Federal Dmeocratic Republic of Ethiopia
Ministry of Health

Implementation Guideline For CLTSH Programing

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Contents

Acronyms

CAP	Community Action Plan
CBO	Community-Based Organization
CC	Community Conversation
CHP	Community Health Promoters
CLTBCHS	Community Led Total Behavioral Change in Hygiene and Sanitation
CLTS	Community Led Total Sanitation
CLTSH	Community Led Total Sanitation and Hygiene
DU	Development Unit
FBO	Faith-Based Organization
FMOH	Federal Ministry of Health
HEP	Health Extension Program
HIP	Hygiene Improvement Project
HEW	Health Extension Worker
KETB	Kebele Education and Training Board
MOE	Ministry of Education
MOWE	Ministry of Water and Energy
MOWR	Ministry of Water Resources
NGO	Non-Governmental Organization
ODF	Open Defecation Free
PTA	Parent Teacher Association
PSO	Private Sector Organization
RHB	Regional Health Bureau
SNV	Netherlands Development Organization
TOT	Training of Trainers
TVETC	Technical, Vocational Education and Training College
UAP	Universal Access Plan
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Aid
WASH	Water, Sanitation and Hygiene
WASHCOs	Water, Sanitation and Hygiene Committees
WHO	Woreda Health Office
WSP-AF	Water and Sanitation Program Africa
WSR	Whole System in a Room

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- WB-Water and Sanitation Program/Africa
- UNICEF
- World Health Organization
- Netherlands Development Organization (SNV)
- Plan International Ethiopia

The ministry extends special thanks to UNICEF, Plan International Ethiopia, WSP-AF, and USAID's Hygiene Improvement Project (HIP) for initiating the community-led approaches that are instrumental in eliminating open defecation and improving household water supply management and hand washing practices across Ethiopia.

The ministry further extends its gratitude to UNICEF, who provided the support and funding to produce all CLTSH publications. The ministry owes special thanks to SNV for reviewing, editing and finalizing these documents.

Foreword

Ethiopia continues to be ranked among the countries with to the lowest levels of hygiene and sanitation coverage. Health statistics indicate that much of the disease burden in the country is preventable, and that a considerable proportion is directly related to unsafe water, inadequate sanitation and poor hygienic practices. On average, an Ethiopian child experiences five to twelve diarrhea episodes a year. More than 250,000 children under five years of age die annually as a result of diseases related to poor environmental sanitation and hygiene. Moreover, acute watery diarrhea continues to be a threat to the social and economic development of the country.

The health risks associated with the current state of hygiene and sanitation in Ethiopia are well recognized by the government and partners, who together are applying tireless efforts to reverse the situation. The government's commitment to the cause is embodied in the national Health Extension Program and in the formulation of a National Hygiene and Sanitation Strategy in 2006. The Universal Access Plan (UAP) is an action plan outlining that strategy.

The initial UAP deadline for achieving sanitation and hygiene coverage nationwide was 2012, now revised to 2015. Moreover, in 2006, a Memorandum of Understanding was signed by the Ministry of Health, the Ministry of Water Resources, and the Ministry of Education, formalizing the launch of the National WASH program. Ethiopia is also pursuing Millennium Development Goals, also set for 2015

In partnership with bilateral, multilateral and none government organizations (NGOs), the Ministry of Health is working to upscale sanitation and hygiene endeavors through the establishment of an effective and efficient approach known as Community-Led Total Sanitation and Hygiene (CLTSH). The CLTSH approach is seen as critical to realizing the goal of universal access.

The CLTSH approach in Ethiopia is built on global and national experiences gained in the pursuit of previously attempted community-driven approaches, including Community-Led Total Sanitation and Community-Led Total Behavior Change in Hygiene and Sanitation (CLTBCHS). The CLTSH approach combines the basic principles of Community-Led Total Sanitation with intensive interpersonal communication to foster improvements in hygiene practice through problem solving and collective action. The approach is well integrated within the national Health Extension Program.

The purpose of this CLSTH implementation guideline is to facilitate implementation of CLTSH at all levels with the utmost synergy, momentum, commitment and coordination. It has been developed with the strong conviction that it will provide a solid common platform and clear direction for all actors working in the hygiene and sanitation sector to pursue the objectives of universal access.

The Federal Ministry of Health commends the Hygiene and Sanitation Task Force and particularly the Technical Working Group for their tireless efforts in producing this implementation guideline.

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Definition of terms

Advocacy

Refers to activities undertaken to persuade and mobilize people/decision makers to take action.

Behavior change

With respect to hygiene and sanitation, behavior change refers to practicing safe disposal of feces through the construction and consistent use of improved latrines by all family members, hand washing with soap (or substitute) and water at critical times, and safe transport, treatment, storage and handling of household drinking water.

Community Conversation

Also called community dialogue is a tool that empower communities to discuss their hygiene and sanitation behaviors and design their own action plan with clear targets and institute a follow-up mechanism

Community-led development

A development model whereby communities lead their own development through issue identification and exploration, identification of action points, resource mapping, implementation of planned activities, review of progress made and sharing of outcomes.

Coffee for Health Club

A tool used to bring together neighbors to discuss their hygiene and sanitation behaviors and design an action plan to adopt new behaviors. The tool helps maintain peer support and peer pressure, fosters a competitive sprit among neighborhoods and identifies early adapters and pioneers to model new behaviors.

CLTSH - Community-led total sanitation and hygiene

Emphasizes changing sanitation and hygiene behavior of communities towards open defecation free environment, hand washing practice and keeping drinking water safe. This is done through a process of social awakening stimulated by facilitators from within or outside the community. The approach concentrates on the behavior of the community as a whole rather than on individuals.

Family dialogue

Also called mikikir (the Amharic term). Family dialogue is an approach used to facilitate discussion on small doable actions among members of a family/household about the adoption of improved hygiene and sanitation behavior.

Gott

A gott (Amharic word) is the smallest sub-administrative unit in Ethiopia. A gott comprises a group of 30-40 rural households. The term can be used interchangeably with the term “village” or “community” in CLTSH

Hygiene

Describes a practice where a given community exercise safe human excreta disposal (ODF), hand washing with detergents (soap or substitute) and safe water management cycles.

Ignition

Also called “triggering,” ignition refers to the process wherein an outside facilitator mobilizes communities to take action to change their hygiene and sanitation behavior.

Natural leaders

Individuals who show exceptional leadership skills and interest in the process of hygiene and sanitation behavior change as a result of community ignition. At village level, community health development army leaders can play a role of natural leaders in mobilizing communities for ODF status.

Open defecation free (ODF)

Refers to an environment wherein no feces is openly exposed to the air. It describes a state in which all community members practice use of latrine at all times and a situation wherein no open defecation is practiced at all. ODF is a term used in CLTSH to describe the attainment of 100 percent latrine coverage and use by all families in a village, including small children.

Pre-ignition

A process comprises preparations made to mobilize villagers. Pre-ignition activities include a strategic selection of kebeles and villages, fixing appropriate date, time & place for community ignition.

Sanitation mapping

A simple drawing depicting the village showing households, latrines, sites for open defecation under normal conditions and in case of emergencies. Also shown are major landmarks (foot paths, churches, mosques, health posts, schools, water sources, etc.) and other institutions.

Scale-up

The process of expanding a tested approach over a larger area.

Social pressure

The influence exerted by individuals and groups to enforce commonly agreed and accepted norms.

Social solidarity

A union of interests, purposes, or sympathies among members of a group and the degree of cooperation among the group to take corrective action.

Sustainable sanitation

Describes a state in which sanitation facilities operate satisfactorily and generate health benefits over their life-cycle without threatening the quality of the environment.

