwanda’s biggest success. Adapting *Imihigo*, a tradition that Rwanda has institutionalized as a means to enhance local government reform and stimulate development, has been the key to this success.

Imihigo draws on a cultural practice of publicly committing to achieving specific goals. Failing to meet these commitments was considered to be a dishonor for the individuals and the community. Following the reforms in the early 2000’s, Rwanda’s Ministry for Local Administration (MINALOC) and the Ministry of Finance and Economic Planning (MINECOFIN) developed performance contracts in the tradition of *Imihigo* holding the President of Rwanda and the district leaders accountable for specific goals in each district, including sanitation coverage. These contracts have now been signed at all levels of the decentralized system including at the household level and individual level.

The signed contract between the head of household and local leaders includes baseline data for the district, district development targets, performance indicators, and the budgetary allocation for the achievement of each target. *Imihigo* evaluations are carried out three times a year by a task force comprising the Prime Minister’s Office, MINALOC and the President’s Office. Each district presents its evaluation findings to the task force in the presence of stakeholders.

Responding to other weaknesses in the decentralization process, the government developed the Rwanda Decentralization Strategic Framework (RDSF) in 2007 to guide the ongoing implementation of the decentralization policy. The RDSF serves as the overall framework of reference for current and future interventions towards decentralization in Rwanda. This strategy further reinforces the link between good governance and the attainment of broad reaching development objectives, and is expected to secure the targets under Vision 2020, the MDGs, and the EDPRS.

VI. Looking Ahead: Evaluating Sector Performance

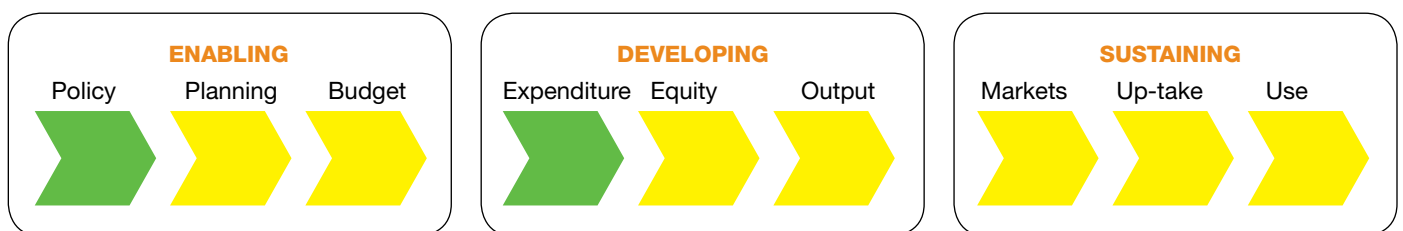
The Country Status Overview (CSO), which benchmarks African countries and helps countries assess their own service delivery pathways for turning finance into sanitation services, shows that Rwanda is currently performing above the regional peer-group average for both rural and urban sanitation. There is, however, still a long way for Rwanda to meet its target of 100% sanitation coverage and, more importantly, sustain the gains. The CSO points out that policy tools with agreed national targets and a subsector policy are largely in place, but there is still institutional fragmentation, mainly because the process of decentralisation is still fairly recent (See Figure 3). The central government is developing a coherent and effective coordination role, but districts are not yet sufficiently informed and mobilised.

While promotion programs to trigger demand for better sanitation have been effective, the market for rural sanitation on the supply side still needs to be strengthened. Improved sanitation technologies are still too expensive for many households and the network of suppliers and masons is weak. CBEHPP will address this through incremental upgrades, where communities focus on small actions that they can afford, but private sector interest in investing in sanitation markets needs to be encouraged.

The CSO also highlights that there need to be specific reforms to the budget structure to disaggregate subsector spending. The Africa Infrastructure Country Diagnostic report observes that Rwanda has been able to make considerable progress moving people up the sanitation ladder with very little public spending.⁹ Looking ahead, however, the government will need to plan on investing more if it is to meet its targets. The annual capital investment to provide improved sanitation infrastructure for just over 500,000 people a year is estimated at US\$ 41million per year. Under the government’s strategy of leveraging household funds by investing in sanitation and hygiene promotion, users are expected to bear around 70 percent of these costs. The government has already planned for a budget of US\$9 million per year, of which US\$8 million is allocated for rural sanitation. This leaves a deficit of US\$4 million year mainly in urban sanitation. Given the rapid population growth of the capital Kigali, which is expected to grow to over a million people by 2015, there is likely to be demand for more sophisticated and expensive technology sanitation options including sewerage.

⁹ Morella, Elvira; Foster, Vivien; Banerjee, Sudeshna Gosh. “Africa Infrastructure Country Diagnostic Summary Of Background Paper 13”. Page 8. June 2008.

FIGURE 3: RWANDA COUNTRY STATUS OVERVIEW SCORECARD: RURAL SANITATION



The CSO scorecard for Rwanda shows that policy tools are largely in place, but the scores for planning and budgeting are minimized because of the lack of a costed investment plan and the need to develop an integrated M&E system to enable planning and budgeting that is established on the basis of consolidated progress reports. Sustaining gains by strengthening sanitation markets will need to be a focus going forward.

VI. Conclusions

From the ruins of years of war and genocide, Rwanda has moved to improve household access to hygienic sanitation facilities faster than in any other country in Sub-Saharan Africa. Rwanda's experience shows that progress is possible even in these difficult circumstances. Three key elements stand out from Rwanda's experience that other countries can adapt and implement to improve access to sanitation and improved hygiene:

Turning crisis to opportunity: In the immediate aftermath of the war, the government of Rwanda, donors, relief agencies, and NGO's embarked on a massive housing reconstruction program that essentially brought improved sanitation facilities to hundreds of thousands of people. While this was of course under unique circumstances, other countries and donors should be prepared to take advantage of similar opportunities to leverage funding and other efforts to improve sanitation access. Furthermore, while sanitation and hygiene were not always central to other structural reforms such as land reform during these years, there are lessons to be learnt on how progress and reforms in other sectors can influence and unlock gains in the sanitation sector.

Formalizing traditional elements into administrative frameworks: Drawing on familiar traditional practices to develop and formalize administrative frameworks has been a particularly successful strategy in Rwanda. While developing policies and national commitment to improving access to sanitation has been critical to progress, the process of translating these national targets and policies into action on the ground has been Rwanda's biggest success. Harnessing *Imihigo*, a tradition that Rwanda has institutionalized as a means to enhance local government reform and strengthen

ownership and accountability, for example, made it easier for the government to implement national sanitation strategies into decentralized networks that reached right down to the smallest administrative unit in each village. Similarly, the *Ubudehe* program, based on the tradition of mutual assistance, provided a successful network that helped the government target and support poor households. Similar approaches can be adopted in other countries, particularly other post-conflict nations.

However, while some traditional practices can be beneficial, there are others that the government broke down in order to meet new challenges. Perhaps the most important example in the context of sanitation was empowering the role of women within Rwandan society. Extending the right to own land, for example, was an important reform that improved access to financing and encouraged investments in permanent housing.

Forging strong political will supported at all levels of decentralization: Translating national policies and strategies into results on the ground is critical to improving access. However, these gains are only possible at the national scale if political leadership actively supports and drives progress towards the targets. In Rwanda, this support has come from the very top, where the President identified sanitation as a key approach to reducing poverty under national poverty reduction strategies and other policies. This level of support was unprecedented and was critical in driving action to putting the country on a development path that includes access to these basic needs. Support from lower levels of administration was no less important. While devolution may begin at the centre, it must find equally willing expression at all levels if it is to cascade down to access on the ground.

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