Federal Democratic Republic of Ethiopia
Ministry of Health

National Hygiene and Sanitation Strategy

To Enable 100% Adoption of Improved Hygiene and Sanitation

December 2005

Safely manage excreta

Your health is in **YOUR** hands

Apply safe water chain from a safe source to your mouth

Wash hands with soap or a substitute and water after defecation

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The Sanitation Vision for Ethiopia

100% adoption of improved (household and institutional) sanitation and hygiene by each community which will contribute to better health, a safer, cleaner environment, and the socio-economic development of the country.

Conditions for Success

- Getting consensus that the current limited and inappropriate access to sanitation and hygiene is a problem.
- Ensuring dedicated political commitment, support and action.
- Achieving accountability through 'minimum' performance contractual agreements at all levels.
- Gaining intersectoral collaboration using convincing promotion of the benefits while emphasising the risks.
- Allowing for minimum contact time of health extension workers (guidance and health education) with households.
- Realizing community empowerment and responsibility through using viable local solutions.
- Implementing effective supportive supervision and monitoring processes which are linked to performance contractual agreements.

The Three Strategic Pillars for Improved Sanitation and Hygiene

Pillar 1

An enabling framework to support and facilitate an accelerated scaling-up through policy consensus, legislation, political commitment, intersectoral co-operation, partnership, capacity building linked to performance contractual agreements, supportive supervision, research and monitoring.

Pillar 2

Sanitation and hygiene promotion through participatory learning, advocacy, communication, social marketing, incentives or sanctions to create demand and forge behavior change.

Pillar 3

Improved access to strengthen the supply of sanitation through appropriate technology solutions, product and project development, and support to local producers and artisans.

Why is a Strategy Necessary?

- In Ethiopia more than 250,000 children die every year from sanitation and hygiene related diseases.
- Some 60 percent of the disease burden is related to poor sanitation and hygiene.

- A low number of households (between 6 and 18 percent) have access to improved sanitation.
- Less than 1 percent of the health budget is dedicated to sanitation and hygiene improvement.
- The annual sanitation 'fall-out' costs are devastating.

What are the Benefits of Improved Sanitation?

- Health - diarrhoea prevention, mortality decreased, curative care reduced and nutrition improved.
- Socio-economic - fitter workforce, less time caring for the sick, less money spent treating sickness.
- Educational – enhanced girl child school attendance and attaining higher levels of education
- Social – privacy, dignity, safety and a cleaner environment.
- Gender – women stand most to gain from improved sanitation and hygiene benefits.
- Political – women represent 50 percent of the electorate, making sanitation an important political issue.

How Big is the Challenge?

- The 2015 Millennium Development Goal (MDG) is to halve the proportion of Ethiopians without access to improved sanitation which is equivalent to 11 million households in 11 years (1,000,000 households per year).
- 100% sanitation and hygiene means SOME FOR ALL not more for some.
- The imbalance between curative and preventive health care requires raising the sanitation profile.

Where Are the Opportunities?

- Positive examples from the regions and zones offer lessons of the scale that can be achieved such as:
- The Southern Nations and Nationalities People's Regional State (SNNPRS)
- has achieved 65 percent latrine coverage with their own resources through political (and budget) commitment, inter-sectoral collaboration, accountability and community ownership.
- There is increasing intersectoral convergence around a single sanitation strategy.
- The new Health Service Extension Programme (HSEP) has seven dedicated sanitation packages.
- The WaSH Movement is gathering momentum through its focus on handwashing in 2004.
- An advancing decentralisation is dedicated towards people taking ownership of their own development.
- Donors are recommending funds to be dedicated for sanitation and hygiene in WaSH programmes

ACRONYMS

AA	Addis Ababa
CBO	Community Based Organization
CHW/A	Community Health Worker/Agent
CRDA	Christian Relief and Development Association
CSFB	Community Sanitary Facility Builder
DRA	Demand Responsive Approach
DW	Drinking Water
EOC	Ethiopian Orthodox Church
ECOSAN	Ecological Sanitation
EH	Environmental Health
ESA	External Support Agency
FINIDA	Finland International Development Agency
GoE	Government of Ethiopia
IEC	Information Education Communication
HEW	Health Extension Worker
HSEP	Health Service Extension Program
INGO	International Non-Government Organization
ISH	Improved Sanitation and Hygiene
KABP	Knowledge, Attitude,Beliefs and Practice
LSP	Local Service Provider
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MoAg	Ministry of Agriculture
MoH	Ministry of Health
MoWR	Ministry of Water Resources
NACID	Nazareth Childrens Centre and Integrated Development
NWSSP	National Water Supply and Sanitation Porgram
PBTK	Picture Based Tool Kit
PHAST	Participatory Sanitation and Hygiene Transformation
PPP	Public Private Partnership
RHB	Regional Health Bureau
RWSEP	Rural Water and Supply Environmental Programme
RWSSH	Rural Water Supply, Sanitation and Hygiene
S.M.A.R.T.	Specific, Measurable, Achievable, Replicable and Timebound
SNNPRS	Southern Nations and Nationalities People's Regional State
TBA	Traditional Birth Attendant
TOR	Terms of Reference
TIPPY TAP	Community handwashing facility
TPL	Traditional Pit Latrine
UNICEF	United Nations Children's Fund
WaSH	Water Supply, Sanitation and Hygiene (WaSH campaign)
WaSHCo	WaSH committee
WATSAN	Water and Sanitation
WSP-AF	Water and Sanitation Programme - Africa

PREAMBLE

Many government agencies and NGOs have undertaken sanitation and hygiene improvement programs in Ethiopia. Lessons have been learnt which have informed the development of this strategy to support 100% improved sanitation and hygiene throughout the country. It is understood that the strategy is useless unless individuals, communities, kebele, woreda, regional and zonal federal decision-makers as well as other officials in public and private domains will:

- Recognize that current sanitation access and hygiene behaviour in Ethiopia is a major problem
- Accept personal and collective responsibility for achieving 100% sanitation and hygiene status
- Exert pressure for improved sanitation and hygiene in their own sphere of influence
- Choose to allocate a portion of their annual budget to promote improved sanitation and hygiene
- Have access to appropriate promotional materials and technical options
- Know to whom they can turn for specialist advice and support.

Prevailing wisdom suggests that 100% sanitation and hygiene improvements will depend on:

- Dedicated funds in the budget for 100% improved sanitation and hygiene
- Consensus that the current limited access to sanitation and hygiene is a problem
- Political commitment, support and action
- 'Minimum' performance contractual agreements for 100% sanitation and hygiene from household through to kebele, woreda and ultimately the region
- Intersectoral collaboration using a variety of creative methods with consistent messages (based on understanding and research into behaviours) delivered by health, water, education, rural development and agriculture offices
- Minimum contact time of health extension workers (guidance and health education) with households
- Empowered communities that take responsibility for improved sanitation and hygiene using viable local solutions as demonstrated by voluntary community health promoters who are supported by health extension workers
- Convincing communication to promote options and benefits while, at the same time, emphasising the risks
- Effective supportive supervision, monitoring (assessing performance) and evaluation which should be linked with performance contractual agreements.

Responsibility for creating an appropriate enabling environment is being decentralised to the woreda administration. The focus is on improving knowledge and information dissemination, and creating demand. It also involves managing and monitoring the process while ensuring that there are a diverse range of 'local service providers' and locally mobilized financial resources to meet these requirements.

The strategy will not be a blueprint but a set of guiding principles for interpretation at the different levels of administration. It is designed to serve a number of purposes. These include to:

- Foster convergence among stakeholders

- Provide a working tool for advocacy
- Provide a dynamic framework for planning, implementation and monitoring.

The essence will be on 'using local resources more effectively' to increase latrine access and use, and to encourage attitudinal change leading to sanitation and hygiene behaviour transformation. The challenge for the different 'facilitators' is to explore a wide range of 'carrot and stick' approaches to find the most appropriate mix to effect social change. An example is synergy between health extension workers, local service providers and communities. While health extension workers increase awareness, local service providers could be engaged to get involved in social marketing to entrench sanitation and hygiene in the market place and create sustainable supply streams. The community in turn, sets the rules and standards on non-compliance which would be subject to local sanction.

Understanding the appropriate technical options people want, can afford and will use is a central pillar of the strategy. The construction of appropriate demonstration facilities at schools, health centres and markets presents one opportunity for testing technologies. Promotion will be a central theme and the success of promotional methods and messages (based on understanding and research into behaviours) could be measured in terms of:

- Increased knowledge and understanding of the linkage between improved sanitation and hygiene and health leading to:
  - » Behavioral transformation - improved personal and food hygiene, sanitary excreta management practices with particular emphasis on young children
  - » A willingness to pay for some form of sanitation and hygiene improvement with a minimum of capital subsidies (except in special circumstances).

Such changes would be motivated by informed decisions, wider social change, peer pressure and a developing sense of national sanitation and hygiene awareness. The overall objectives of the strategy will be progressive individual and collective behaviour change which leads to 100% sanitised households within 100% sanitized communities, woredas, regions and zones, and ultimately within a 100% sanitized Ethiopia.

1. BACKGROUND

This section will address:

1.1 What is the strategy?
1.2 What is sanitation and hygiene?
1.3 What is the current sanitation and hygiene status in Ethiopia?
1.4 What are the effects of poor sanitation and hygiene?
1.5 What are the benefits of improved sanitation and hygiene?
1.6 What is being done to improve sanitation and hygiene?

1.1. What is the Strategy?

1.1.1. The context

This National Strategy for Improved Hygiene and Sanitation has been developed to complement the existing health policy (developed by the MoH) and the national water sector strategy (developed by the Ministry of Water Resources) in placing greater emphasis on 'on-site' hygiene and sanitation. The primary focus is on blocking faeces from entering the living environment through the safe management of faeces, hand washing at critical times and the safe water chain from source to mouth. It places responsibility for improving 'on-site' household hygiene and sanitation firmly in the hands of the household with the direct support of the health extension worker and other resources at community level. The strategy is harmonised with the Health Sector Development Programme which places a strong focus on high impact, broad reach, public health interventions.

1.1.2. The strategy does NOT…

The National Strategy for Improved Hygiene and Sanitation does not replace existing policies, strategies or guidelines. It does not attempt to cover, in any depth, the important issues of vector control and food hygiene which are covered by separate MoH guidelines. While solid waste is addressed in the context of small scale, community managed reduce, reuse and recycle approaches, full scale urban solid waste management is not considered as it is covered under the strategy developed by the Environmental Protection Agency. Other urban public health issues will be addressed in the forthcoming urban health extension package currently under development by the Ministry of Health which in turn will lead to the development of additional protocols.
The issue of water borne sewerage systems is not covered as the focus is towards 'on-site' sanitation. Small bore sewerage is alluded to in the context of small-scale gravity fed bio-digesters where there is sufficient space for effluent management. Sewerage is covered within the Ethiopian Water Strategy developed by the MoWR.

1.1.3. A Road Map

This improved sanitation and hygiene strategy is a 'living' document which has been developed through consultation with the Ministries of Health, Water Resources, Education, Agriculture and the Environmental Protection Agency as well as Regional Health, Water and Education Bureaus, donors and NGOs. The document is designed to bring together policy guidelines and lessons learnt to help forge consensus among the many stakeholders on the development of a 'road map' which will lead to 100% adoption of improved sanitation and hygiene in Ethiopia. The term 'sanitized' will be used throughout the rest of these Strategy Document to denote this vision.

1.1.4. Why 100% Sanitized Households and Villages?

The case for 100% sanitized households and consequently villages has its roots in terms of ensuring maximum public and private health benefit. It is also a strong political statement designed to elevate

the status of sanitation to achieve parity with other development imperatives. It represents an important paradigm shift from a long-standing curative focus to one of prevention.

1.2. What is Improved Sanitation and Hygiene?

1.2.1. Definitions

WHO and UNICEF have produced definitions of environmental health and sanitation to encourage consensus around the key component parts. The Ethiopian definition draws on these definitions while emphasising the key principle of 100% improvement.

1.2.2. Our Definition

100% adoption of improved sanitation and hygiene is the process where people demand, develop and sustain a hygienic and healthy environment for themselves by erecting barriers to prevent the transmission of diseases, primarily from faecal contamination.

1.2.3. Faecal contamination

Faecal contamination occurs when faeces are allowed to enter the living environment through people (particularly young children) defecating on the open ground either close to or even in the domestic compound or in fields where onward transmission occurs through:

- Fluids: faeces can enter unprotected water sources (including rainfall run-off) as well as water stored for drinking
- Fingers: fingers touch faeces when mothers (or carers) clean a baby's (or child's) bottom or during anal cleansing leading to contamination of food during its preparation or ingestion
- Flies: they land on faeces and then land on and contaminate food and/or fluids
- Feet: worms are transmitted through stepping in faeces.

1.2.4. Barriers to Improve Sanitation and Hygiene

Improved sanitation and hygiene is about erecting physical and behavioural barriers to stop contamination. The primary barriers have the biggest preventive impact and concentrate on the safe management of faeces to prevent contact with fields, fluids, fingers, feet, flies and food.

Barrier 1

- Build and use a safe, durable, sealed latrine for containing all faeces when around the compound.
- Bury faeces when out in the fields.
- Use safe public latrines when at the market or in town.