Total sanitation

A situation wherein no open defecation is practiced and in which the cycle of fecal contamination through vectors including flies, fingers, animals, feet, wind, flood and rain runoff has been broken.

Safe water management

The management of drinking water at home (including the practices of household water treatment, safe storage and use).

Sanitation marketing

Sanitation marketing is an approach that focuses on improving formal and informal supply chains, products and services to expand the delivery of affordable basic sanitation, coupled with the application of commercial marketing techniques to stimulate demand to increase the number of households investing their own resources to build and maintain an improved sanitation facility

Transect ("shame") walk.

A transect walk entails walking with community members through a village from one end to the other, looking for clues and insight into sanitation and hygiene practices. The transect walk includes identifying sites used for open defecation and types and conditions of sanitation facilities and related health risks

Whole System in the Room

A participatory and focused advocacy meeting involving all key stakeholders designed to build consensus, set common ground and agree on a common plan of action.

Verification

Is a process of endorsing that a given Village/Kebele/Community/ is totally free of open defecation practices.

BACKGROUND

Following the commitment made in the Growth and Transformation Plan (GTP) and the forth Health Sector Development Plan (HSDP IV)of the government of Ethiopia, the FMOH has developed a Strategic Action Plan (SAP) to guide its programs targeting at improving sanitation and hygiene. The SAP set an ambitious target to achieve 100 per cent sanitation coverage in both rural and urban areas of the country by 2015. To reach these goals, the Ministry of Health has put in place numerous initiatives and strategies, among which is the Health Extension Program (HEP), the flagship of the health services delivery system. So far more than 34,000 health extension workers (HEWs) have been trained to deliver essential preventive health interventions, among which are services related to environmental sanitation and hygiene. Health extension workers are deployed in over 14,000 health posts, covering more than 80 per cent of rural kebeles nationwide. Recently, the program is tailored to the urban context and the Urban Health Extension Package, is now being implemented in urban areas as well.

The formulation of a National Hygiene and Sanitation Strategy (2006) is one measure of the high level political commitment shown in recent years to substantially improve the hygiene and sanitation situation in the country. Based on this important national policy provision, a national step-by-step hygiene and sanitation protocol and financial needs assessment were undertaken to determine what needed to be done to achieve universal, that is, 100 per cent, access to and use sanitation facilities by 2012 which is recently shifted to 2015. These efforts were complemented with the signing of a Memorandum of Understanding by the Ministries of Health, Water Resources, and Education and by the launch of a National WASH program in 2006.

On the other hand, the Health Sector Development Plan(HSDP IV) of the Ministry of Health sets four targets for Sanitation and Hygiene to be achieved in 2015.These are: (1) proportion of HHs using improved sanitation facility (toilet utilization) from 33% to 84%, (2) increase proportion of households practicing hand washing with soap (a substitute) at critical times from 7% to 77%, (3) increase proportion of Open Defecation villages (kebeles) to 80% and (4) increase proportion of household water treatment and safe storage practices to 77%.To realize the targets, the government prepared the National Hygiene and Sanitation Action Plan (SAP) envisaging improved access and utilization of sanitation facilities in both rural and urban areas. In implementing the HSDP IV and SAP at grassroots level, the Health Development Army (HAD) will play a key role by complementing efforts by the health extension workers.

Before the initiation of the HEP and the deployment of health extension workers, national sanitation coverage at household level was around 20 per cent; this figure had remained unchanged for many years. Efforts to promote behavioral change with respect to hygiene and sanitation showed some improvements following the commencement of these national efforts. However, following progress reviews, it was agreed to change the target date set for achieving universal access from 2012 to 2015. The implementation modalities agreed on were also amended with a view toward developing a standardized approach that could be applied systematically by all actors in the water, sanitation and hygiene (WASH) sector.

Deriving from the National Hygiene and Sanitation Strategy, HEP activities promoting hygiene and sanitation are geared toward the adoption of three key behaviors: (1) safe disposal of child and adult excreta, (2) handwashing with water and soap (or a soap substitute such as ash) at critical times, and (3) safe management of household drinking water. To support the work of health extension workers and other agents of the HEP to behavior change efforts, the national strategy sets out three "pillars":

Pillar 1: An enabling environment to facilitate the scale-up of improvements through policy consensus, legislation, political commitment, inter-sectoral cooperation, and capa city building through contractual agreements. The priority on creating amenable policy is evident in the design of the national strategy, in the design of an onsit e sanitation protocol, and in training and deployment of health extension workers.

Pillar 2: Sanitation and hygiene promotion through communication, social mobilization, social marketing, incentives, and sanctions to create demand for products and behaviors.

Pillar 3: Improved access and affordability of necessary products and services, such as latrines, water for handwashing, soap or soap substitutes, and locally produced slabs

The Health Extension Program stipulates that health extension workers promote hygiene and sanitation through household outreach supported by community volunteers and health development army. To increase the effectiveness of such direct promotional efforts and achieve accelerated results, however, stakeholders must make greater use of community-led approaches and work together in a coordinated and harmonized manner.

INTRODUCTION TO THE GUIDELINE

Until recent years, community-led approaches to hygiene and sanitation in Ethiopia have not been popular. The gains from conventional approaches have remained limited in terms of their success in mobilizing entire communities to effect sustained behavioral change. Moreover, the pace of change has been too slow to achieve universal access within the stated time frame. Following piloting with community-led approaches to improved hygiene and sanitation – beginning in 2007, Ethiopia has implemented the Community-Led Total Sanitation approach and the Community-Led Total Behavioral Change in Hygiene and Sanitation program in selected areas -- stakeholders in the water, sanitation and hygiene (WASH) sector now realize the added value of community-led approaches can bring.

Community-Led Total Sanitation (CLTS) was introduced in Ethiopia after a hands-on workshop organized by Vita, an Irish international development agency working in the Horn of Africa, and facilitated by Dr. Kamal Kar, in October 2006. The workshop was followed by a national level dissemination session attended by bilateral and multilateral organizations, NGOs and government offices. Following this session, Plan International Ethiopia, UNICEF, the Netherlands Development Organization (SNV), the Federal Ministry of Health (FMOH), and regional health bureaus and international and local NGOs began to adopt CLTS as the main approach for their hygiene and sanitation programs.

Concurrently, in 2006, the Federal Ministry of Health's Environmental Health Department requested the assistance of the Water and Sanitation Program/
World Bank-Africa and the USAID/Hygiene Improvement Project to implement the National Hygiene and Sanitation Strategy. This initiative led to the remarkably successful implementation of Community-Led Total Behavioral Change in Hygiene and Sanitation in Amhara Regional State.

To harmonize, coordinate and scale up achievements gained through the community-led approaches being implemented by various organizations around the country, the FMOH, with technical and financial support from UNICEF, organized a national level consultation meeting on community-led approaches and CLTS in 2008. This consultation led to the establishment of a National Hygiene and Sanitation Task Force under the leadership of FMOH. The task force in turn assigned smaller working groups (made up of representatives from FMOH, UNICEF, WSP, USAIDÐ-HIP, Plan International Ethiopia, SNV and the World Health Organization) to develop a harmonized approach and a set of guidelines, training manuals and verification protocols for implementing CLTS, now with an added hygiene component (CLTSH) throughout the country. The CLTSH approach is solidly grounded in individual and social behavior change theory and best practices.

This guideline is one of four official documents – an implementation guideline, a training manual, verification and certification protocol and a monitoring and reporting framework.

The context

This implementation guideline is prepared within the framework of the health policy, Sanitation strategy, National Health Extension Program to enable hygiene and sanitation experts at all levels and health extension workers working at community level to achieve the objectives of the Federal Government of Ethiopia's Universal Access Plan.

The guideline emanates from national and regional consensus on improving hygiene and sanitation conditions in Ethiopia through focus on woreda-level action. To support the woredas in the planning and follow up of CLTSH activities, certain policy, budget, and programming supports have been put in place at national and regional levels. Kebele and village action will follow woreda planning and ignition through an additional set of guides and tools available for kebele- and village-level action.

The guideline emphasizes the use of participatory approaches and principles for igniting collective action. Stakeholders should embrace the strong influence of families on group behavior and in the power of communication to bring about sustainable improvements in hygiene and sanitation. Correct application of the guideline should further the goals of universal access and more generally strengthen inter-sectoral collaboration and cooperation between development actors and community groups.

The design of the guideline is based on lessons and experiences from a rural/ agrarian context but may be adapted for urban, semi-urban and pastoral contexts. This implementation guideline is complemented by a CLTSH training manual, an ODF verification protocol and a monitoring and reporting framework. Users of this guideline should be aware of and have access to these important complementary documents.

The purpose of the guideline

The main purpose of this guideline is to facilitate the implementation of CLSTH approach with utmost synergy, momentum, coordination and commitment so that it enables to achieve the critical hygiene and sanitation behavior. The guideline is developed to support nation-wide change with respect to three critical hygiene and sanitation behaviors: (1) disposal of human excreta, (2) handwashing at critical times and (3) safe management of household water. The guideline sets out a systematic, coordinated, harmonized and structured approach that summarizes the national consensus on hygiene and sanitation promotion and lays the foundation for a programmatic approach to hygiene and sanitation promotion. It also recommends a practical way to harmonize and coordinate various interventions under the leadership of the Ministry of Health and regional health bureaus and proposes a framework for measuring results of the hygiene and sanitation promotion interventions.

Objective

The objective of this to harmonize the different CLTSH approaches and provide a clear programming roadmap for governmental and non-governmental entities involved by:-

1. Providing clearly set phases and steps for all stakeholders to guide hygiene and sanit ation programming
2. Strengthening the synergistic effect of social networks and social mobilization strate gies
3. Strengthening inter-sectoral collaboration of all government and non-government stakeholders at all administrative levels in the process of CLTSH implementation

Strategy

In order to achieve this, the guideline lays down the following strategies:

- Multi-level advocacy through consensus building from national to woreda level,
- Strengthen community conversation (CC) and household outreach through family dialogue (mikikir) to facilitate behavior change
- School hygiene and sanitation to change school conditions and establish a school-led sanitation and hygiene program which serves both schools and communities
- Media support for multiplying messages and reinforcing changes
- Increased availability and affordability of hygiene and sanitation products through sanitation marketing without any form of direct subsidy to the community

Who is it for?

This guideline is intended for program managers from government and non-government organizations engaged in implementing community-based hygiene and sanitation programs. .

How is it organized?

The guideline describes 4 phases along with their steps of CLTSH implementation, which elaborates the purpose, process, methods and expected outputs relevant to each step and identifies the parties responsible for implementation at different levels(See annex 1). The phases are:

PHASE I: PREPARATION AND PLANNING
PHASE II: IGNITION
PHASE III: POST IGNITION
PHASE IV: VERIFICATION, RECOGNITION AND SCALE UP

PHASE 1: PREPARATION AND PLANNING

This is the first and most important phase to pave a way towards CLTSH implementation. The phase consists of three key steps which mainly focus on consensus building, planning and capacity building.

STEP 1: CONSENSUS BUILDING/ADVOCACY

Changing hygiene and sanitation behaviors in the country must be the concern of all stakeholders including government, non-governmental and private organizations, donors, and communities, community institutions and private individuals. As CLTSH is adopted by stakeholders as a national approach to hygiene and sanitation in Ethiopia, all actors should have common understanding regarding the approach and agree on implementation modalities and guidelines (which are articulated in this manual and in the other three CLTSH national documents) and craft a common action agenda to tackle challenges related to H&S. Therefore, consensus building/advocacy workshops should be organized at all administrative levels to gain political commitment and support for implementing CLTSH.

I. NATIONAL, REGIONAL/ ZONAL LEVEL ADVOCACY WORKSHOP

A two-to-three day orientation workshop led by the Federal Ministry of Health and supported by the National Hygiene and Sanitation Task Force, the National WASH Coordination Office, and government and non-government partners is organized at national level. A key aim of this workshop is to gain buy-in for and commitment to the CLTSH implementation, including the national guidelines.

Similar workshops are organized at regional/zonal level are led by Regional Health Bureaus and supported by regional and national hygiene and sanitation task forces, regional and national WASH coordination offices as well as other sector partners.

Purpose

- To advocate for the need to address problems related to poor sanitation and hygiene conditions
- To create a supportive environment for the implementation of CLTSH
- To secure support and commitment for funding and other inputs from government; international, bilateral, and non-governmental organizations; communities; and the private sector
- To commit timely release and proper utilization and liquidation of funds
- To herald the beginning of a new era of behavioral change in hygiene and sanitation in the country

Participants

At National level, the workshop participants are:

- Line ministries: Water and Energy, Education, Agriculture, Urban Development and Construction, Finance and Economic Development, Ministry Women, Children and Youth Affairs and Government Communication Affairs Office
- Regional line bureaus: Health, Water and energy, Education, Agriculture and Rural Development, Finance and Economic Development, Women, Children and Youth Affairs and Information and Communication
- Donors, Major partners- multilateral, bilateral and non-governmental organizations
- Private sector organizations, faith-based organizations, teaching institutions, profes sional associations and media

At Regional/zonal level, the workshop participants are:

- Regional line bureaus: Health, Water and Energy, Education, Agriculture and Rural Development, Finance and Economic Development, Women, Children and Youth Affairs and Information and Communication
- Zonal line departments-Health, Education, Water and Energy development and Admin istration offices
- Woreda line offices for health, education, water development, women and youth affairs, and so on (although the workshop is held at zonal level, woreda representa tives are also invited to participate).
- Donors, multilateral, bilateral and non-governmental organizations working in the region/zone

- Private sector and faith-based organizations, media, professional associations and training institutions, such as universities, technical and vocational education and training colleges

Methods

- Whole System in a Room/multi-stakeholder participatory workshop
- Presentation on the status of water , sanitation and hygiene conditions of the specific Region/Zone/Woreda where CLTSH is to be introduced or scaled up
- Film or gallery show focusing on situation analysis and the underlying causes
- Field visits (in the case of regional/zonal level workshops) to open defecation free villages/communities

Processes and Tasks

The national and regional level advocacy workshops are conducted using the blend of CLTSH pre-planning and Whole System in the Room (WSR) technique. The tools place emphasis on bringing together key decision makers, experts, skilled facilitators and mangers to foster and attain high level commitment in a joint session to set common understanding and goals.

Prepare for Whole System in the Room

- Conduct desk review (using studies, inventories, morbidity and mortality data, reports).
- Prepare a brief report on the hygiene and sanitation situation and related initiatives in the country/Region/Zone/Woreda.
- Prepare a brief overview on what needs to be done to improve the hygiene and sanita tion conditions including resource needs.
- Prepare an advocacy package including the brief reports and one-to-two-page su mary handouts to stakeholders.
- Identify a venue that can comfortably accommodate all invited stakeholders.
- Recruit skilled facilitators.
- Prepare and send invitation letters well ahead of time.
- Handle logistics (refreshments, transport, workshop facilitation materials).