Barrier 2

- Wash hands with soap (or a substitute) and water after defecation or after any potential contact with faeces (particularly children's faeces[1]).
- Wash hands with soap (or a substitute) and water before preparing food and before eating food.

Barrier 3

- Implement a safe drinking water chain from collection through to storage and consumption.

The barriers must be applied by the WHOLE family and EVERYONE in the community to achieve maximum prevention and total benefit.
The secondary set of barriers focus on food hygiene and environmental cleanliness.

Barrier 4

- Practice food hygiene.

Barrier 5

- Keep the environment clean by safely managing liquid and solid waste (all types of sewerage).

This strategy is targeted at implementing the primary barriers. Transmission routes and their barriers are well illustrated in Figure 1 ('F' diagram) which can be applied in different forms for different audiences. The barriers appear simple in their diagrammatic form but require considerable individual and collective behaviour change to become effective.

1.3. What is the Current Sanitation and Hygiene Status of Ethiopia?

1.3.1. Current Hygiene and Sanitation KABP in Ethiopia

Building and using latrines

With such low access to improved latrines in Ethiopia it is not surprising to report its lowly status on the list of domestic priorities. Although robust data are not available, KABP studies[2] reveal a low commitment to latrine construction and use. Reasons are multiple ranging from the poor reputation of Ethiopian latrines (their apparent lack of stability, privacy and safety), the shortage of available, durable building materials, and the reported resistance of men to 'build a house for faeces'.

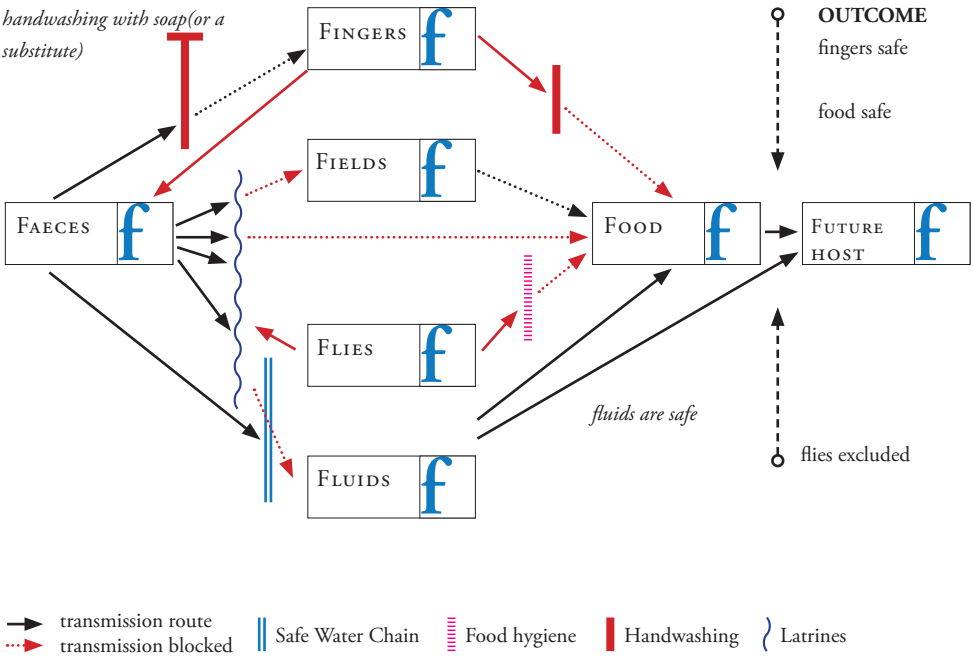
Handwashing with soap (or a substitute) after defecation and/or any contact with faeces

While there are a variety of cleansing rituals there does not appear to be a strong tradition for handwashing with soap (or a substitute) after defecation or contact with children's faeces. Reasons given are chronic water shortages and the absence of surplus cash to purchase soap.

[1] Contrary to common belief, the faeces of young children is dangerous. It is more likely to be diarrhoea and indiscriminately scattered around the compound. Children's faeces can also carry high worm loads.

[2] WaterAid – KABP study on sanitation preference (2003), UNICEF – KABP study (1997)

Figure 1. "F" diagram with barriers



Implementing and applying a safe water chain

The safe drinking water chain requires commitment to understanding the different quality or safety of the sources of water. It also covers understanding the need to protect drinking water at its source and then continue to protect it during extraction, collection, transport, storage and finally delivery for consumption.

Limited access breaks the safe drinking water chain at source. Other issues include cleaning pots for transporting and storing water as well as ensuring fingers do not touch the water when drinking (using two cups or a tap).

1.3.2. Latrine Status in Ethiopia

Although there are regional variations, it is thought that some kind of latrine access ranges between 9 percent in rural areas to 72 percent in the urban[3]. This gives a national average of 18 percent which is mainly traditional latrines made from locally available materials.

[3] Prof G.E. Teka & Mulugeta – Issues Paper, WSP-AF – World Bank (2003)

Table 1. Defecation practice – Ethiopia, 2000

Facility	Country %	Rural %	Urban %
Flush Toilet	1.7	0.8	7
Pit Latrine	16.3	8.1	64.6
Container	0.1	0.0	0.7
Open Defecation	81.5	90.7	26.9
Other	0.5	0.8	0.8

Source: CSA 2000

Some of the traditional latrines do not address expressed[4] concerns about smell, rising gas, structural collapse, fear of falling in, flies, privacy and shelter from the elements. In addition there is an inherent conflict with the concept of convenience where local custom dictates that human faeces should be deposited as far from the home as possible. Improving traditional latrines with a variety of concrete slabs has been essentially a donor and NGO initiative. The initiative has been conducted without a common policy on subsidy leading to unsustainable construction and distribution.

1.3.3. Urban sanitation: High Density Equals High Risk

Although urban sanitation figures generally far outstrip rural access, it is widely known that the poor, unplanned, densely populated areas are badly underserved. This density therefore poses a greater risk of contamination than thinly populated rural areas. Limited sanitation options and high demand are compounded by poverty and limited space, creating a major challenge. Mobile urinals and communal latrines meet only a fraction of the unmet excreta disposal needs of the urban poor who resort to high-risk disposal practices.

1.3.4. Public, School and Institutional Sanitation Facilities

Figures on coverage vary by region/zone. An important element of the strategy will be to develop working regional and woreda baselines to help measure progress to facilitate corrective action. It will be important to firm up woreda, regional, zonal and national data on the numbers and condition of:

- Public latrines at markets, bus terminals and lorry parks
- Patient and staff latrines at health facilities
- Teacher and pupil latrines at schools.

1.3.5. Liquid Waste Disposal

Liquid waste disposal is an unresolved and mounting urban issue. The sewerage network (limited to Addis Ababa) reaches a very small percentage of the more affluent households with the result that there is a huge reliance on septic tanks and pit latrines for planned housing. This requires considerable investment in 'evacuation'. There has been limited exploration of the condominial/neighbourhood

[4] WaterAid – KABP study on sanitation preference (2003), UNICEF – KABP study (1997)

sewerage in new housing development for the more affluent in terms of affordability, willingness to pay and who should pay.

1.3.6. EcoSan and Biogas

EcoSan and biogas options with their wide-ranging long-term benefits require further investigation. There are many variations which do not require the high initial investment and considerable donor subsidy needed for successful scaled-up implementation. Toilets linked to biogas digesters have been successfully applied in institutions such as prisons, hotels and colleges as well as private and public latrines. Over 500 EcoSan latrines converting urine to fertiliser and faeces to compost are in use. Garden space and people willing to manage faeces and urine on a daily basis are important conditions for success.

1.3.7. Solid Waste Disposal

A considerable amount of urban solid waste is contaminated with human and animal faeces making safe disposal and management an important domestic priority in rural areas, and a civic or communal responsibility in towns. There are successful examples of organic waste being added to biogas digesters in Addis Ababa.

1.4. What are the Effects of Poor Sanitation and Hygiene in Ethiopia?

1.4.1. Health Status

It is reported that up to 60 percent of the current disease burden in Ethiopia is attributable to poor sanitation where 15 percent of total deaths are from diarrhoea, mainly among the large population of children under five. Some 250,000 children die each year.[5]

As well as diarrhoea, there is a high prevalence of worm infestations (causing anaemia) which have a synergistic effect on the high levels of malnutrition. This, in turn, impacts on school attendance and level of education attained.

The effect of HIV/AIDS is another important factor. While the epidemiological links with improved Water Sanitation and Hygiene remain relatively unexplored, HIV/AIDS patients are known to be at an increased risk from all opportunistic infections and therefore effective barriers will prolong life.

1.4.2. Socio-economic Costs

There are currently no official figures for Ethiopia but the well-known negative synergy of diarrhoeal disease, malnutrition and opportunistic infections are known to have short-term health impacts and long term debilitating effects. In the long term, child development is impaired resulting in growth retardation and diminished learning abilities. It is estimated that 4 in 10 children will not realise their

[5] WHO (1997) – Health and environment in sustainable development.

educational potential which ultimately inhibits socio-economic development. In addition there is the potentially productive time lost to illness, caring for the sick and attending clinics. There are also the financial costs of treatment for medicines and clinic attendance.

14.3. Environmental Degradation

Besides being pollutants of surface waters (necessitating higher treatment costs), faeces and urine are a potential (under-exploited) source of compost and fertiliser which could help address decreasing soil fertility and reduce the high cost (both financial and environmental) of chemical fertilisers. They can also be used to produce biogas (a renewable energy source) which as well as safely containing excreta could contribute to reducing deforestation which is a key environmental issue. Biogas digesters can also be 'fed' with organic solid waste in urban areas as an efficient treatment and use of 'waste'.

1.4.4. Poor Educational Performance

As well as the diminished learning abilities mentioned above, it is widely believed that a significant number of school days are lost due to diarrhoea. This mainly affects girls who end up staying at home to care for siblings. Worm infestations, anaemia and Vitamin A loss have been shown to decrease learning abilities among 4 in 10 girls. The lack of separate, private, secure, hygienic latrines, particularly in adolescence (during menstruation) is associated with a high drop out rate of girls.

1.5. What are the Sanitation and Hygiene Benefits?

1.5.1. Potential Health Benefits

Improved sanitation and hygiene have been shown to prevent disease transmission. Robust epidemiological studies by Esrey[6] and others when assuming a critical mass of more than 80 percent of adopters demonstrated the following:

- Pit latrines, when used by adults themselves and for the disposal of infant's stools, can reduce diarrhoea by 36 percent or more, cholera by 66 percent, and worm infestations by between 12 and 86 percent
- Handwashing with soap (or a substitute) and water after contact with stools can reduce diarrhoeal disease by 35 percent or more
- Eye and skin infections can be reduced with more frequent face and body washing
- Improved water supply is generally associated with a 15 percent reduction in diarrhoea
- A combined safe water supply, sanitation and hygiene can reduce diarrhoea by 65 percent.

1.5.2. Time and Cash Savings

Reduced bouts of sickness (including worm infestations) can lead to time and cash savings. This is in terms of being sick, caring for the sick, medical payments, and increased earning opportunities through

[6] Esrey et al (1991): Effects of improved water supply, sanitation and hygiene. Bulletin of the Royal Society of Tropical Medicine and Hygiene Vol. 77, No 4, pp 5151-521.

being productively available. There is evidence that reduced child diarrhoea and anaemia combined with better nutrition improves academic performance. In Ethiopia malnutrition is high so repeated episodes of diarrhoea greatly contribute to increased malnutrition as children do not get the full benefit of the little nutrients they receive. Mothers, instead of caring for sick and lethargic children, have more time for psycho-social development activities with their children such as play and skills learning.

1.5.3. Girl Child School Attendance and Performance

Access to a safe, private, separate, hygienic latrine in schools is known to be an important contributing factor for girl-child attendance. In particular this applies to adolescent girls during menstruation where the drop out rate is known to increase where facilities are inadequate. Diseases prevented at home reduce time-off school for the sick as well for girls caring for the sick.

1.5.4. Social Benefits

Improved sanitation and hygiene have been associated with increased self-esteem, social change and gender freedom.

1.6. Factors Currently Blocking Effective Sanitation in Ethiopia

1.6.1. Poverty

Persistent drought conditions exacerbate poverty, increase indebtedness, and reduce funds available for water, latrines and soap.

1.6.2. Gender

Men remain dominant in dictating domestic priorities making it difficult for women to voice their special personal hygiene needs and sanitation priorities. Men perceive latrine construction with some scepticism.

1.6.3. Low Level of Priority for Sanitation at All Levels

With so many other pressing needs at household, village, kebele, woreda, zonal, regional and federal levels, it is hardly surprising that sanitation rarely reaches the top five in priority assessments. It is often, unfortunately viewed as a luxury component of service delivery rather than as a preventive health intervention.

1.6.4. Water Not Supplied as Part of an Integrated Environmental Health Package

Water has tended to be supplied in relative isolation as an end in itself and not as a means to promote improved environmental health.

1.6.5. Limited Resources to Promote Sanitation and Hygiene

Few regions budget exclusively for improved sanitation and hygiene. The environmental health department has limited resources to promote latrine construction and hygiene, and has largely depended

on donor and NGO support. It has been estimated by the UNICEF WES section that only one percent of the health budget is available for sanitation and hygiene promotion.