Present topics

- Review hygiene and sanitation situation and initiatives in the country as a whole and in each region. (Regional level meeting stress conditions within their zone or region.) Resource requirements are discussed.
- Discuss national implementation guideline for CLTSH (covering community-led approaches, implementation process, ownership of the process, monitoring and repor ing, etc.).
- Discuss and agree on the way forward.

Facilitate WSR process

- Facilitators form stakeholder groups composed of ministries, regional bureaus, associa tions, donors, civil society organizations, and so on.
- Facilitators guide group analysis of the past, present and future of hygiene and sanita tion in the country.

Expected outputs

- Agree on adopting CLTSH approach as a tool to empower communities to improve sanitation and hygiene condition of their area
- Reach consensus on implementation of CLTSH in Ethiopia.
- Define financial and managerial roles and responsibilities for stakeholders at all levels.
- Ensure commitment and support for follow up and monitoring of CLTSH.
- Agree on how to improve fund allocation and utilization.

STEP 2: WOREDA AND KEBELE WASH PLANNING AND ADVOCACY

i) Develop/review Woreda and Kebele WASH plans

The CLTSH initiators to the woreda must initiate the actors in the woreda to develop an integrated woreda WASH plan that integrates CLTSH implementation, monitoring, evaluation and reporting into its mainstream plan. Budgets must be also estimated and secured well in advance of the start of program activities. In a woreda where the WASH plan is already in place, the stakeholders should revise the plan to integrate CLTSH implementation, monitoring and reporting accordingly.

Each kebele in a woreda must also develop its WASH plan in accordance with the CLTSH implementation modalities. The kebeles are supported by a woreda WASH team and health office while developing the plan.

Purpose:

- To develop a comprehensive Woreda and kebele WASH plans that lay a foundation for sustainable CLTSH program implementation in the woreda
- To estimate a program budget along with possible sources of funding
- To alert program implementers to the importance of estimating the cost of program activities before they begin

Participants:

At woreda level, the participants are experts form Woreda WASH sectors, representatives of NGOs, CSOs and other stakeholders involved in WASH program implementation. At kebele level, the HEWs, kebele administrators, religious leaders, health development army heads and other relevant stakeholders are expected to participate in the planning process.

Duration: 2-3 days

Method: Gather information, analysis, budgeting and compilation

Process and tasks: The planning process is facilitated by the initiators (RHB, WWT, International, bilateral or NGOs). The initiators must collect and analyze relevant information concerning sanitation and hygiene facilitation situation in the woreda and kebeles and compile a plan/document that guide the woreda and kebeles to implement hygiene and sanitation program in accordance with CLTSH principles. All fundable tasks under each phase and steps are identified and budgeted for with possible sources for funding.

Expected output:

- A woreda and Kelebe WASH plans that enable implement CLTSH program
- Estimated budget (at all levels) to implement the activities indicated in the implemen tation guideline.

ii) Pre-planning with Political leaders in the woreda

CLTSH initiators to the woreda must compile relevant information concerning sanitation and hygiene problems from reports, health center morbidity statistics and photographs as evidences to draw the attention of political leaders. This process is led by program initiators such as RHB, International, bilateral and NGOs who want to start a CLTSH program in the woreda with the support of woreda Health Office, RHB, Zonal Health department.

Purpose:

1. To mobilize political leaders and other sector offices to establish a sustainable CLTSH program in the woreda
2. To discuss the issues in a forum where political leaders and sector offices understand the magnitude of the problem, take ownership, commit and make hygiene and sanita tion a key activity and a performance indictor for all woreda stakeholders.
3. To prepare for capacity building , baseline data collection, a whole-system in the room multi stakeholder meeting and planning/ budgeting
4. To discuss the possibility of accessing funds for CLTSH implementation in the woreda.

Participants: Woreda political leaders and sector offices

Duration: Half a day

Method: Presentation and discussion

Process and tasks: This meeting will be conducted by the initiators (RHB, International, bilateral or NGOs). The facilitation of this meeting should lead to reach to a consensus and to forge a common ground and action plan so that CLTSH program could be supported by the highest decision making body in the woreda.

Expected output: Common action agenda to start sanitation and hygiene behavior change in the woredas.

iii) Woreda Consensus building/Advocacy

In woredas, a one-day workshop is organized with a leading role of Woreda Health Office and supported by the Woreda Administration Office, Water and Education Offices, Woreda Hygiene and Sanitation Task Force/Woreda WASH team, the zonal health department and other government and non-government partners active in the woreda.

Purpose

- To create a supportive environment within woredas for CLTSH implementation
- To advocate for the need to address problems related to poor sanitation and hygiene conditions
- To reflect collectively on the state of hygiene and sanitation and agree on a way forward
- To strengthen networks, partnerships, harmonization and coordination for imple menting CLTSH at woreda, kebele and village levels

Participants

Woreda level

- Woreda cabinet
- Faith-based organizations
- Representatives of non-governmental organizations
- Woreda WASH team
- Woreda support groups
- Woreda WASH sector (health, education and water) supervisors/experts
- Environmental Health professionals
- Health extension program (HEP) coordinators
- Private sector organizations working in hygiene and sanitation
- Town managers
- Associations (women, youth, etc.)
- Communications office and/or media

Kebele level

- Kebele administrators
- Kebele managers
- HEP supervisors
- Cluster-school supervisors
- Health extension workers
- Health Development Army leaders
- Agricultural development agents
- School directors
- Village elders/influential persons
- Religious leaders
- Associations (women and youth)

Methods

- Whole System in a Room
- Film showings
- Field visits

Processes and Tasks

Prepare for Whole System in the Room

- Prepare an advocacy package including one-to-two-page summary handouts to stake holders. Use the formats provided in the training manual to summarize woreda and kebele data
- Identify a venue that can comfortably accommodate all invited stakeholders
- Recruit skilled facilitators from zonal/regional health bureaus, major partners
- Prepare and send invitation letters well ahead of time and create banners
- Handle logistics (refreshments, transport, workshop facilitation materials

Present topics

- Review the hygiene and sanitation situation and initiatives in the region using available data including morbidity and mortality statistics, studies and evidences from kebeles in a woreda.
- Introduce CLTSH approach and national implementation guideline, ownership of the process, verification and certification, monitoring and reporting framework, etc.

Facilitate WSR process

- Facilitators organize stakeholder groups composed of regional bureaus, associations, donors, faith-based organizations
- Facilitate action plan development for the future courses of actions to be followed
- Woreda administrator hands over commitment banners to kebele administrators

Expected outputs

- Agree on a common agenda regarding hygiene and sanitation issues
- Reach consensus on implementation of CLTSH in the woreda
- Define roles and responsibilities for stakeholders
- Ensure commitment and support for hygiene and sanitation sector
- Agree on how to improve utilization of allocated funds
- Stakeholders agree on action plans and accept commitment banners to support and spearhead implementation of CLTSH in their respective areas

STEP 3: CAPACITY BUILDING

To strengthen the capacity of various actors to implement CLTSH, a training of trainers (TOT) methodology to be delivered in two levels is recommended. The first one is a national or regional level ToT for trainers and the second one is a woreda level facilitators training. A group of selected people from sector offices and partner organizations at the national level will be trained in subject matter, facilitation skills and training techniques, who then, in turn, train regional/zonal/woreda resource persons until functional skills are passed from the highest level to the lowest staff level in woredas and kebeles. A successful training program will result in an enhanced ability to conduct Whole System in Room (WSR) workshops, develop plans, ignite or trigger CLTSH activities and facilitate community conversation (CC) and family dialogue to negotiate small doable actions and sustained behavioral change.The types of trainings required at each implementing level – national, regional/zonal, woreda and kebele are outlined below.

i). National/Regional capacity building training

Capacity building workshops at the national level are led by the Federal Ministry of Health and supported by government ministries, NGOs, donors, bilateral and multilateral organizations and others.

Types of Training

- WSR methods and facilitation
- CLTSH principles, methods and facilitation
- Community empowerment techniques (CC, FD/mikikir)
- Monitoring, evaluation and reporting
- Planning and budgeting

Purpose

- To equip participants with the skills to carry out a range of community-led behavior change approaches
- To enable participants to give backup support to regions implementing CLTSH

Participants

- Environmental health professionals from the MOH
- WASH experts from both government and non-government partner organizations
- Representatives from the private sector engaged in WASH
- At regional level, participants include environmental health professionals from RHBs and health institutions, WASH experts from government and non-

government partner organizations, representatives from the private sector, relevant training institutes/universities/technical and vocational education training centers (TVETCs)

ii). Woreda level capacity building training

Woreda level workshops are primarily the charge of the Woreda Health Office (WHO). Supporting partners are regional health bureaus and woreda administrative offices and partners engaged in hygiene and sanitation service delivery.

Types of Training

- WSR
- CLTSH
- CC and family dialogue
- Monitoring, evaluation and reporting
- Planning and budgeting
- Verification protocol

Purpose

- To equip participants with the skills to facilitate community-led approaches to behavio ral change, including at the level of households
- To enable participants to train and provide backup support to kebeles
- To strengthen planning and budgeting for CLTSH implementation
- To strengthen monitoring and evaluation

Participants

- Environmental health professionals from WHO and health institutions
- HEP supervisors
- Experts from government and non-government partner organizations
- Representatives from the private sector
- Relevant training institutes (if any)
- Teachers, DAs

iii). Kebele level capacity building training

Likely training needs for kebele level stakeholders:

- Introduction to CLTS
- Hygiene and sanitation promotion
- Dialogue and links with activities of HDA
  - o One to one dialogue
  - o Family level (e.g. MIKIKIR for small doable action
  - o Small groups level (e.g. One to five network)
  - o Community conversation
  - o Other community empowerment techniques (e.g. coffee for health club, campaign etc.)
- Planning techniques

- Assessment- simple data collection analysis and displaying, record keeping and mapping
- Analysis
- Action planning and budgeting
- Monitoring, Evaluation and reporting

- Linkages with other programs (e.g. CBN, malaria control etc.)

Purpose

- To equip participants with the skills to facilitate and implement community-led approaches to behavioral change
- To enable participants to train and provide backup support to community volunteers/natural leaders
- To strengthen planning and budgeting for CLTSH implementation

Participants

- Kebele administrators
- WASHCOs
- Kebele managers
- Health extension supervisors
- School teachers
- Agriculture development agents
- Religious leaders
- Leaders of community institutions ("iddir", "debo," etc.)
- Leaders of women and youth associations (if any)
- Leaders of health development army (yetena lemat serawit)
- Head teachers
- Parent-teacher Associations (PTA)
- Kebele Education and Training Boards (KETBs),
- Woreda and Kebele education and health officers
- Development partners
- School directors/administrators
- Partner NGOs/civil society organizations

PHASE 2: PRE-IGNITION AND IGNITION

It is during Phase 2 that CLTSH is ignited or "triggered" at community level. Phase 2 involves a process of facilitated participatory dialogue with communities. The goal is to engage communities in an examination of their sanitation and hygiene practices and empower them to improve their situation collectively.

STEP 1: COMMUNITY (KEBELE AND VILLAGE) SELECTION

The first part of Phase 2 begins with a strategic selection of kebeles and villages in order to begin with the approach in favorable conditions. The reason for this initial, targeted selection is that some areas are more "ripe" for action than others. Initiating CLTSH in areas more amenable to change helps to gain experience and build confidence for further scale up in areas where there may be resistance to change. It is also a way of stimulating other communities horizontally to learn and begin the process of adopting new behaviors. Besides, communities with "favorable conditions" are more likely to attain ODF (open defecation free) status and adopt improved hygiene practices in a sustained manner and in a shorter period than communities without such favorable aspects. Such communities should be selected during the pre-ignition/early triggering phase by using favorable conditions ranking tables (See CLTSH training manual).

It is advisable to start with few villages in a kebele and follow them until ODF declaration so as not to overburden the kebele workforce. However, this does not mean that the program will be limited only to the selected villages or kebeles. Lessons learned through early triggering will be applied as the program is rolled out on a larger scale.

Purpose

- To identify kebeles and villages with favorable conditions for ignition
- To prioritize kebeles/villages for ignition
- To gain experience and scale up the program to more villages/ kebeles and woredas

Kebele selection

Who leads?

- Woreda Health Office
- Woreda cabinet/administrators

Who supports?

- HEP supervisors
- School cluster supervisors
- Kebele administrators & managers
- HEWs
- Partners/NGOs operating in the area

Village selection

Who leads?

- Kebele managers
- Health extension workers
- Health Development Army leaders
- WASHCOs

Who supports?

- HEP supervisors
- Environmental health officers (based in health centers)
- School teachers
- CBOs, FBOs

Method

- Favorable conditions ranking tables (see CLTSH training manual)

Processes and Tasks

- Prepare lists of all kebeles or villages.
- Gather information based on the favorable conditions ranking table.
- Rank all kebeles or villages using the ranking table.

- Select kebeles or villages with the highest ranks for pre-ignition
- Kebele cabinets

Expected outputs

- List of kebeles and villages with favorable conditions for ignition identified

STEP 2: PRE-IGNITION VILLAGE VISIT

Visits to selected village prior to community ignition should be made mainly to meet local leaders and agree on a convenient time and place for village ignition.

Purpose

- To prepare villages for the establishment of the CLTSH program
- To plan the ignition process with village and sub-village leaders
- To demarcate the village and get an estimated size of population
- To identify the dirtiest (most excreta laden) area in the village-common defecation site
- To find out whether there is any history of subsidies in the area
- To reach consensus on convenient date, time and place for the community ignition meeting

Who leads the village visit?

- Health extension workers
- Health extension supervisors
- HDA leaders

Who supports the village visit?

- Kebele managers

- Village elders
- WASHCOs
- School committees (PTA, KETB)

Methods

- Community visit-transect walk to locate common and isolated defecation areas
- Observation, discussion with community members (men, women , children and the elderly)

Processes and Tasks

- Form a group to visit villages.
- Schedule the visit.
- Conduct the visit as scheduled.

Expected outputs

- Acquire basic information.
- Reach consensus on the date, time and place of ignition

STEP 3: COMMUNITY IGNITION AND PREPARATION OF ACTION PLAN

Village CLTSH ignition refers to the process of mobilizing villagers using a set of participatory tools to analyze their hygiene and sanitation situation and agree on collective action for change. This process is handled by trained facilitators and targets entire members of communities in all households and institutions in a village. Facilitators guide program implementers at kebele-level, such as HEWs, HAD, kebele administrators and managers, in the application of technical concepts and behavior change approaches at village/gott and households levels.To ignite a village, program implementers, using Community-Led Total Sanitation tools, call a meeting where they mobilize/inspire villagers to analyse the sanitation and hygiene condition of their village and decide to take action to stop open defecation and related behaviors.

Purpose

To enable villagers to

- Identify, analyze and recognize their hygiene and sanitation status
- Identify solutions and map resources required to address their hygiene and sanitation problems
- Share responsibility and draw up an action plan
- Plan for regular participatory review meetings
- Establish a structure which is responsible for the follow up and implementation of CLTSH (village, Kebele and woreda CLTSH task team).

Who leads?

- Trained external facilitators

Who supports?