1.6.6. Unclear Institutional Framework, Roles and Responsibilities

Sanitation and hygiene promotion have been seen as dependent on donor funding, and as an initiative which has taken responsibility away from elected leaders and civil servants. Intersectoral collaboration has traditionally been weak, resources have not reached woreda or kebele level, and the private sector has been under-utilized.

1.6.7. Available Human Resources Under-utilised

Human resources for sanitation and hygiene promotion exist throughout the different administrative tiers of government but in the past they have relied on NGO and donor mobilization to reach out into the community.

1.6.8. Equipped Skilled Human Resources Not Readily Available

Promoting the construction and use of latrines by all members of the family requires a diverse range of skills. These range from encouraging the adoption of new behaviours to the construction process using traditional or new technologies. Facilitators skilled in participatory methods such as Participatory Sanitation and hygiene Transformation (PHAST) are not widely available. Trainers who train other trainers with appropriate manuals and materials might exist in the project setting but this is limited. Increasing decentralisation has exposed skill gaps at woreda level. Environmental Health (EH) skills are outdated or under-utilised since many extension staff do not travel out to the communities they are charged to serve.

1.6.9. Advocacy Not Prioritised

Elected leaders and decision-makers in government have not been targeted with strategic advocacy to allow for sanitation and hygiene political imperatives to be finally translated into key government development programs or implementation strategies. Advocacy and marketing strategies have not been aggressively applied to sanitation and hygiene promotion.

1.6.10. Badly Built Traditional Pit Latrines (TPLs) Give a Bad Reputation

Traditional pit latrines (TPLs), built without proper technical support, supervision or subsequent proper maintenance, can negatively effect promotion. Poorly constructed latrines without sealed covers suffer from pungent smells, rising gases, structural collapse, fear of falling in, flies and questionable privacy. All of these act as a disincentive to use or build new TPLs.

1.6.11. Affordable, Durable, Desirable Latrine Design Options Not Readily Available

There are a variety of cost-effective technologies which have been successfully applied worldwide which might address public concerns about current latrine technologies. As yet these have not been extensively

tried in Ethiopia,. While the emphasis should be on low-cost Ethiopian local solutions, it might be necessary to consider alternatives.

1.6.12. Subsidies have Created Unrealistic Local Expectations

With such widespread poverty, a variety of subsidised slab prices (from Birr 30 upwards) have been applied by Regional Health Bureaus (RHBs), donors and NGOs. They have been gratefully accepted by the few who have been lucky to benefit. It is widely accepted that unless 'hand-outs' are made available to all, they actually depress demand because people feel they have missed out on something to which they were entitled.

1.6.13. Minimum Fundable Promotion Packages Not Identified

Despite considerable investment in sanitation and hygiene, the minimum fundable packages to achieve minimum levels of impact have not yet been identified or costed.

1.6.14. Credit or Mutual Savings Not Applied for Sanitation

Women's mutual savings groups and credit for sanitation have been successful in other countries. No such micro-savings, credit strategies or traditional mechanisms have been employed for sanitation in Ethiopia.

1.6.15. Special Needs Groups Unmet

With such low general coverage, the needs of special groups such as pastoralist and nomadic groups have not been assessed. Special design features for paraplegic people and HIV/AIDS patients have not been researched.

1.7. Progress to Date to Improve Sanitation and Hygiene

1.7.1. Some Good Examples From the Past

There are positive examples of extensive community latrine construction in woredas supported External Support Agencies (ESA) such as UNICEF, EU, Finida and WaterAid. The same support has been eceived from local NGOs such as Progynist, the Relief Society of Tigray, Kale Heywot Church and WaterAction.

1.7.2. Some Hope For the Future

The forthcoming Government of Ethiopia (GoE) Health Services Extension Program and the Child Survival Initiative will place the environmental health focus inside the village. This, in turn, will be complemented by the Government of Ethiopia National Water Supply, Sanitation and Hygiene Program (NWSSP) and the ongoing Local Capacity Building Programme.

1.7.3. A New Paradigm is Emerging

Examples are emerging from regional reports where woredas have experienced substantial latrine construction without external assistance. Strong political leadership has proved important in driving elected leaders and civil servants to persuade householders to construct traditional latrines using locally available materials. In the Amhara region, sanitation coverage has been benchmarked as a performance indicator for elected woreda and Kebele administrators. The administrators have, in turn, dedicated themselves to achieve a minimum coverage by a given time leading to 100% by 2007. The health extension workers and community-based volunteers (contact[7] women and community health providers) set examples and then influence others to follow suit. Southern regions and zones have managed to increase latrine coverage from 16 to 65 percent[8] in one year. While such an increase in latrine coverage is heralded as a meteoric achievement, the regional bureau recognizes that this is only the beginning. Access to a latrine is only one part of the 100% adoption of improved sanitation and hygiene transformation process. They also acknowledge that household clustering and deforestation are contributing factors in reducing open defecation options which is increasing latrine demand. SNNPRS is the first region with a dedicated budget for sanitation and hygiene promotion.

1.7.4. Regional Consensus on the Way forward

As discussed SNNPRS has demonstrated substantial increases in 100% adoption. Encouragingly, other regions and zones have reported similar levels of success on more localised levels. There is growing consensus among the regions and zones that traditional household latrine construction can be facilitated without considerable and unsustainable investment or donor dependency.

The key ingredients for increasing coverage are that:

- Public health proclamation is ratified at regional level and is subject to regulation
- A strategy for 100% sanitation and hygiene improvement is adopted
- A specific budget for improved sanitation and hygiene is ratified
- A commitment is given to mobilizing existing human resources
- An advocacy process is adopted which includes:
  - An extended process of consensus building that low sanitation and hygiene is a problem and previous approaches have failed to improve disease prevention
  - Universal acceptance that it is everyone's responsibility – both individual and collective
- There is consensus on the basic minimum level of traditional household latrine which has a hand-washing facility
- Political leadership and commitment is backed up by:
  - Performance contractual agreements reflecting a minimum performance level agreed by all
- The community is empowered and mobilized through traditional leaders (including religious and political leaders) supported by:

[7] Contact women are chosen to demonstrate best practice for the community in the Finida funded RWSEP

[8] The total reported figure is 75 percent but during monitoring 10 percent of those built were found to be defective

  - » Voluntary Community Health Promoters
  - » Community Health Assistants
  - » House to house contact (minimum contact time with health extension workers) and follow ups
- Intersectoral collaboration which would include health, water, education and rural development. There are examples from the regions of creative, complementary sanitation promotion such as:
  - » Water supply has been made conditional upon households building latrines
  - » Schools have been closed until children can report that they have latrines at home
- Donor funding is provided which is appropriate for institutional latrine construction and gives an opportunity for demonstrating improved options
- Supportive supervision (with checklists) and monitoring (performance contractual agreements).

It should be noted that discussion papers have been developed to explain the different processes which are available from the regional bureaus.

2. THE POLICY ENVIRONMENT

This section will address:

2.1 Policy convergence
2.2 Programs
2.3 Laws and policies affecting sanitation

2.1. Policy Convergence

2.1.1. Shared Goals, Objectives and Roles

Improving sanitation and hygiene is recognized by the GoE as an important precursor to poverty eradication. Although there is some variance in emphasis and approach, sector policies converge around overall environmental health goals which emphasize sanitation and hygiene promotion as key interventions to prevent disease, protect the environment and enhance socio-economic development. The future lies in ensuring roles and responsibilities are clarified according to the comparative advantage of different cadres within the different sectors to demystify the process and ensure maximum impact is achieved. Both the Ministries of Health (MoH) and Water Resources (MoWR) have sound sanitation components in their wider policies which converge in the goals:

- To protect and promote the health of the population and assure a friendly and healthy environment by controlling the environmental factors which are the direct and indirect cause for the spread of environmental health-related disease
- To increase access to sustainable sanitation services and safe water.

2.1.2. Main Strategy Objectives in Line with Policies

Households

All households have access to and to use a sanitary latrine. The resulting behaviour aimed at is:

- Reduced incidence of diseases deriving from faecal contamination
- Reduced incidence of waterborne, washed, water related, and water based disease

Institutions

Appropriate latrines with urinals and hand washing facilities are installed at schools, health posts, markets and public places.

Communal Latrines

Where space is limited in peri-urban and urban slum areas, appropriate communal latrines are made available under community or private sector management.

Liquid waste management

Effective liquid waste management systems are in place for promoting re-use and recycling. In particular this covers organic matter, and exploring and promoting biogas or ecological sanitation options.

Safe Water

All drinking water supplies are routinely monitored for chemical and bacterial pollutants.

2.1.3. Special Sanitation and Hygiene Responsibilities

Primary responsibility for the different aspects of sanitation and hygiene promotion lies with the Ministry of Health (MoH) and the regional health bureaus. Responsibility for facilitating complementary activities is allocated between ministries and bureaus as follows :

- Water Resources for water supply, water point drainage and waterborne sewerage
- Rural development for overall rural community development and administration
- Municipal and Urban Health Departments for urban on-site sanitation, hygiene promotion and solid waste management
- Environmental Protection Agencies for environmental policy, strategy development and regulation
- Education for school water sanitation and hygiene
- Agriculture for biogas and ecological sanitation development.

2.2. Programs

2.2.1. The Essential Package for the Health Services Extension Programme

The new health extension programme is perceived to be a primary vehicle for driving sanitation improvement at the kebele level. It has 16 packages, of which the following are dedicated to preventive health:

- Excreta, solid and liquid waste disposal
- Water quality control
- Food hygiene
- Proper housing
- Vector control (arthropods and rodent)
- Personal hygiene, health education and promotion.

It will be important for dedicated sanitation staff to positively influence the training programme (e.g. PHAST) and provide close supportive supervision for extension staff.

2.2.2. MoH/RHB/UNICEF Supported WatSan Community Based Program

The objectives of the national community based sanitation program are disease prevention with a special focus on women and children. The objective is community based approaches and improved, decentralised service delivery. The proposed strategy is to improve methodology and practice with a strong emphasis on coordination and integration (particularly Public Private Sector Partnerships), and sustainable sanitation management by the community.

2.2.3. World Bank supported RWSSH (WaSH) Program

The national rural water supply, sanitation and hygiene (RWSSH) program is a $130m decentralised integrated programe built on partnership. It positions the community as the initiator, contributor, owner and manager which is enabled by the government which assists in contract management with local service providers.

2.2.4. Finida RWSEP in Amhara

The main purpose of the rural water supply and environment programme (RWSEP) is empowerment with a specific objective to improve health via increased latrine coverage, clean water from tap to mouth, and improved awareness of sanitation and hygiene. Key features are a sound institutional framework with intersectoral collaboration, demonstration latrines at institutions, interim subsidized san-plats, and contact women.

2.2.5. NGOs

There are an increasing number of local NGOs active in the sanitation and hygiene sub-sector such as Progynist, Water Action, Nacid, Kale Heywot Church and Sudea (EcoSan) as well as international NGOs like WaterAid, Care, Oxfam and Concern.

2.2.6. Private Sector

Although relatively unproven in sanitation, the private sector is opening up. The ‘Dynamic’ group with membership by ‘street kids’, now runs an effective garbage pre-collection system and has even developed a biogas digester for organic matter. The Salem centre is actively engaged in biogas development and other technologies along with private individuals. There are also a large number of artisans (men and

women) who have received training in slab and latrine construction. Roto Molder is producing square (and dome in Kenya) plastic latrine slabs and there are local porcelain sanitaryware producers. In particular, a urine diversion unit designed by Sudea for ecological sanitation is being produced.

2.3. Laws and Policies Affecting Sanitation

2.3.1. Policies

The key policies which include sanitation are:

- The Health Policy
- The Ethiopian Water Resources Management Policy
- The Draft Environmental Health Policy.

2.3.2. Proclamations

There are a number of proclamations which provide support for regions, zones and woredas to develop a regulatory framework which can back-up the different promotional methods.
The proclamations include the following:

- Public Health Proclamation - the proclamation states that no person shall dispose of solid, liquid or any other waste in a manner which contaminates the environment or affects the health of the society. Art. 12 No. 2 (no enabling bylaws).
- Ethiopian Water Resources Management Proclamation
- Environmental Protection Authority Establishment Proclamation.

3. INSTITUTIONAL FRAMEWORK

This section will address coordination and technical roles and responsibilities:

3.1 The responsibility of all
3.2 Community / Kebele
3.3 Woreda
3.3 Region
3.4 National
3.5 Responsibility matrix

3.1. The Responsibility of All

100% improved sanitation and hygiene is the responsibility of all individuals, households, and communities. In short it is the responsibility of all Ethiopians. It will be achieved through collective responsibility with mutually reinforcing roles played at each level. While sector professionals have responsibility to create the enabling environment, success will depend on committed political, administrative and budget support. Under the umbrella of the national strategy, regions will engage

woreda administrations in 'performance contractual agreements' to drive the process through sectoral desks, supported by an intersectoral coordination forum all tiers of government. While the primary focus is on communities empowering themselves through individual and collective behaviour change to own and lead sanitation improvements, the woreda will take responsibility for developing the right mix of mobilization, promotion and sanctions to achieve 100% coverage. The woreda administration enables the process with support from the regional coordinating forum which, in turn, is supported at the national level. Public Private Partnerships (PPPs) will be fostered through the development of local service providers and woreda support groups. On contract, they will support the implementation process in the provision of a variety of software and hardware packages including institutional latrine construction[9].