- Health extension workers
- Trained school teachers
- Trained kebele managers
- Trained HEP supervisors
- Kebele administrators
- HDA leaders
- WASHCOs

Participants

- All household members (men, women and children)
- Community leaders (religious and other social groups)

Methods/tools

•Transect (“shame”) walk.

A transect walk entails walking with community members through a village from one end to the other, looking for clues and insight into sanitation and hygiene practices. The transect walk

includes identifying sites used for open defecation and types and conditions of sanitation facilities and related health risks. The key sites to be visited include household toilets, backyards, water points, roadside bushes, ditches, burial grounds, and institutions such as schools, health posts/centers, market places, churches and mosques.

•Sanitation/social mapping.

Sanitation mapping is a simple drawing depicting the village showing households, latrines, sites for open defecation under normal conditions and in case of emergencies. Also shown are major landmarks (churches, mosques, health posts, etc.) and other institutions. Facilitators gather villagers together and guide their drafting of the sanitation map. Sanitation mapping is used to stimulate discussion among all community members and helps identify which households are without latrines, where the dirtiest areas are located (i.e., places where open defecation is heavily practiced), etc.

- To plan for regular participatory review meeting
- To establish strong link between schools and communities to implement CLTSH

Who leads?

- Trained external facilitators

Who supports?

- School teachers(trained on CLTSH)
- School cluster supervisors (trained on CLTS CLTSH)
- Trained HEP supervisors
- HEWs
- Parent-Teacher Associations (PTAs), Kebele Education and Training Board (KETB)

Participants

- All school community members (teachers, students, WASH club members, support staff)

Methods

The methods used to ignite WASH in schools are the same as those used in the larger community: transect walks; village sanitation mapping and others (see Step 3, above).

Processes and Tasks

- Identify problems/concerns regarding hygiene and sanitation in school using CLTSH tools
- Analyze problems and concerns
- Identify solutions
- Assess available resources and skills
- Action planning (who, what, when, where)
- Agree on responsibility sharing
- Plan for regular participatory review meetings and follow up

Expected outputs

- Mobilize school community members to commit to working together to combat open defecation and poor hygiene practices.
- Stimulate social solidarity/mutual support.
- “Ignite” members of the school community to apply social pressure and to agree to be governed by bylaws they have developed and endorsed.
- Prepare a school-based action plan.

• Shit calculation

. A calculation of how much human excreta is being generated by individuals, households and by the village as a whole per day, per week, per month, and per year. Households can use their own methods and local measurements for calculating how much feces they are contributing to the problem in the village.

• Shit flow diagram

.
This tool helps villagers to understand the environmental impact of open defecation (air pollution, food and water contamination, etc).

• A glass of water/bread exercise (alternatives can also be used).

A water exercise prompts villagers to visualize that they are drinking water contaminated with human excreta and helps them to understand the role of flies in contaminating water and food in households.

Processes and tasks

- CLTSH ignition team/external facilitators arrive at the village at the appointed date and time.
- With the help of HEWs and HDAs, as many residents (men, women, children) as possi ble are gathered in a central location.
- Facilitators introduce themselves and explain their objective for the visit.
- Facilitators “ignite” villagers by using CLTS tools

Expected outputs

- Mobilize villagers to commit to working together to combat open defecation and poor hygienic behaviors.
- Stimulate social solidarity/mutual support among villagers.
- “Ignite” villagers to apply social pressure and to agree to be governed by bylaws they have developed and endorsed
- Prepare Community Action Plan (see CLTSH training manual).
- Establish CLTSH structure from village to woreda level for monitoring and follow up (also see CLTSH training manual)

STEP 4: SCHOOL IGNITION AND PREPARATION OF ACTION PLAN

School-based interventions are an integral part of Community-Led Total Sanitation and Hygiene approach. School interventions encompass hardware and software components, technologies and curricula to ensure that a school is made WASH friendly, with adequate

water for hygiene, safe water for drinking, facilities for handwashing and ample private latrines for girls and boys. School-based hygiene and sanitation also means integrating WASH themes into classroom activities; furthermore, school WASH clubs help maintain WASH facilities and promote overall WASH awareness. School children also help catalyze CLTSH programming beyond school, bringing lessons learned into their households and into the wider. Through school-based WASH interventions, school teachers and pupils take a lead role in CLTSH ignition and post-ignition activities. The ignition of WASH in schools mirrors the process applied to the wider community (Step 3, above).

Purpose

To enable school communities

- To organize School Groups for ignition purposes
- To identify, analyze and recognize their hygiene and sanitation problem
- To identify solutions and map resources required to address their problems
- To share responsibilities and draw action plan

PHASE 3: POST- IGNITION

Post-ignition is another important phase in which concerted training, coaching, support and persistent follow-up are required. During Phase 3, it may become necessary to provide additional training and support to natural leaders, volunteer community health promoters, community resource people, faith-based organizations, model households and associations. The more people in a village and in a kebele who are actively involved in promoting CLTSH, the more quickly, widely and new behaviors will be adopted. Furthermore, greater numbers means a greater chance that new behaviors will be maintained.

Specific training is mandatory for the leaders of health development army, natural leaders or WASHCOs in methods of community conversation, small group facilitation, family dialogue (mikikir) on simple techniques for constructing latrines and handwashing facilities, and household water treatment and safe storage.

STEP 1: TRAININGS AND CAPACITY BUILDING

i). Community level trainings for natural leaders and health development army heads

Health development army leaders and natural leaders need to be trained in community conversation (CC), family dialogue/mikikir techniques and appropriate hygiene and sanitation technologies in order to support CLTSH ignited villagers attain ODF status and sustained behavioral change in hygiene and sanitation.

Purpose

- To enable community volunteers & natural leaders to facilitate family level dialogue to address hygiene and sanitation behaviors
- To enable HDA/natural leaders to facilitate dialogue among villagers during regular participatory review meetings
- To enable community volunteers to support households in the construction of latrines, handwashing facilities, and safe water handling

Who leads?

- HEP supervisors
- WHO

Who supports?

- Health extension workers
- WASHCOs
- Kebele administrators
- Kebele managers

Participants

- HDA heads
- Natural leaders/ community volunteers
- WASHCOs
- Model Households

Methods

- Transect walk/sanitation mapping/storytelling (for problem identification)
- Resource mapping matrix (resource mapping)
- Community Action Plan (CAP) matrix (action plan)
- Negotiation/mikikir card (family dialogue)
- Media
- Political /high level officials

Processes and tasks

- Prepare the contents of the training.
- Select venue(s) for the training.
- Schedule the training.

- Invite participants.
- Conduct the training sessions.

Expected outputs

Natural leaders and community volunteers can:

- Facilitate community dialogues.
- Facilitate family dialogue.
- Follow CAP implementation at household level.
- Support villagers in adopting appropriate hygiene and sanitation technologies.

ii). School level trainings for school community members

School communities need to be trained in community conversation and dialogue methods to support CLTSH implementation in schools.

Purpose

- To enable school teachers to facilitate the dialogue among school community members during participatory review meetings in schools.

Who leads?

- Trained teachers
- Trained School WASH club

Who supports?

- Health extension workers
- Woreda Health & education Offices
- KETBs
- School cluster supervisors

Participants

- School teachers
- Students
- School WASH (hygiene and sanitation) clubs
- Parent-Teacher Associations

Methods

- Transect walk/social mapping/storytelling (for problem identification)
- Resource mapping
- School-Based monitoring and reporting

Processes and Tasks

- Prepare the contents of the training.

- Select venue(s) for the training.
- Schedule the training.
- Invite participants.
- Conduct the training sessions.

Expected outputs

Teachers and students can:

- Facilitate conversations among students in their respective schools to adopt healthy hygiene and sanitation behavior.
- Support households, families and villagers to adopt healthy hygiene and sanitation behavior.

STEP 2: SUPPORTING COMMUNITIES AND SCHOOLS TO CHANGE HYGIENE AND SANITATION PRACTICES

It has been shown in this guideline that much effort and resources are required to get communities to commit to ending open defecation and practicing consistent handwashing and latrine use. However, the most significant work begins after those commitments have been made. If newly adopted behaviors are to be maintained, communities and households must be supported to change age-old practices through encouragement, collective action, social pressure, and help with simple new technologies. The various methods of engaging communities mentioned above are essential to this process. These include community bylaws, community conversations, family dialogue and fostering partnerships.

i). Set and enforce community/school bylaws

After the Community/school Action Plan has been prepared, villagers /school community should come together (during the first post-ignition participatory review meeting) to develop and endorse bylaws to govern the implementation of their action plans. Implementation, monitoring and enforcement of bylaws is among the activities articulated in the action plan.

Purpose

- To ensure the implementation and follow-up of community/school action plans on hygiene and sanitation.

Who leads?

- HDA/natural leaders facilitated by HEWs
- WASHCOs
- School WASH club facilitated by lead teaches (in schools)

Who supports?

- Health extension workers
- Community groups (“iddir,” religious institutions/leaders)
- Kebele administrators
- PTA heads
- School cluster supervisors
- Kebele administrators and managers

Participants

- All villagers
- School community (teachers, students, PTAs etc.)

Methods

- Community conversation
- Mini media, small groups conversation etc.(in schools)

Processes and tasks

- Villagers/school community establishes bylaws at the first post-ignition participatory review meeting as decided during action plan preparation.
- Villagers school community discuss pertinent hygiene and sanitation issues, expecta tions and outcomes in their villages/school compound
- Villagers/ school community list and agree on governing rules and regulations to achieve and sustain their expectations and outcomes and enforce these rules

Expected outputs

- Villagers/school community endorses bylaws and enforces their implementation.

ii). Empower community for behavioral change

a) Conduct regular community conversation, review meetings and clean-up campaigns

Purpose

- To follow the progress in community action plans
- To foster dialogue on handwashing and water supply chain management
- To initiate community collective actions for a clean living and working environment

Who leads?

- Villagers/school communities, facilitated by HDA/natural leaders/teachers
- WASHOs
- Community health development army groups/school groups

Who supports?

- Health extension workers
- HEP supervisors
- Parent-Teacher Associations
- Cluster school supervisors
- Kebele administrators

Participants

- All members of the respective villages and schools

- Members of youth & women
- Members of and religious associations

Methods

- Community conversation
- Visits to households and former sites for OD
- Clean-up campaign

Processes and tasks

- Villagers/school groups attend regular meetings.
- Meeting participants discuss the progress made and challenges faced in the community action plans developed on ignition day
- Participants update the village sanitation map by undertaking visits and/or reports by HDA/natural leaders
- Discuss tasks for fostering new behaviors and prepare an action plan.
- Recognize villagers/school group members who excelled in fulfilling community action plans.

Expected outputs

- Review and evaluate previous community action plans
- Identify poor CLTSH achievers and those who are doing well; update village sanitation map
- Develop updated action plan.
- Begin sustained clean-up campaigns.

b) Conduct 'Coffee for Health' events with groups of families

Purpose

- To avail neighborhoods of a platform to discuss "doable" actions that households can do immediately to help create a clean living and working environment (not part of the com munity action plan but an additional strategy to help enforce household behavior)
- To initiate competition among neighborhoods
- To initiate dialogue by groups of women on hygiene and sanitation packages
- To initiate collective action by groups of women for a clean living and working environ ment

Who leads?

- Community volunteers/model households

Who support?

- Health extension workers
- Health development army leaders

Participants

- Groups of women in a neighborhood

Methods

- Community conversation

Processes and tasks

- Form a neighborhood women's group
- Group members attend regular meetings
- The group discusses the progress made and challenges faced in the previous CAP(s)

Participants

- CBOs, FBOs and PSOs

Methods

- Participatory partners' meeting
- Manuals featuring different facility options developed by FMOH/MOE and partners
- Training on entrepreneurship and production of hygiene and sanitation products
- Experience-sharing visits to ODF villages/kebeles

Processes and tasks

Participatory partners meeting

- Identify and invite relevant CBOs, FBOs and PSOs.
- Discuss the roles and responsibilities of these organizations in respect of the hygiene and sanitation status of their communities.
- Ensure their commitment to support the ongoing implementation of hygiene and sanitation packages in their communities.
- Organize-experience sharing visits.

Training for entrepreneurs (PSOs)

- Prepare trainings for PSOs in hygiene and sanitation technologies (sanitation market ing) technologies.
- Identify and invite relevant PSOs
- Organize experience-sharing visits

Expected outputs

- CBOs, FBOs and PSOs commit to promoting hygiene and sanitation in their communi ties.
- The availability of hygiene and sanitation products in local markets increases.

c) Facilitate institutional WASH in public facilities

Unhygienic public facilities are serious public health threats; clean and convenient institutional sanitation facilities are an important way of setting a standard and serving as a model for the National Hygiene and Sanitation Program as a whole. Public institutions include health centers/posts, clinics, government offices, churches, mosques, market places, prisons and others.

Purpose

- To improve sanitation and hygiene conditions in institutions
- To give institutional stakeholders the skills and knowledge to reach out to their com munities to support improved hygiene and sanitation practices

Who leads?

- Woreda WASH team
- HEP supervisors
- Cluster schools supervisors
- Religious institutions

Who supports?

- Relevant public/Civil society organizations (including Prison Administrations)
- Regional/Zonal WASH team
- Non-governmental partners

Participants

- Institution heads and staff

Methods

- Promote and enforce National/Regional guidelines, manuals and ptotocoles on institu tional WASH (e.g. School WASH management manual by FMOH/UNICEF)

Process and tasks

- Map and select institutions.
- Meet with principals, institutional heads and relevant management committees.
- Train institutional trainers of trainers (TOT) or focal persons (consider interested stakeholders such as NGOs and CSOs working on institutional WASH).
- Facilitate the integration of key hygiene and sanitation messages into institutional environmental health clubs (for example, school hygiene and sanitation (WASH) clubs,prison health clubs and the hygiene and sanitation committees of other organ izations). Support the building and maintenance of sanitation facilities and safe water management.
- Advocate for the use of institutional mandates or curricula to promote hygiene and sanitation.

Expected outputs

- All schools, health facilities and other institutions in a woreda have improved facilities actively being used by staff, patients, clients, guests, students, etc.

STEP 3: MONITORING EVALUATION AND REPORTING

The monitoring and evaluation component of CLTSH implementation encompasses all important supportive supervision, review meetings, reporting, evaluation and rewards carried out in the process of assessing the effectiveness of various tasks being performed at village, kebele and woreda levels. At this stage, standard monitoring, reporting and data management systems are put into use (see CLTSH monitoring framework manual).

Purpose

- To follow the progress of the implementation of hygiene and sanitation programs at all levels
- To identify challenges and respond with timely corrective actions
- To determine the effectiveness, efficiency and sustainability of implementation

Approaches

- To document and share best practices and reward better performance

Who leads?

Actors at all levels of the health sector

- F-MOH: Health Promotion and Disease Prevention General Directorate; Plan, Policy and Finance General Directorate
- Regional/zonal health bureaus: Health Promotion and Disease Prevention Core process
- Woreda Health Office: HEP coordinators, HEP supervisors
- Health posts: health extension workers
- Schools: school directors

Who supports?