3.2. Community / Kebele

3.2.1. Households

Sanitation is a basic right for all Ethiopians but it is also a responsibility. Individuals will have collective responsibility for creating and sustaining 100% sanitised households. They will be supported by 'contact women'[10], Community Based Health Workers[11], Health Extension Agents and community facilitators/ mobilizers.

3.2.2. WaSH Committee (WaSHCo)

Deciding the sanitation focal point at community level will depend on consideration of existing bodies to ensure a representative, sustainable and committed group are in place. In the absence of an appropriate existing structure, one option is to elect a community WaSHCo or Kebele Sanitation Committee which will be responsible for supporting household and communal sanitation

Structure

Membership criteria can be developed at woreda and community level but it is recommended that more than 50 percent of the committee should be women. Women should hold at least one of the executive functions as chair, secretary or treasurer. At Kebele level, the committee should include the Kebele executive committee, health post, Water and Sanitation (WatSan) Committee, school director, Traditional Birth Attendant (TBA), and or Community Health Worker/Agent (CHW/A), development agents, Women's Groups, Community Based Organizations (CBOs) such as the Idirs (burial support groups).

[9] There is already a substantial weight of documentation (manuals etc.) in support of the WASH programme

[10] The Rural Water Supply Environmental Programme (RWSEP) in the Amhara region has successfully promoted the mobilisation of 'contact women' as the 'early adopters' who demonstrate model sanitized households and encourage their 10 immediate neighbours to do the same.

[11] In Tigray, once CHW/As have applied the sanitation package training, householders take a sanitation oath (proclamation) under penalty of a 3 birr fine if they renege.

Responsibilities

The intention would be to participate and then lead into an integrated WaSH triple A planning cycle (baseline, planning, implementation, management, monitoring). The committee members will be responsible for promoting individual and community behaviour change, and lead by example.

3.2.3. Health Extension Workers (HEWs)

The HEWs will facilitate sanitation promotion at the local level as they present the different environmental health packages to the community. Different WaSH approaches (such as PHAST), technical options and manuals will be shared between the different players.

3.2.4. Artisans

There is a great need for skilled and less-skilled personnel who have on-the-spot skills to boost construction both at household and institutional levels. These people include community sanitary facility builders (CSFB), sani-men or women, slab-makers and pit-diggers.

3.2.5. Influential Leaders

Kebele administrators, religious leaders and other influential figures will be co-opted particularly in situations where the campaign approach is being applied.

3.3. Woreda

3.3.1. Woreda Administration

In evolving the decentralised system, the woreda administrator is the key figure responsible for spearheading sanitation and hygiene promotion throughout the woreda, and to ensure targets set are achieved. Examples of best practice from within the relevant region will be arranged in a professional, convincing advocacy package for presentation to woreda administrators. 100% adoption of improved sanitation and hygiene, within a given time period, will be made a key contractual performance indicator for the woreda and kebele administrations. The day to day promotion of improved sanitation and hygiene will be delegated to appropriate line ministries.

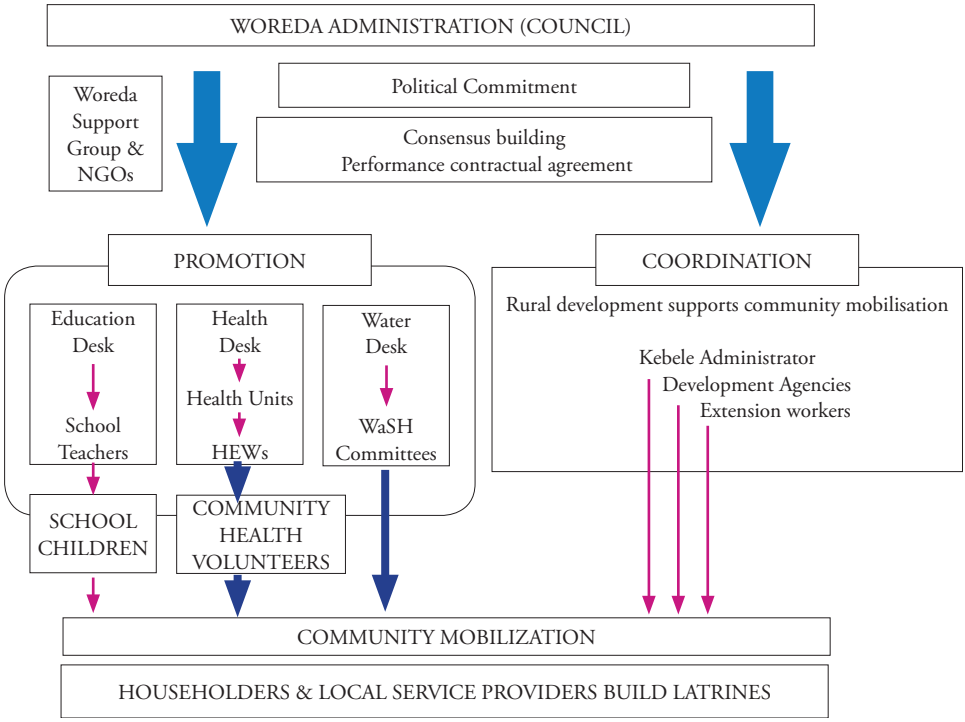
3.3.2. Woreda sectoral desks

The health desk will take the lead but work closely with water, education and rural development desks. Key responsibilities will include:

- Integrated woreda sanitation and hygiene promotion planning and budgeting
- Planning and implementation arrangements for sanitation and hygiene promotion with kebeles including schools and other institutions
- Sanitation and hygiene promotion campaigns
- Budget and resource mobilisation

- The development of appropriate and sustainable methods (testing a variety of mixed media) to promote enduring individual and collective behaviour, and ultimately social change
- Community contract management for school and institutional latrine construction
- The enactment and enforcement of bylaws for sanitation and hygiene (including water quality)
- The provision of a sustainable system for supportive supervision and monitoring of sanitation and hygiene promoters. This includes sanitarians, health extension workers and contact women

3.3.3. Woreda 100% Improved Sanitation and Hygiene Flow Chart



3.3.4. Woreda/Zonal[12] Sanitation and Hygiene Coordinating Forum

The Woreda Coordinating Forum is led by the woreda administrator. Membership is primarily drawn from the Health, Water, Education, Rural Development and Agriculture desks but could also co-opt Women's Affairs, women's associations, the youth and prominent persons such as Kebele administrators, NGOs, learning institutions and HEWs. The main responsibilities of the Woreda Co-ordinating Forum

[12] Zonal (where operational)

are to oversee and monitor hygiene and sanitation promotion throughout the woreda and ensure coordinated and linked development.

3.3.5. Local Contractors

NGOs, CBOs or the private sector could be identified at the woreda or zonal levels to carry out sanitation and hygiene assessments with the community, leading to institutional latrine construction through technical support. Tasks could also include pit digging, slab production, toilet construction (including institutional and public toilets), soap making and the distribution of sanitary products such as soap, taps, jerry cans and pans.

3.3.6. NGOs

NGOs will continue to support government in service delivery. The focus will be on developing and testing different software and hardware approaches, improving planning and fostering PPPs. Some NGOs will have important training responsibilities with local service providers and artisans

5.3.7. Woreda Support Groups and Local Service Providers

In the RWSSH Program there will be a role for designated organizations to support the woredas. This role will be to effectively formalize the existing roles of NGOs and local consultants.

3.4. Region

3.4.1. Regional Bureaus

The regional health bureaus will be the principal drivers of sanitation and hygiene promotion through their existing institutional mandates. They will work in tandem with water and education bureaus to ensure integrated planning and coordinated complementary activities. Their work will focus on strengthening woreda capacity and commitment through the following approaches.

Woreda mobilization

The region will mobilize woreda administrations to take responsibility for 100% adoption of improved sanitation and hygiene in their respective woredas.

Advocacy

The region will develop a convincing advocacy package reflecting examples of best practice (emphasizing the methods used) using attractive mixed media for presentation to woreda administrators. This process will be ongoing with examples of best practice continually documented and disseminated.

Capacity building

Human resource assessment and development will be required supporting inter-woreda exchange visits. In addition, regular supportive supervision to woredas to monitor progress against performance contractual agreements will be needed.

Research, monitoring, evaluation and feedback

The region will implement research, development and dissemination of cost effective software and hardware options to facilitate choice and application of appropriate technology such as EcoSan and biogas.

Planning – rational (Triple A) planning cycle to support woredas

- Preparation of annual workplans and budget (source funding) – identify areas with special needs
- Sanitation and hygiene promotion campaigns
- Ensure training and other capacity building measures are in place for all levels
- Carry out technical supportive supervision to ensure physical and financial accountability
- Back up technical support for construction operation and maintenance to support woredas
- Ensure water quality standards and assurance
- Disease and impact monitoring.

Budget - resource mobilization

Discrete sanitation funds will need to be delineated within the overall health budget. In addition, mobilization of local funding and foreign investment will be required as will creative financial mechanisms such as credit, savings and community cross-subsidies.

Ratify guidelines, standards and rules

Support is required for the development of sanitation and hygiene promotion technical manuals as well as for guidelines for regulatory frameworks (with systems for enforcement). This includes quality assurance and review.

3.4.2. Regional Co-ordinating Forum

The Regional Improved Sanitation and Hygiene (ISH) Coordinating Forum is responsible for overseeing the sanitation and hygiene promotion work of the bureaus, monitoring progress and ensuring a coordinated, complementary and linked approach is being followed. It will be 'housed' in the regional health bureau with membership comprising the main government bureaus, donors, academic institutions, and the private sector, NGOs and local CBOs where appropriate. The Forum will primarily be responsible for overseeing sanitation and hygiene promotion activities in the regions.

3.4.3. Autonomous Municipalities

Coordinating forums need to be formed in autonomous municipalities and preferably be headed by the city administrator.

3.5. National Level

Different line ministries will have their own special areas of focus for improved sanitation and hygiene promotion but the primary driver will be the Environmental Health Department (EHD) of the Ministry of Health (MoH).

3.5.1. Ministry of Health – Environmental Health Department (MoH-EHD)

The responsibilities of the MoH-EHD will be to:

- Finalize and enact the sanitation and hygiene promotion strategy and guidelines through a consultative process
- Develop the advocacy campaign by raising the sanitation profile, lobbying for earmarked funds and seeking influential sanitation champions
- Support the testing and development of appropriate Information Education Communication (IEC) materials (e.g. PHAST approaches)
- Liaise closely with training institutions to ensure consensus on the sanitation strategy, the inclusion of 'best practice' in the curriculum, and the equipping of extension staff with appropriate tools
- Source funds from donors and the private sector – promote the sector wide approach
- Support research, development and dissemination:
  - Collect and disseminate examples of best 'soft and hard' practice both from national and international sources and experience
  - Facilitate national and international exchange visits
  - Facilitate national conferences with external resource persons
  - Edit and distribute national sanitation newsletter
  - Network regions and zones
  - Establish and run sanitation website
  - Maintain a register of core sanitation experts and resource persons
  - Support procurement to facilitate economies of scale
  - Research, develop and disseminate of technology options
  - Co-ordination
- Collect, develop and disseminate examples of legal and regulatory documents (bylaws)
  - Strong machine for law enforcement
  - Incentives for adherence to laws.

3.5.2. National Coordinating Forum

Membership will be drawn from the Ministries of Health, Water Resources, Education and Agriculture as well as the EPA, NGOs, Academic Institutions, private sector sanitary suppliers and donors. As a coordinating and advisory body, the main general responsibilities of the National Coordinating Forum will be to:

- Implement policy overview and co-ordination, monitoring and evaluation of national sanitation strategy

- Facilitate intersectoral convergence and broad-based stakeholder participation
- Set standards for sanitary facilities and water including quality monitoring
- Build up extensive sanitation network
- Develop impact monitoring systems and assessments
- Disseminate information
- Ensure national meetings rotate between regions.