- F-MOH: National WASH Coordination Office, Hygiene and Sanitation Task Force; partner government and non-governmental organizations
- Regional/zonal health bureaus: regional WASH Coordination Office, regional Hygiene and Sanitation Task Force, Partner government and non-governmental organizations
- Woreda Health Office: Woreda WASH team
- Health post: Natural leaders, HDA leaders, kebele administrators, kebele managers
- Schools: School WASH clubs

Participants

- Supervisory teams at all levels (see Verification and Certification Protocol manual)

Methods

- Supportive field visits (using monitoring templates)
- Regular reporting (reporting formats)
- Joint review meeting with all actors (leaders and supporters) mentioned above (meeting minutes
- Survey (structured and unstructured questionnaires)
- Database system (for woreda and above)

Processes and tasks

- Establish supervisory team.
- Review monitoring and evaluation instrument and make only necessary changes.
- Plan (schedule) and conduct routine monitoring and evaluation (use standard check lists and reporting formats provided in CLTSH monitoring and reporting template [see monitoring manual]).
- Analyze findings and compile reports.
- As per findings: a) Offer encouragement and recommend rewards for good perfor mance, b) Develop sound guidance for corrective actions.

Expected outputs

- Ascertain status of hygiene and sanitation program.
- Identify, document and share lessons learned at all levels.
- Ensure timely corrective action.

PHASE 4: VERIFICATION, RECOGINITION AND SCALE-UP

Implementing a CLTSH program demands standardized verification and certification systems for harmonized implementation by all actors rigorous monitoring and follow-up at all levels to attain the intended outcomes and impact. Doing so not only creates a foundation for reviewing progress but also allows for the rewarding of good performance. The national CLTSH program includes monitoring, reporting, (at this stage, the user is advised to use these manuals along with the implementation guideline).

STEP 1: VERIFICATION AND RECOGINITION

A major purpose of verification is to give communities an incentive to maintain and build on their improved sanitation and hygiene practices by rewarding achievements. To this end, the role of CLTSH committees at village, kebele and woreda level is instrumental. Following the CLTSH ignition, these committees document the observe changes through review meetings, periodic reports, observations and interviews and verify the community for ODF and subsequent behavioral changes in hygiene and sanitation.

Verification usually begins with an internal step followed by external endorsement. For instance, a village CLTSH coordination committee, having performed verification at village level, may then invite kebele level CLTSH verification. Similarly, the kebele CLTSH coordination committee may request woreda CLTSH verification and so on up the ladder to level national verification of regional achievements (See the National CLTSH verification protocol)

Purpose

- To promote standard tools for CLTSH verification and certification nationwide
- To promote standardized recognition and award system to motivate, empower and encourage communities and organizations toward successful implementation
- To promote use of participatory monitoring/verification methods in CLTSH

Who leads?

- Regional/zonal verification teams
- Woreda verification teams
- Kebele verification teams

Who supports?

- Health sector actors at regional, woreda and kebele levels

Participants

- Verification team members at respective levels
- Natural/HDA leaders in villages undergoing verification

Methods

- Joint visits using transect walk
- Review meetings
- Household visit and feedback meeting
- Key informant interviews (children and adults)

Processes and tasks

- Villages, kebeles and woredas declare their hygiene and sanitation status.
- Organize verification teams at kebele, woreda and regional levels.
- Kebele verification team verifies all villages in the kebele.
- Woreda verification team verifies certifies and awards all kebeles in the woreda.
- Zonal verification team verifies, certifies and awards all woredas in the region.
- Regional verification team verifies, certifies and awards all zones in the region.

Expected outputs

- Kebele verification teams verify all villages.
- Woreda verification teams verify, certify and award kebeles for their hygiene and sanita tion achievements.
- Regional/zonal verification teams verify, certify and award woredas for their hygiene and sanitation achievements.

STEP 2: SCALING UP APPROACHES AND PRACTICES

Successful promotion of sanitation and hygiene — including the broadening of access to key WASH products and services — requires the use of various media to disseminate consistent and

timely messages tailored to specific audiences. Among the possible vehicles for transmitting messages are village meetings, interpersonal contacts, churches and mosques. Mass media vehicles include billboards, TV, radio and text messaging. Experience sharing-visits, invitations to ODF celebrations, church, mosque and cultural gatherings are among the ways CLTSH can be scaled up from village to village and beyond.

Purpose

- To expand best practices and achievements in CLTSH across kebeles, woredas and regions/zones
- To reinforce individual, household and community commitments for behavior change
- To involve the media in the implementation of CLTSH

Who leads?

- Kebele, woreda and regional/zonal hygiene and sanitation task force
- FMOH ,regional health bureaus and woreda health offices
- Government and private communication actors

Who supports?

- Government and non-government partners
- WASH forum (platforms at national, regional and woreda level important for scaling-up through knowledge sharing, networking, lobbying and resource mobilization

Methods

- Traditional, print and electronic media
- Working with and through research centers
- Action plan development for scaling up at all levels

Processes and tasks

- Document the necessary practices and methods.
- Prepare appropriate and timely messages for dissemination through media agencies, religious institutions, traditional singers, youth groups, choruses, local business, etc.
- Disseminate messages on a regular basis.

Expected output

- Document and disseminate best practices across a wide or wider geographic area.
- Harness the potential of media and research institutions to help spread CLTSH mes sages.

Annex 1: CLTSH Implementation Modality at Grassroots LEVEL

PHASES	STEPS	MAIN TASKS	LEAD ROLE	SUPPORT ROLE
Phase 1: Preparation and planning	Woreda WASH planning	Develop/revise Woreda WASH plan to inncorporate CLTSH	Woreda administrator with WWT	WHO RWT/ZWT NGOs and other partners
	Advocacy /consensus building	Organize Whole system in a Room/advocacy workshops	WHO	ZHD/RHB NGOs and other partners
	Capacity /consensus (woreda & kebele)	Organize trainings	CLTSH facilitators	WHO/ZHD/RHB
	Kebele WASH/ODF Planning	Develop kebele WASH plan, budget and schedule	Kebele Admin	WOHs WASHCOs KETB(kebele Education and Training Board)
Phase 2: ignition	Preparation for ignition	Village/community selection Identity external CLTS facilitatore Set date & meeting place Invitation & mobilization	HEW kebele HDA	HEP supervisor WASHCOs WHO School committee (PTA & clubs
	Ignition	Facilitate community ignition Community ODF plan	External facilitators	HEWs HDA kebele Admin WASHCIs

Phase 3: post-ognition	**Supportive supervision Capacity building & Technical advise**	**Ensure follow through ODF plan Ensure toilets are safe and hygienic**	**HEP supervisor HDA WASHCO**	**WHO NGOs Schools leaders**
	Implement ODF plan **Enforece community/school bylaws for toilet construction and ending OD**	**Conduct regular CC, GD, FD with focus on toilet construction and use & hand washing**	**HDA Natural leaders** **School clubs**	**HEWs Agriculture Dev. army religious/ institutons leaders**
Phase 4: Verification, Recognition and scale up	**support communities and schools to change H&S behaviour School and institutional sanitation**	**Mobilization of Schools & instituitions** **Environmental clean-up campaigns**	**Institutions WASHCOs**	**School directors PTAs**
	Monitoring evaluation and reporting	**Track progress and report to HCs Conduct periodic program evaluation**	**HEW** **WHO**	**HDA** **ZHO/RHB**
	Verification & certification	**Ensure implementation is executed as per the Verfication protocol Organize schemes and**	**Village level HEWs HDA** **kebele level WHO**	**Kebele Admin WASHCO** **WWT NGOs**
	Recognition	**events for recognition of ODF status**		