3.6. Responsibility Matrix

	Community/ Kebele	Woreda	Regional	National
Administration	Kebele Administrator	Woreda Administrator	Regional Administration	Office of PM
Administration	Responsible for achieving 100% sanitized households, villages, and Kebele Support those unable to complete construction process Agree and abide by sanitation bylaws with sanctions Allocate and manage sanitation budget	Lead 100% improved sanitation and hygiene with accountability Mandate sectors to promote improved sanitation - fund minimum support packages Allocate/manage sanitation budget Monitor progress	Administration of funds Micro-finance options Sanitation budget preparation	Budget allocation for sanitation
Health	Community Health Agents	Health Desk	Health Bureau	EH Department
Health	HEW package School WaSH Enable KABP to inform communication, social marketing Explore technical options Facilitate behaviour trials Monitor change	As above Program, NGO coordination Support WaSH in schools Health post facilities Design options Develop social marketing approach Engage local contractors Behaviour profiling	Coordination Prepare workplans and budget Promote health education and sanitation campaigns Arrange capacity building Supportive supervision Back up technical support Water quality standards Disease profiling	Day to day review of progress Strategy review Funding support through budget, donors Support development, test and dissemination of IEC materials Liaison with training institutions Research development and dissemination Health impact
Water	WaSH Committee	Water desk	Water Bureau	MoWR
Water	Organize community for construction support and funds for O & M	WaSH promotion Water options	WRM WQM Water point drainage Urban sewerage	Integration with, and support for sanitation coordination Consider liquid waste options

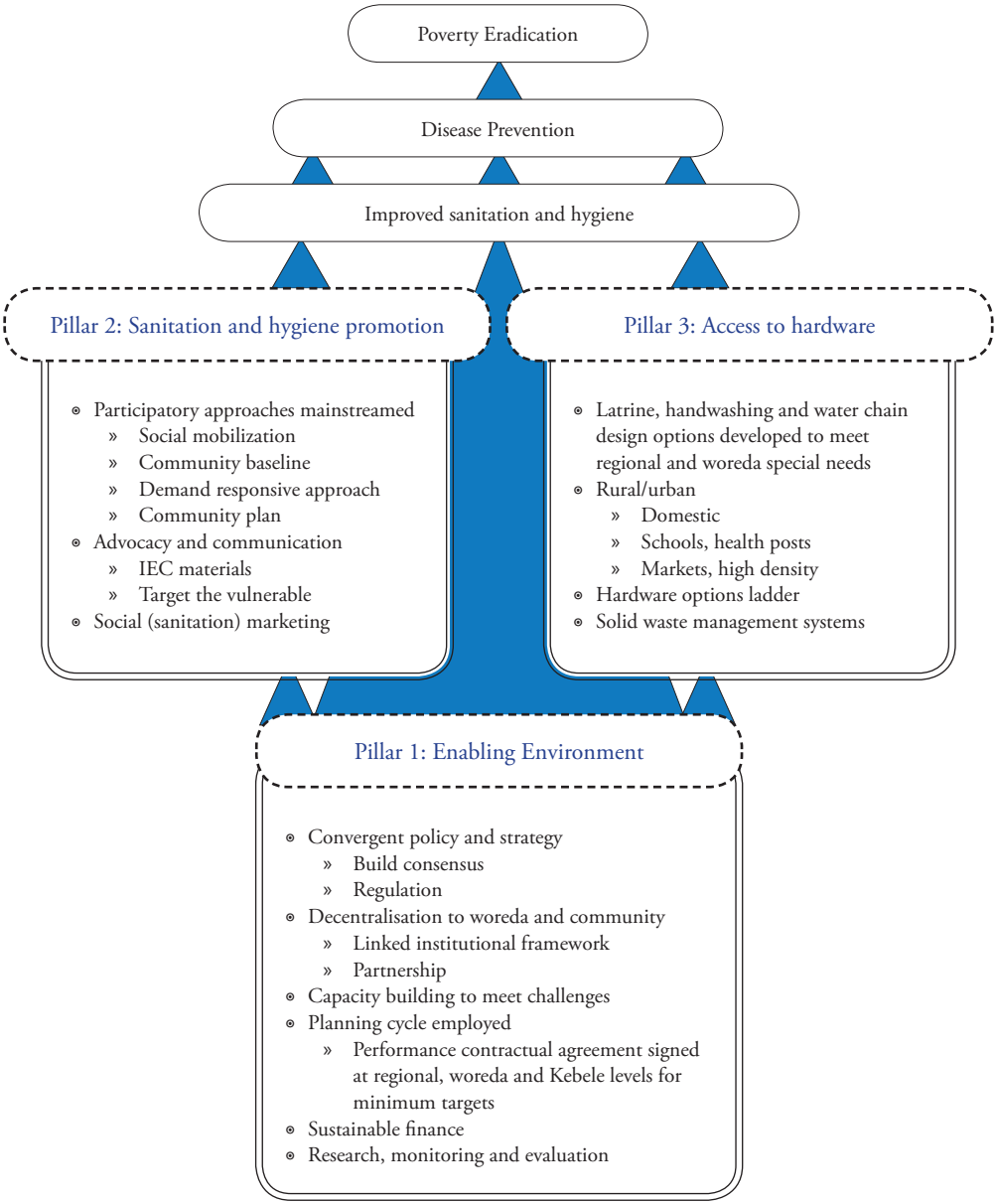
Education	School teachers and Parents Teachers Association (PTA)	Education desk	Education Bureau	MoE
Education	PTA engage School clubs	School WaSH development with WaSH team	School WaSH strategy	School WaSH policy Curriculum development
Rural Development	Extension workers	Rural Development Desk	Rural Development Bureau	MoRD
Rural Development	Community mobilization	Kebele mobilization	Coordination of overall development activities	Rural development overview
Agriculture	Extension workers	Agriculture desk	Agriculture Bureau	MoA.
Agriculture	Trials on reuse of urine/faeces Zoonotic disease control – irrigation	Advice to households/farmers on agricultural reuse of excreta	EcoSan and biogas trials and promotion	EcoSan and biogas research, and development and dissemination
Co-ordinating Forums	Participation in baseline CAP, KABP Leadership with ownership of implementation process 100% sanitized households 100% sanitized villages Clubs and team – micro-credit etc.	The main responsibilities of the Woreda Coordinating Forum are to oversee and monitor hygiene and sanitation promotion throughout the woreda and ensure coordinated, linked development.	The Regional WaSH Forum is responsible for overseeing the sanitation and hygiene promotion work of the bureaus, monitoring progress and ensuring a coordinated, complementary and linked approach is being followed. It will be 'housed' in the health bureau.	Policy review Strategy development Coordination Regulation Monitoring Supervision Research, monitoring and evaluation

4. STRATEGIC FRAMEWORK

This section will introduce the sanitation framework and the three sanitation pillars

4.1 The three pillars
4.2 The strategic matrix
PILLAR 1: The Enabling Environment
PILLAR 2: Sanitation promotion (marketing)
PILLAR 3: Access to hardware

4.1. Strategic Framework - The Three Hygiene and Sanitation Pillars



4.2. Strategic Matrix – Logical Framework

The Strategic Matrix draws together policy imperatives and strategic objectives of the Ministries of Health and Water while emphasizing guiding principles and indicators to measure progress towards achieving stated objectives.

Policy Objective	Strategic Outputs	Guiding principles	Initial Indicators
Vision: 100% adoption of improved (household and institutional) sanitation and hygiene by each community contributing to better health, a safer, cleaner environment, and the socio-economic development of the country.	Create an enabling environment to facilitate sanitation promotion and marketing and access to appropriate hardware	◦ Accountable government facilitation ◦ Community leadership ◦ Some for all (100% sanitised village approach) ◦ Sector convergence	» Reduced child infant morbidity/ mortality or increased child survival » Number of 100% sanitised villages, Kebeles, and woredas
PILLAR 1	**ENABLING ENVIRONMENT**		
◦ Develop and promote guidelines, rules and regulations ◦ Update and apply the EH component of the Public Health legislation and regulations ◦ New Public Health Act	1. Converging Policy ◦ One sanitation policy agreed ◦ One strategy finalised but with regional variance to reflect diversity ◦ Legal backing established ◦ Performance related contracts	◦ Sanitation: a right and a responsibility ◦ Community/ Public/Private Sector/NGO Partnership	» Policy and strategy ratified by government at all levels » Regional strategy amendments » Regional legal sanctions
◦ Define collaborative (intersectoral) and cooperative institutional framework ◦ Define roles and functions ◦ Promote the involvement of NGOs, ESAs and private sector	2. Decentralized Services ◦ Strengthened, joined-up, effective institutional framework ◦ Process owned by community ◦ Partnerships forged ◦ Management skills learned	◦ Community based leadership to manage EH risks effectively ◦ Government enables, facilitates change, regulates ◦ Private sector engaged ◦ Institutional assessment (SWOT)	» Community WaSH action plans » Community WaSH fund management » Strategy documents

Policy Objective	Strategic Outputs	Guiding principles	Initial Indicators
◦ Initiate programs for capacity building for all levels of environmental health professionals	3. Capacity building ◦ Human resource (HR) assessment carried out. ◦ Comprehensive HRD programme developed	◦ Appropriate capacity building including supportive supervision ◦ Users particularly WOMEN as decision-makers/ managers	» Intersectoral technical teams active (planning together) in selected woredas with NGOs and private sector engaged
◦ Ensure integrated planning for WaSH interventions at all levels	4. Rational planning cycle adopted ◦ S.M.A.R.T. rational planning cycle applied at all levels on an annual basis	◦ Intersectoral broad-based plans for sanitation are developed on an annual basis ◦ Costing, budgets, resource allocations	» Linked plans in use in pilot woredas – informing effective monitoring of process and progress
◦ Improve the allocation and utilization of finance and other resources to accelerate the delivery of the service	5. Sustainable finance package for sanitationformalized ◦ Sector-wide approach with WaSH funds dedicated to sanitation and hygiene ◦ Subsidy used for promotion and product development to lever broad-based but sustainable funding such as micro-credit	◦ Consistent regional policy on, and strategic use of, subsidy ◦ WaSH programmes commit 10-30 percent for sanitation	» Government allocates funds for sanitation promotion in health budget » Donors dedicate 10-30 percent of WaSH funds for sanitation promotion
◦ Conduct, promote and facilitate applied research and surveys and disseminate information on environmental health issues. Ensure drinking water quality ◦ Facilitate environmental impact assessment	6. Research, M&E capacity formalized ◦ National and regional research centres selected and operational ◦ Priorities for applied research refined	◦ Robust information to inform evidence based planning ◦ Independent systems of verification	» % of water points tested and approved » Monitoring and evaluation system piloted in self-selecting region

Policy Objective	Strategic Outputs	Guiding principles	Initial Indicators
PILLAR 2.	**SANITATION AND HYGIENE PROMOTION**		
◦ Increase awareness and participation of communities to assume responsibility for their own health and well-being ◦ Promote the sanitation service based on participation-driven and responsive principles without compromising social equity ◦ Promote food hygiene	7. Participatory approaches mainstreamed ◦ Participatory toolkits developed as packages with clearly defined applications and process indicators	◦ Participatory tools facilitate ◦ Social mobilisation to facilitate gender inclusion ◦ Appropriate methods to reflect regional diversity ◦ Tools facilitate community empowerment ◦ Hygiene promotion	» PHAST toolkits developed for baseline planning, promotion and monitoring » PHAST toolkits included with other IEC materials piloted, reviewed and customised for regional use
◦ Advocate the construction, use and maintenance of low-cost sanitation facilities in urban and rural areas ◦ Promote sanitation and hygiene education at federal, regional and community level by developing promotional and educational materials	8. Advocacy campaign agreed ◦ Advocacy campaign (cross-cutting) developed and applied ◦ Appropriate communication media for different people and circumstances developed ◦ Vulnerable groups (special needs) reached	◦ Balance of hardware and software appropriate to local situations ◦ Participatory demand creation and demand responsive approaches	» Advocacy campaign developed, applied and tested for efficacy at different levels
◦ Promote the development of attitudes and practices conducive to the strengthening of community self-reliance in EH issues by mobilizing and optimally utilizing internal and external resources.	9. Social marketing tried ◦ Private sector and NGOs engaged to test the application of commercial marketing methods) to drive sanitation.	◦ Create household and community demand	» Private 'marketing/ advertising companies contracted to conduct sanitation marketing campaigns in selected woredas

Policy Objective	Strategic Outputs	Guiding principles	Initial Indicators
PILLAR 3:	**ACCESS TO HARDWARE**		
◦ Promote affordable, acceptable and sustainable latrine technologies and increase the coverage from its current low level ◦ Ensure that residential, health institutions, schools, camps, prisons, recreational places, etc are provided with adequate access to EH services ◦ Define standards for rural and urban domestic, communal and institutional latrines	10. Latrine options developed ◦ Design options are developed to meet regional and woreda special needs ◦ Options designed for rural and urban situations: » Domestic » Schools (primary/ secondary) » Health facilities, markets » High density » Hardware options ladders developed at region	◦ Users engage in design ◦ Culturally and socially acceptable systems ◦ Water saving systems ◦ User-friendly (privacy, safety) ◦ Recycling ◦ PPP ◦ Social marketing ◦ School and HP focus ◦ Special needs ◦ Research, M&E	» Latrine options manual completed with regional variations developed and piloted
◦ Ensure delivery of EH education integrated with practical components in teaching institutions ◦ Promote the construction, use and maintenance of low-cost sanitation facilities	11. Handwashing options developed ◦ Design and service options are developed to meet regional and woreda special needs in homes and institutions ◦ Soap distribution and making explored ◦ Private sector engaged and equipped ◦ School and Health post facilities developed	◦ Users engage in design ◦ Culturally and socially acceptable systems ◦ Water saving systems ◦ User-friendly » Tippy tap, soap substitutes ◦ Research development M&E ◦ Engage soap industry	» Handwashing with soap (or substitute) and water is elevated to a priority status in planning WaSH at all levels

Policy Objective	Strategic Outputs	Guiding principles	Initial Indicators
◦ Create conditions to ensure that hygiene requirements are practised in living and working environment.	12. Safe water chain options developed ◦ Design and service options are developed to meet regional and woreda special needs ◦ Safe DW available in schools (classes) and public institutions	◦ Users engage in design ◦ Culturally and socially acceptable systems ◦ Water saving systems ◦ User-friendly ◦ Research M&E	» The safe water chain is elevated to a priority status in planning WaSH at all levels

PILLAR 1

5. ENABLING ENVIRONMENT

PILLAR 1:

5.1 One sanitation strategy at all levels with regional interpretation
5.2 Strengthened, linked, effective institutional framework
5.3 Human resource assessment and development programme
5.4 Integrated planning - Triple A – rational planning cycle
5.5 Funding sanitation
5.6 Research, monitoring and evaluation

5.1. One Sanitation Strategy at All Levels With Regional Interpretation

5.1.1. 100% Sanitized Villages

The strategy centres on building individual and collective responsibility for 100% sanitized households and villages. This will be facilitated through:

- Intersectoral collaboration
- More available and accountable civil service
- Public Private sector NGO partnerships
- More effective service delivery
- Flexible but sustainable finance
- Improved communication
- A wider range of feasible technical options more readily available and affordable.

Promotion will be backed up by regulation such as the sanitary oath[13] and the 'performance contractual agreement'.[14]

5.1.2. Integrate Water, Sanitation and Hygiene (WaSH)

There is a general consensus among the different sectoral policies that sanitation is the mitigating cause of contamination within the living environment. The key Ministries of Health, Water Resources, Education, Rural Development and Agriculture will enable integrated WaSH delivery.

- The health sector, with such a wide area of contact between health professionals and the people, must give consistent messages (based on understanding and research into behaviours) which emphasize prevention and increase individual and collective responsibility for EH risks. Health units will set an example.
- The water sector must see beyond water supply as an end in itself. It must view water as the means to help sanitize villages but understand that it is not the only component. Water is one part of the sanitary trinity and a powerful lever to make a sanitized whole. Water supply can be made conditional on latrine construction as a complementary 'promotional strategy'.

The education sector can positively influence current children and future parents. Schools need to provide hygienic and healthy environments to protect pupils, enhance learning and set examples of best practise for the home. As well as the more conventional 'child to child' approach, schools have also been closed until all children can report latrines constructed at home.

5.1.3. One Size Does Not Fit All

It is recognized that one size does not fit all and there are important regional variations which will impact on creating, and responding to demand for improved sanitation and hygiene. Regions will be encouraged to make appropriate modifications to reflect local conditions.

5.1.4. Consistent Approaches to Include Urban Areas

Regions and woredas should seek to develop approaches that can be applied throughout their jurisdiction, including urban areas. Certain basic principles should apply everywhere. Households and communities are expected to use their own resources, and to mobilize and allocate resources made available to them. All households are encouraged to make an informed choice based on social, technical and financial factors.

Where it might be better for some sanitation services to be offered on a communal basis (such as septic tank emptying and sewerage), this becomes the subject of a political process (informed choice), which

[13] In Tigray Region, Health Extension Workers, after presenting their environmental health packages to householders, exact an oath of compliance to the environmental health proclamation

[14] Southern Regions have developed their own 'home-grown' strategy to promote household latrine construction by consensus backed up by signed agreements against which performance will be assessed. Different sectors have also introduced their own conditions to promote change.

should take note of many factors. Such factors include the affordability of each household's capital contribution and, even more important, the affordability of running costs and repaying loans where these would be incurred. In this context, the use of grant finance for high levels of service would be inequitable and probably counter-productive if the lack of income for maintenance leads to system failure.

Whereas the range of technology options may be larger in urban areas than in rural areas, the choice of technology must still be affordable, socially acceptable, institutionally manageable and environmentally sound. Systems that cannot be properly managed due to a lack of skills or income can quickly become health hazards so environmental soundness includes the robustness of a system under adverse circumstances.

5.1.5. Crossover Learning

While there are differences, there will also be some lessons common to all and the proposed coordination framework at different levels will foster improved documentation of examples of best practice with options for crossover learning.

5.1.6. Regulation

Examples of regional public health proclamations could be shared and the National Coordinating Forum could prepare a draft sanitation bylaw for circulation. Different woredas within different regions and zones will employ appropriate 'carrot and stick' methods to promote and enforce sanitation. In the Tigray region, the sanitation oath backed up by locally administered fines is being applied with the health extension package.

5.2. Strengthened, Linked, Effective Institutional Framework

5.2.1. Integration and Intersectoral Co-ordination

While it is important for the community to view integrated WaSH activities as the means to achieve 100% sanitized village status, it is important to recognize that the implementation of the different components will require varying degrees of individual and collective effort, and external support. The job of the different sectors is to work together to maximize the use of limited resources by taking advantage of, and sustaining the momentum created by the demand for water.

5.2.2. Institutional Framework

- The community (through the WaSH Com and kebele leaders) will lead and own the process.
- The woreda (through the administration, the desks and the WaSH forum) will mobilize communities and identify, regulate and facilitate local service providers (NGOs and the private sector) to construct institutional latrines.

- The region (through administration, bureaus and the Coordinating Forum) will advocate, budget, support, research, monitor and coordinate.
- The national level (National Sanitation Co-ordinating Forum and Line Ministries) will continue to develop the strategy, mainstream sanitation funding, and will facilitate crossover learning and will evaluate.

It will be important that institutional maps are developed at regional level to ensure key responsibilities are allocated to institutions with the potential to deliver (such as matching institutional mandates with resource flows).

5.2.3. Community Based Leadership

The focus will be on creating a sense of responsibility for sanitation at the household and the community level so that 100% sanitized households create 100% sanitized villages. The community should empower themselves to lead the management of their environmental health risks more effectively. The community based WaSH committee will play a strong coordination role backed up by extension staff and local contractors.

5.2.4. Woreda

The Woreda administration through the desks (with support from the Woreda Sanitation and Hygiene Promotion Forum) will be responsible for facilitating integrated community WaSH plans which will reflect the different technical, service and financial options available. The Forum is responsible for registering local contractors, either NGOs or the private sector, with the potential for WaSH service delivery.

5.2.5. Region

The regional bureau with support from the Coordinating Forum will identify woreda support groups to build capacity at woreda level including skills for Local Service Pproviders The team will support planning, budgeting and advocacy as well as providing supportive supervision.

5.2.6. Public Private Sector NGO Community Partnership

Creating an enabling environment for public-private sector partnership will be an important intermediate step to consolidating increased coverage. Testing different approaches to find cost effective packages which yield results will be a critical first step in making the best use of limited resources.

5.3. Human Resource Assessment

5.3.1. Assessment

In line with decentralisation it will be important to review job descriptions against roles and skills identified and prepare a Human Resource Development Programme matching job requirements with necessary skills

5.3.2. Development Program

It will be important to bring the sanitation strategy in line with various local capacity building initiatives and ensure harmony of approaches by stakeholders operating in the same woreda (e.g manuals, participatory skills and tools developed and tested in programmes or projects should be made widely available).

5.3.3. Supportive Supervision

All human resources should be adequately supported and supervised, particularly where skills have been upgraded. There should be no training without the facility to assess the value of that training and, where appropriate, refresh skills.

5.3.4. Skills Learning Packages

From the institutional and human resource assessment it will be possible to consider existing and potential skills as well as gaps. Environmental health officers will be required to give up some of their regulatory focus and develop participatory, facilitating skills. Mutually reinforcing, complementary skills learning
packages, tools and manuals will need to be pooled from the wealth of different experiences and initiatives (including programs and projects). Skills learning packages will be needed in the following areas:

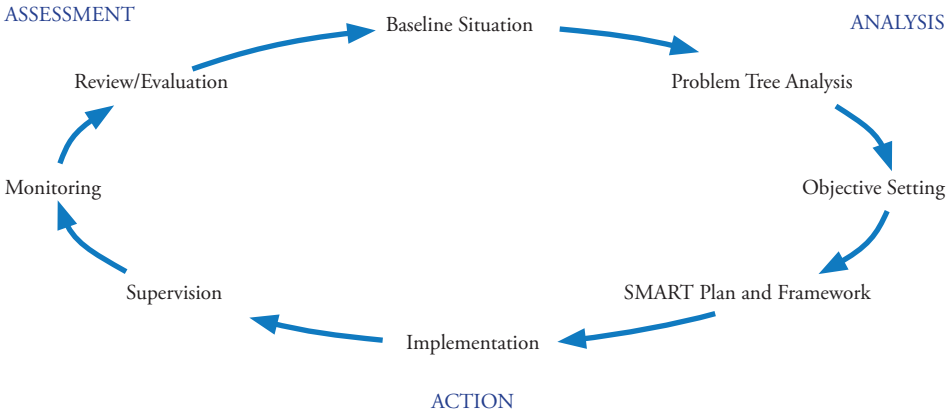
- Community / Kebele level - WaSH Committee, contact women, hygiene promoters, Health Extension Workers, influential leaders such as traditional and religious leaders
- Woreda level (Woreda ISH Forum) – contract local CBOs, contractors, artisans and masons, and sanitary retail outlets for slabs, soap, taps
- Systems - establish systems and software or hardware packages of support for different levels, transparent accounting procedures, clarify roles and functions of different stakeholders and sanitation supply streams
- Staffing and lines of accountability - identify key staff with lines of accountability between tiers (institutional linkages) and ensure job descriptions reflect new lines of responsibility.

5.3.5. Cross Region Zonal Woreda Kebele Learning

As well as the proposed newsletter, website and forum/committee meetings (including the rotating national forum meetings in different regions and zones), funds should be allocated for a programme of

cross kebele, woreda and regional visits to share experience and examples of best practice. Visits to other countries for workshops, conferences and experience sharing should also be considered.

Figure 2. Program Planning Cycle for Integrated WaSH



5.4. Integrated Planning - The Triple A Rational Planning Cycle

5.4.1. Improved Planning

Integrated planning of WaSH activities should be carried out by line ministries, bureaus, and desks in cooperation with each other where possible and appropriate. Improved planning could be institutionalised at Kebele, woreda, zonal, regional, and federal levels. Planning headings could be aligned with selected strategic objectives to encourage compliance with the strategy. Facilitating the rational planning cycle requires good facilitation skills and a good understanding of the cycle.

5.4.2. Situation Analysis and Baseline

Key stakeholders will be consulted (stakeholder analysis) at woreda level to collect secondary data and make at least one Kebele visit to collect information about the water, sanitation and hygiene (WASH) needs in the local government area including issues and problems relating to service delivery. The process could start with a stakeholder analysis.

5.4.3. Problems, Option Appraisal and Objective Setting

The process will involve considering key problems inhibiting effective service delivery and uptake, prioritizing options and translating problems into objectives.

5.4.4. Implementation

This phase will cover the application of sanitation packages including school WaSH, sanitation, and hygiene promotion campaigns.

5.4.5. Supervision, Monitoring and Evaluation

Monitoring and continuous feedback will be a constant theme requiring the design of a performance monitoring framework that allows measurement of cost-effectiveness, benefits and implementation processes, and application of mid-course corrections.

5.5. Financing Sanitation

5.5.1. Key Principles

In Ethiopia, ISH has been funded through donor support with only limited regional examples of allocated budget provision. A review of emerging thinking and practice suggests that a shift in sanitation financing is required from financing 'subsidies and grants for sanitation facilities' to funding 'sanitation promotion and leveraging resources' from, for example, households. It is recognized that aspects of the three pillars will require funding primarily to lever investment in line with the 'user/beneficiary pays principle'. Other key principles will include:

- Householders in rural and urban areas should contribute their own resources for domestic sanitation facilities with public finance dedicated to leveraging private resources
- Subsidy should only be applied if it is sustainable to the point where all needs are met
- Public financing should be used for public health worker costs and all software activities such as advocacy, social marketing, capacity building and regulation. It could also be used for institutional sanitation facilities
- Public/communal latrines should be funded out of 'user' charges
- Exploring alternative finance strategies such as mirco-finance
- Advocacy is a key element to leverage budgeting for specific ISH budget lines. This will require more work on costing activities for better budgeting.

5.5.2. Process for the Development of a Public Financing Strategy for ISH

Box 1 describes a five (5) point plan for developing the public financing strategy for ISH. A summary is given below:

(i) Consensus building on approach

There is a need to develop and get local consensus on the methods and approach to be used in sanitation and hygiene promotion, and for leveraging resources.

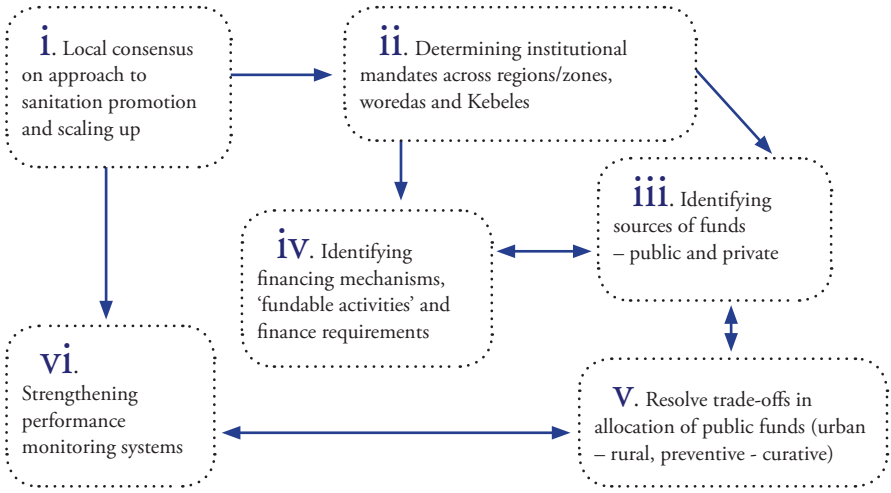
(ii) Determining institutional mandates

There is a need to determine and foster clarity on institutional mandates across ministries and at different levels of government.

(iii) Identifying sources of funds

It will be necessary to identify and mobilize all potential sources of finance, both public and non-public, and determine the appropriate mix.

Box 1: Steps in Developing a Public Finance Strategy for Scaling Up Sanitation Access



(iv) Identifying financing mechanisms

It will be necessary to identify activities to be funded (refer box 2) with related financing mechanisms for flow of funds to create reliable and predictable cash-flows, provide fiscal incentives for promoting sanitation with local governments, and ensure appropriate targeting of needed subsidies and grants.

(v) Resolving trade-offs

This will include addressing tradeoffs in the allocation of public funds for appropriate sanitation activities. Examples are shifting from curative to preventive health, and a trade-off between public resources for 'basic sanitation' versus 'urban sewerage.

(vi) Strengthening performance monitoring systems

It will be necessary to design a performance monitoring framework that allows measurement of cost-effectiveness, benefits and implementation processes, and application of mid-course corrections

Box 2: Fundable activities and sources of funding	
A. Creating an Enabling Environment	**Source of funding (budget line)**
Strengthening Health bureaus to effectively spearhead sanitation promotion programs and support sanitation coordination forums (e.g. technical assistance)	Health national/regional – capital
Policy and legislation development	Health national – recurrent
Documentation and dissemination of best practices, learning events, seminars and exchange visits	Health national – recurrent
Sanitation monitoring and information system development, continuous data collection and analysis	Health all levels – recurrent
Training and reorientation of extension staff	Health / Capacity building national – capital
Applied research in environmental health (e.g cost effectiveness and impact of various best practices)	Education / Health national / regional – recurrent
Continued Advocacy and consistent lobbying for integration of ISH into national and regional development programs	Health national / regional – capital
B. Promoting Demand for Sanitation	
Social marketing campaigns in small towns and urban centres (consumer needs assessment, creative development, implementation of campaign, and evaluation)	Health regional – recurrent
Wages, transport and facilitation material for health extension staff	Health all levels – recurrent
Performance-linked incentives for local government and local leaders (e.g. awards)	Health national / regional – recurrent
Total sanitation and home improvement campaigns and public (community) meetings	Woreda – capital (start up campaigns)
Sanitation and hygiene education in schools	Education all levels- recurrent
Development of promotional material, school curricula and guidelines for ISH	Health/Education national / regional – capital
C. Strengthening Supply of Sanitation Facilities	
Training and technical support (provision of basic tools, moulds, etc) for small-scale service providers (artisans)	Regional / Woreda Health – capital

Supporting measures for access to credit for artisans and households – feasibility studies and negotiations with micro credit institutions/associations	Health national / regional – capital
Regulation and supervision of service providers	Regional / Woreda Health – recurrent
Development and product research for options and tested alternatives e.g. twin (lined) pits, biogas	Health national / regional – recurrent
Demonstration toilets to showcase alternative technologies and designs	Regional / Woreda Health – capital
Sanitation facilities for schools and health centres	Regional / Woreda Health/Educ – capital
Construction of public sanitation facilities	Municipalities – capital and private sector (recovery through user charges)
Construction of Household sanitation facilities	Household financing
Construction of sanitation promotion/sales and information centres	Municipalities – capital
Development of sewerage systems or sludge management systems in cities and large towns	Municipalities – capital, loans (user charges)

5.6. Research, Monitoring and Evaluation (M&E)

5.6.1. Research

As well as the regional research stations are monitoring water quality, regional research initiatives by different public health learning institutions could look into different software and hardware approaches tried elsewhere to be adapted to local conditions. Such research might assess the relative merits of:

- Contact women, hygiene promoters – house to house promotion approach
- School environmental sanitation and hygiene clubs, and the child to child approach
- Religious leaders 'picture based tool kits' such as those done by PHAST and RWSEP (Church style pictures[15], "colour my beautiful home"[16])
- Other media such as folk songs, drama, role play, and radio
- Latrine options for urban, rural, domestic, institutional, local and manufactured materials such as:
  - Pit lining, platforms and superstructure
  - Ecological sanitation
  - Biogas.

[15] Church style paintings have been used in the RWSEP project (refer to cover page)
[16] "Colour my beautiful home"is a community monitoring process developed by UNICEF in Papua New Guinea

5.6.2. Monitoring

The epidemiology of health impact measurement is complex and unpredictable. In WaSH, it is now acceptable to use proxy indicators of health improvement. Changes in health status depend on the adoption of safer hygiene behaviour and it is therefore better to adopt behaviour change as proxy indicators of health improvement. The 100% sanitized household and village target reflects the requirement that a critical mass of greater than 80 percent must adopt a safe behaviour for the health impact to be felt.

Community Planning and Monitoring

Key indicators at community level might include:

- Numbers with safe dry season water access within 300 meters (women and children as primary water carriers)
- Safe excreta management systems (particularly for young children)
- Handwashing after contact with faeces (particularly targeting mothers and child minders)
- The number of households actually practising the full safe water chain.

Measuring behavioural impact can be part of the ongoing monitoring by the community of their own progress and is an integral part of the Hygiene Evaluation Procedure. This approach ('plausible inference') measures something which is clearly measurable, close to the intervention, and is easily understood by the community because they are the ones who set the targets

Water Quality

Regional water quality testing laboratories will be boosted by the increased availability of potable water quality testing kits together with Global Positioning System (GPS) mapping of water points.

Supportive supervision

Regular supportive supervision as well as being an essential personnel management tool, is also an effective means of monitoring process and progress.

5.6.3. Evaluation

Systems for the independent and objective evaluation of projects and programs need to be introduced to capture examples of best practice as well as assessing the costs.

PILLAR 2

6. SANITATION PROMOTION AND MARKETING

This section will discuss:

6.1 Behavior and social change
6.2 Advocacy and communication
6.3 Social marketing

6.1. Behaviour and Social Change

6.1.1. Self Motivation for Change

Shifting from traditional teaching approaches to the process of facilitating people's participation is an important step but the strategy requires extension workers to push the process one step further. People must take individual responsibility for sanitation in their households and collective responsibility for sanitation in their communities. Extension workers will need new attitudes, skills and tools which enable and support the empowerment process.

6.1.2. Participatory Hygiene & Sanitation Transformation (PHAST)

One possible approach, custom built for WaSH, is PHAST (Participatory Sanitation and Hygiene Transformation). This is a synchronised participatory tools package including Picture Based Tool Kits (PBTKs) which can be used for baseline WaSH information collection with the community, community level action planning, promotion and monitoring. UNICEF and IRC have PHAST trainers and are producing a range of toolkits (WaterAid also have pictures) to link with the proposed PHAST training program. In Amhara, RWSEP has also developed church-based pictures which could be adapted for wider use.

6.1.3. Participatory Skills

Facilitating participation is about attitude and the willingness to "hand-over the stick and listen". The participatory tools must be simple and easily understood by the facilitator (whether contact women, HEWs, HPs or LSPs) and all participants. Participatory skills cannot really be taught but rely on experience and supportive supervision. The important issue is that the participatory process is defined in S.M.A.R.T[17]. packages with clear indicators so that both the facilitator and participant know where they are going and how they plan to get there.

6.1.4. Community Mobilization

Sanitarians and HEWs from MoH, community mobilizers and engineers from the MoWR plus school inspectors, head teachers (MoE) and extension workers (MoRD) must share a common commitment to the task of fostering 'self-motivation for change'.

An example is an inter-sectoral WaSH Woreda team which together go to the community to:

- Present water, sanitation, hygiene (WaSH) to the community as integrated environmental health components to be managed by the community itself
- Explain the 'Triple A' cycle
- Elect WaSH Committee with 50 percent women

[17] S.M.A.R.T. – Specific Measurable Achievable Replicable and Timebound

- Facilitate an integrated community WaSH plan where the community commits to the principle of 100% sanitized households, 100% sanitized schools and 100% sanitized village. This commitment could be made a pre-condition of the WaSH finance package.

6.1.5. Demand Responsive Approach

An important underlying principle is that facilitators apply a Demand Responsive Approach (DRA) which is designed to move all stakeholders away from a supply driven, one size fits all service provision top-down methodology to a process where the 'users' own and manage the process. DRA lets users identify and articulate their demand through participatory methods which allow them to make an informed choice from a range of technical and service level options. Different participatory tools can be applied so that users and facilitators can consider the following key aspects and plan their sanitation interventions accordingly:

- Environmental factors
- Social and cultural norms
- Technical factors and options
- Perceptions and priorities
- Financial constraints
- Institutional and legal framework.

6.2. Advocacy and Communication

6.2.1. Advocacy Opportunities

The profile of sanitation will require constant emphasis and reinforcement at all levels:

- From the community level to encourage uptake through intermediary levels to invoke promotion
- At the policy level to leverage political commitment and funding.

There are also important opportunities from the private sector particularly in the context of leveraging investment and improving the availability of soap and sanitaryware. There are a number of convincing arguments:

Sanitation as a basic human right

- Simple sanitary arrangements afford people dignity, self respect, convenience and safety.
- Women and girls face risks being forced to carry out their ablutions away from the house particularly at night.

Current sanitation access

- In rural areas less than 13 percent of the population has access to a latrine. While the urban figure of 70 percent appears to show far greater access, it is likely that access for poor people in urban slums is similar to that found in rural areas
- Figures on access to, and use of hand-washing facilities, use of soap (or a substitute) and observance of the safe water chain (based on anecdotal evidence) are thought to be low.

The current health cost

Although there is no hard data for Ethiopia, the UNICEF WES section suggest that sanitation related diseases account for more than 30 percent of the burden of disease in Ethiopia, and that one child is thought to die of a diarrheoal related disease every 2 minutes. Added to the cost of human life, is the cost of lost days due to illness, productivity, learning opportunities and ultimately, socio-economic development.

6.2.2. Sanitation Benefits

There are many convincing arguments which support the benefits of improving sanitation.

Political

- Women stand most to gain from sanitation and represent 50 percent of the electorate. This means that there are potential votes in sanitation

Socio-economic

- Savings on cost of treating sickness (diarrhoea).
- Reduced days lost being sick, caring for the sick, visiting health facilities.
- Increased earnings potential.

Educational

- Less diarrhoea and better nutrition equals improved intellectual development.
- Girl child school attendance is enhanced by access to safe, private, convenient, hygienic latrines with handwashing facilities
- Girl child school attendance is increased because they spend less time caring for sick siblings.

Communication strategies

As suggested in section 6, it will be important to evaluate existing communication strategies to objectively measure cost-effectiveness. This will include looking at the appropriateness of using HEWs,

contact women (Finida), house to house[18] visits, religious leaders, Idir, and local artisans (CSFB) and Picture-based tool kits (PHAST)

- » UNICEF and WaterAid IEC/picture based toolkits for sanitation and hygiene transformation/ promotion (PHAST)
- » RWSEP church style sani-pictures and posters
- » WaterAction flip charts

- Radio where ownership is particularly high in Tigray
- TV where the value of using TV for rural areas is limited for mass mobilization because of limited access (less than 3 percent) but it has been effectively applied elsewhere to influence decision-makers.

6.3. Social (Sanitation) Marketing

6.3.1. Commercializing Sanitation

While recognizing the importance of integration, it is also understood that the demand for key sanitation barriers is low compared to the high demand for access to a water supply source. Key barriers are Safe Management of Faeces (SMOF) and handwashing with soap (or a substitute) and water after defecation or contact with children's faeces, and the safe water chain. The barriers, while needing a behaviour change, also require a variety of technologies and commodities such as latrine slabs, soap (or a substitute) and a handwashing facility or a tap on a water pot for safe extraction of drinking water. While traditionally people have been encouraged to adopt new behaviours through health or hygiene education, it is now recognized that there are other opportunities. As with any commodity there is a need for research into viable technical options, willingness to pay, consideration of retail outlets, assessment of appropriate communication media and safe behaviour trials. This approach is termed social marketing in that it applies commercial marketing methods to achieve social benefits. It has been successfully applied to promote condom use in the context of reducing HIV transmission. The approach looks at preference, product, price, promotion and place.

PILLAR 3

7. ACCESS TO HARDWARE

This section will discuss:

7.1 Safe management of faeces
7.2 Sanitation Technology Preference
7.3 Supply chains
7.4 Targeting special technical needs

[18] House to house (school to school) visits are a simple effective procedure for collecting baseline, promoting, enforcing and evaluating ISH performance. It is ideally carried out by a combined team of politicians and appropriate technocrats – health assistants, extension workers, education officers etc.

7.1. Safe Management of Faeces

7.1.1. Household Latrines 'Do-it-yourself'

Individual householders, where able, will have total responsibility for constructing a traditional pit latrine comprising of a stable pit, secure platform and robust private superstructure (including weatherproof roof). Each latrine will have a handwashing facility made from local materials. Those wishing to expand on the basic traditional design must buy components from the local service provider or sani-outlet. The community will decide how those in need of help will be supported.

7.1.2. Latrine Designs

Latrine designs will depend on a large range of factors discussed in the sections on the Demand Responsive Approach and Sanitation Marketing. The first objective is to exclude faeces from the living environment and for this the Cat's Method (simple burial) is the first step on the ladder to safe management, particularly when applied to children's faeces. The next steps will depend on the availability of space, construction materials, and the ability to dig and construct. These factors are largely influenced by soil structure, topography and climate, all of which will ultimately determine use and durability as well as affordability.

Key features will include:

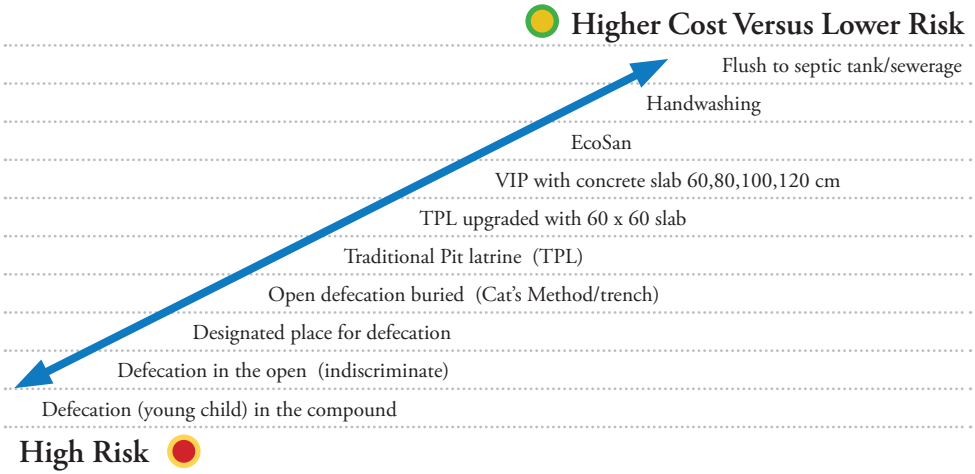
- Secure, stable pit – round, conical and not too deep
- Solid, sealed (tight lid) platform – with termite resistant logs and smooth plastered finish to ease cleaning and ensure that children or animals cannot fall in
- Secure, stable (preferably moveable) superstructure which ensures privacy and a sense of security. It should be strong enough to resist rain, wind and animals
- Ventilation with locally available materials.

7.2. Sanitation Technology Preference

7.2.1. Sani-ladder in Pictorial Form

Different options can be presented in a pictorial ladder format or as a kit which allows people to consider the benefits of different options while understanding the cost of each option. The ladder is often presented as a set of randomly presented pictures which focus group participants can assemble in the form of a ladder which moves from high risk (unsafe practice) to lower risk (safer practice). It is important to emphasize that lower risk often comes with a higher financial cost in the short-term but is cheaper in the longterm because of health benefits. The ladder can also be used to assess people's current situation and where they would like to be, and then set targets and to monitor progress.

Figure 3. Sanitation (S.M.o.F.) ladder



7.2.2. Intermediate Technologies

Where local materials are unavailable or simply inappropriate, it might be necessary to consider different shaped concrete slabs and stabilized soil blocks which combine DRA with social marketing and introduce the need for local service providers and creative finance.

7.2.3. Institutional Latrine Types

In addition to rural and urban domestic latrine designs there are also institutional design issues for schools (different age and sex groups), health posts and public toilets for markets, lorry parks and bus terminals. Communal toilets have also been developed as an option for high-density settlements. Where schools or health posts have space, the portable 'aborloo' or 'ecopit' might be considered. The slab and superstructure are placed over shallow pits. When the pits are 2/3 full, a new shallow pit is dug, and the slab and superstructure are moved to the new pit while soil and ash cover the contents of the old pit and a tree sapling is planted.

7.3. Supply Chains

7.3.1. Informed Demand Creation

An informed demand creation process will, in part, rely on making a variety of desirable and affordable sanitary options available to households either at woreda centres or as mobile production units. These

could service individual households willing to bear the 'call-out' charges as well as communities who elect a sanitation campaign approach.

7.3.2. Local NGOs and Local Service Providers

Local NGOs and local service providers will be encouraged to apply different promotional methods as well as simple construction skills and supply streams. This will include those involved in biogas promotion, recycling and vacuum truck operators.

7.3.3. Local Service Providers and Slab Production Centre (Sani-centre) Establishment

It will be important for woreda teams to define the roles and functions of their local service providers so that householders and community leaders can be secure in the knowledge that they are qualified to do the job:

- Guidelines will need to prepared for tendering, contracting, quality assurance as well as O&M
- LSPs (possibly existing artisans or retailers) will need to be trained and equipped
- Male and female LSPs should be identified, trained and equipped
- Links to vocational training centres (including Selam in Addis Ababa)need to be made.

7.3.4. Standards and Manuals on Latrine Construction

A review and evaluation needs to be done of different latrine technologies in use and preparation of simple guidelines/manuals for construction

7.3.5. Treatment Options

Different treatment options need to be considered where appropriate.

7.4. Targeting Special Technical Needs

7.4.1. Men - the Gate Keepers

By defecating in fields far from home, male family members present a lesser risk of domestic contamination but as the fund holder, digger and builder, they must be persuaded to sanction, support and even carry out latrine construction.

7.4.2. Women Determine Family Health

There is a very real gender divide in sanitation roles and attitudes. Female family members play a central role in determining hygiene standards at the household level as well as having their own special hygiene requirements particularly with respect to menstruation and ritual cleansing. Female family members are the primary stakeholders and must be central to any sanitation promotion campaign. It might therefore be appropriate to follow the lead from other countries and make loans available to women specifically to meet their sanitation and hygiene needs

7.4.3. Pre-school and School children

Young children must share primary stakeholder status with their mothers as they are at greatest risk from their own contamination. Isolating children's faeces from the domestic environment is therefore a major priority. Besides it being important to provide appropriate sanitation facilities at all schools, the school offers a wealth of promotional opportunities:

- Testing, introducing, demonstrating appropriate latrine and handwashing options
- The school can be a production and distribution centre for slabs (once water supply completed)
- Sanitation and hygiene can be mainstreamed in the school syllabus (sanitation and hygiene fables)
- Child sanitation monitors covering child to child, child to sibling, child to parent
- School hygiene clubs
- Drama, song, poster competitions, and colour my healthy, happy, hygienic home.

7.4.4. Special Needs of the Vulnerable

HIV/AIDS Patients

In the advanced stages of AIDS, patients may well have chronic diarrhoea but be unable to walk far from their resting-place. It has been reported that some carers dig a small hole in the corner of the room. A small round or square sanplat would reduce the risk of contamination. Patients might also find it difficult to squat and therefore require some form of pedestal or seat. It will be appropriate to consult with patients, carers and medical staff.

Paraplegic

Other people may well also have squatting difficulties and may prefer a pedestal design. It is important that people with such difficulties are consulted about appropriate solutions.

7.5. Handwashing Options

7.5.1. Handwashing Frequency Constraints

There is frequent finger contact with faeces by people caring for a baby or toddler, particularly one who has diarrhoea,. In rural Ethiopia, there is also quite a high level of intimacy with cow faeces particularly where it is dried and shaped as a saleable fuel source. When washing hands with soap and water is a relative luxury as both water and soap are scarce, it is easy to understand a low frequency of handwashing and lapses of hygiene.

7.5.2. Handwashing Frequency in Ethiopia

Although there are no robust studies about the frequency of handwashing in Ethiopia, it is generally held that handwashing after defecation is low, but higher before and after eating (to remove grease). Among Muslims, particularly the more strict, hand and body washing is widely practised. Where rigorous hygiene education has been applied as reported by WaterAid and RWSEP, handwashing frequency after contact with faeces is reported to be regularly practised by women. An ethnographic

study by CARE revealed that on average only 5 percent of water collected is allocated for handwashing. This represents a considerable challenge.

7.5.3. Handwashing After Contact with Faeces

An improved water supply should result in an increased amount of water available at the household level for improved personal hygiene particularly:

- Hand-washing with soap (or substitute) after contact with faeces
- Face washing (to reduce eye infections).

It is rare to observe a water pot with a tap and some soap (or a substitute) conveniently located, and even rarer to find households with a bath shelter. Water is considered to be such a valuable commodity, it must be preserved.

7.5.4. Soap (or a Substitute)

Although it is accepted the most critical behavioural component of handwashing is the time spent rubbing hands, it is also acknowledged that soap encourages the process, and a significant aspect in creating the habit or ritual is that 'fingers smell and feel clean'. However besides water availability, there is also a pressing need to make soap available at a price which makes it less of a luxury and more of an essential commodity. Again there are no robust data and it will be necessary to apply social marketing techniques to better understand the situation at the household, village, woreda and regional levels. In particular, consideration needs to be given to the role of local producers and retailers as well as the multi-nationals like UNILEVER.

7.5.5. Soap (or a Substitute) – Local Alternatives

Where soap availability is in question, it will be important to consider promoting locally available substitutes such as leaves and ash or consider the viability of local soap production.

7.5.6. Technical Options for Handwashing

Some work has been done by RWSEP, WaterAid, UNICEF and others to develop low water usage handwashing facilities out of locally available materials. Problems occur around filling them up, preventing interference by children (or animals) and leakage

7.5.7. Gourds or Tippy Taps

Locally available gourds with natural spouts have been promoted in the Amhara region. This is usually a plastic container hung from a tree which can be tilted or tipped to release a small amount of water for washing hands

7.5.8. Clay Pots Fitted with Taps

The cost of the taps is currently prohibitive and there is the added problem that children forget to close the tap.

7.5.9. Steel Tanks with Taps

Small tanks with taps and a basin have been fabricated for school handwashing facilities but there are problems with rust and routine refilling.

7.6. Safe Drinking Water Chain Options

7.6.1. The Safe Water Chain

Water is often delivered as an end in itself with little consideration to its health and hygienic use. Generally once the water point is established and some rudimentary hygiene education is carried out, people are left to their own devices as to how they will collect, transport, store and extract drinking water. Preserving a safe water chain from extraction and collection through to consumption is an important barrier to faecal-oral transmission through water.

7.6.2. Water Point Protection and Cleanliness

The design of water points are more effectively and hygienically used when the design reflects the needs of the water collectors who are generally women and children. There might also be special needs around a clothes washing facility and an animal watering option. Ergonomic design features to reduce awkward lifting as well as water wastage can be relatively cheaply included during construction together with durable drainage.

7.6.3. Transport in Clean Covered Containers

Traditional clay pots although heavy are the preferred means of transport and storage. Their advantage over plastic jerry cans is the ease with which they can be cleaned without disinfecting agents and the fact that they keep water cool. Problems occur when covering the pots with grass which stops water loss but introduces potential contamination.

7.6.4. Storage in Clean Covered Containers

Drinking water is stored in clay pots because of their natural cooling properties and ease of cleaning. As with water transport, covers are an important issue.

7.6.5. Extraction with a Separate Cup or Tap

Work has been done to encourage a two cup (gourd) system and RWSEP have developed a kitchen utensil rack for this purpose. Taps have proved expensive and, as with handwashing, there is the risk that children leave them running.

7.6.6. Technical Safe Water Chain Options

As with handwashing behaviour, the water chain is a relatively under-studied area which will benefit from the application of demand responsive, social marketing approaches to understand current practices and improve technical options currently available.

8. ANNEXURES

8.1. Annexure 1: Assumptions

8.1.1. Political Commitment

The strategy depends on woreda administrators embracing 100% improved sanitation as a high priority for the woreda, and making firm commitments on making funds available for promotion and enforcement. If 100% sanitation can be made a performance measure at different levels then the strategy will be effective.

8.1.2. Critical Mass

Early adopters have traditionally played a critical role in sanitation and hygiene improvement and it is hoped that woreda administrations with partners can influence this group. They, in turn, will influence their peers and ultimately the laggards.

8.1.3. The Right Mix

Promoting 100% adoption of improved sanitation and hygiene will rely on political commitment invoking dedicated woreda resource mobilisation. Regions and zones will need to prepare guidelines or 'minimum costed promotion packages' which have already been proved to yield success.

8.1.4. Donor and NGO Compliance

It is important that donor 'projects' and 'programmes' do not subvert government efforts by providing unsustainable incentives to extension staff or by subsidising slab supplies in selected areas.

8.1.5. Intersectoral Collaboration

Achieving synergy between the different but complementary efforts of the woreda administrations through health, rural development, water supply and education is an aspect that needs to be given dedicated attention. Intersectoral collaboration will need to be built, nurtured and rewarded. Again donor and NGO projects must be discouraged from creating privileged partners subject to a parallel reward structure.

8.2. Annex 2: The Way Forward

8.2.1. Protocol

The MoH plan is to develop a protocol detailing information flow, reporting requirements and appropriate minimum packages of assistance to promote improved sanitation and hygiene. The protocol will guide regions in the development of implementation guidelines and manuals.

8.2.2. Co-ordination Forums

The establishment and ratification of co-ordinating forums at different levels will be an important step in linking the different tiers of Government.

8.2.3. MDG Road Map

Regions will be developing their own 'road maps' within their wider development framework to details how to achieve their quota of the millennium development goals. WSP assistance will be available for regional support.